Three methods of dealing with the condition have been advocated — namely, marsupialization, cholecysto-duodenostomy, and choledocho-duodenostomy. I tried each one in succession, the intervals being four and six weeks respectively.

The cyst was a large one, and was found to extend almost from the right margin of the liver to within an inch or two of the cardiac orifice of the stomach. It filled the kidney pouch on the right side and displaced the duodenum in a downward direction. The gall-bladder was normal in size and apparently healthy. An aspirating needle was inserted through the gastro-hepatic omentum and bile-stained fluid withdrawn. The cyst was thought at this time to be pancreatic in origin; a large rubber tube was introduced at the site of the needle puncture and the cyst marsupialized by suturing the edges to the abdominal incision. A biliary fistula was the result, and clay-coloured stools developed. After the first fortnight the fistula made several attempts to close, but on each occasion the patient complained of pain, her temperature rose to 100° to 101°, and the sinus opened again, with the discharge of a large quantity of bile. Up to this time the true nature of the condition was not suspected, although, of course, it was obvious that there was a connexion with the biliary tract.

It was thought that if the gall-bladder were short-circuited by an anastomosis with the intestinal tract, then the fistula might possibly cease to exist on the next occasion when it tried to close. Accordingly, the abdomen was reopened, the cyst was more fully investigated, and the condition was now seen to be a dilatation of the common bile duct itself. It commenced abruptly at the origin of the duct above, but did not involve the intramural portion below. The opening in the cyst was enlarged, and the orifices of the cystic and common hepatic ducts were seen. A probe was easily passed into each, but it could not be made to enter the duodenum. A cholecysto-duodenostomy was carried out, and the cyst again drained.

At the end of another six weeks the wound was still draining copious quantities of bile, and the fistula had shown no sign of closing. The abdomen was opened for the third time, and the anastomosis performed at the previous operation was found to be perfect. There now remained nothing to be done except to try to establish a communication between the dilated common duct and the duodenum. An incision was made in the anterior wall of the first part of the duodenum proximal to the site of the anastomosis with the gall-bladder, and an opening was made through the postero-superior aspect of the bowel directly into the cyst, and without opening up retroperitoneal tissue. A soft rubber tube 3/8 inch in diameter and 1½ inches long was inserted through this newly formed track, and sutured in position with catgut. The incision in the duodenum was closed in layers, and the cyst drained as before. The wound healed, the fistula was closed in about three weeks, and the patient was discharged feeling quite well.

AETIOLOGY

The aetiology of the condition is obscure. Intermittent obstruction, due to a kink, is discussed by Mr. Saint and rejected for the following reasons: (1) The dilatation affects the common duct only (as it did in this case). Taylor[1] states that "where a cyst exists the gall-bladder is as a rule dilated," but the gall-bladder was normal in this case. In the case of a stone in the common duct the gall-bladder is contracted, but this is due to a pre-existing cholecystitis and fibrosis, and, although the obstruction may be intermittent, the two conditions are not comparable. (2) With intermittent obstruction, attacks of jaundice would be a marked feature in the history. This patient could not remember ever having had jaundice. Although it was impossible at the second operation to pass a probe downwards into the duodenum, this could have been due to an inflammatory reaction blocking the duct, since at both the second and third operations the cyst was grossly infected, and the contents foul-smelling. The lower end of the duct must have been patent at the first operation, but unfortunately no attempt was made to demonstrate this.

A theory that the condition may be due to achalasia of Oddi's sphincter is not tenable, because (*a*) jaundice would again be prominent in the history, (*b*) the pancreatic duct would also be affected, (*c*) the whole biliary system would be involved in the dilatation, and (*d*) Fowler's case (quoted by Mr. Saint) rules out the possibility of such a theory. I agree with Mr. Saint that the congenital theory would appear to be the only one that will withstand the fitting together of all the facts, both in the history and in the clinical findings.

TREATMENT

In discussing treatment Mr. Saint says: "The anastomosis most commonly advocated is a choledocho-duodenostomy, but a cholecysto-gastrostomy appears to be equally efficacious." Taylor says: "It is possibly better to short-circuit the bile from its first distended reservoir, as it may be that a recurrent residual cholecystitis will arise later where the second distended reservoir, the cystic common duct, has been drained into the alimentary canal and the gall-bladder left alone."

I submit that the only treatment that can be depended upon is an anastomosis with the dilated common bile duct itself, and not with the gall-bladder. My justification for this statement lies in my experience of the operation of cholecysto-duodenostomy, which completely failed to effect a cure in this case.

REFERENCE

[1] Taylor: *Brit. Journ. of Surg.*, xvi, 327.

Memoranda

MEDICAL, SURGICAL, OBSTETRICAL

FOCAL SEPSIS A PREDISPOSING FACTOR IN MINERS' NYSTAGMUS

In a paper on miners' nystagmus (*British Medical Journal*. April 11th, 1931, p. 616) Dr. W. E. Cooke writes that when investigating the blood picture there is a definite increase in the percentage of monocytes, the average being 8.9 per cent. On a further examination of his figures and comparing them with the normal, the author observes there is also an increase in the percentage of lymphocytes and basophils. He states that there was evidence of toxaemia in each case to account for the abnormal polynuclear picture.

Focal sepsis undoubtedly plays an important part as a predisposing factor in the aetiology of the condition known as miners' nystagmus, and in the series of cases which came under my observation I have paid particular attention to the history of infection, whether present or past. The following case is of exceptional interest, in so far as it tends to substantiate what I have already stated, and may well account for the change in the blood picture discussed above. It is not my intention to deal with the further aetiological factors concerned, of which much has been written by other authors upon the subject. On the other hand, the white corpuscular count investigated by Cooke in patients suffering from miners' nystagmus opens up a new aspect of the subject of clinical importance.

The history of this case is unusual, because prior to an attack of osteo-periostitis, following a deep-seated furunculus of the right leg, about four inches below the buttock, the patient had never displayed any symptoms or physical signs of nystagmus.

The patient, a collier aged 39 years, states that he has worked underground for over 20 years without symptoms of eye trouble. Seven months ago he consulted me, complaining of what he described as a "blind boil" on the leg. The condition resembled a localized abscess, surrounded by a hard area of induration, situated about four inches below the right buttock.

No evidence of Pott's caries could be discovered, but a radiograph demonstrated a well-defined shadow about the region of the upper third of the femur. His Wassermann

reaction was negative. He was advised to rest, hot fomentations being applied three times daily, accompanied by constitutional treatment. The temperature remained normal throughout, the pulse rate being only slightly increased. Nothing abnormal was observed in the other systems. The abscess discharged slightly, but cleared up after about five weeks, leaving a little hard swelling, which was not tender on pressure.

Six months after returning to work, the patient again consulted me, this time complaining of eye trouble—namely, giddiness, photophobia, and dancing of lights. On examination he displayed well-marked physical signs of miners' nystagmus—namely, rotatory oscillations of eyes, conjunctival hyperaemia—his light minimum was increased, and on perimeter test there was marked diminution of the field for blue, green, and red.

On inquiry regarding his leg he stated that the old scar broke down and started to discharge slightly about two months after resuming work, but was not painful. He was strongly advised on this occasion to cease work, and submit himself for operation, and is at present awaiting admittance.

We may, in consequence, conclude that the prolonged suppuration resulting from the diseased bone must have considerably weakened the patient's system, predisposing in due course to the nystagmic symptoms of which he later complained. It will be interesting to note, after the sinus has been explored and a radical cure obtained, whether the eye symptoms will quickly improve, also whether the nystagmus will recur on resuming work underground.

F. O'SULLIVAN, M.B., B.Ch., B.A.O.

Cwm, Monmouthshire.

HYDRONEPHROTIC PELVIC KIDNEY

Cases of this condition are sufficiently rare to warrant publication.

CASE HISTORY

A collier, aged 32 years, was admitted into the Mountain Ash Hospital on February 20th, 1930, with the following history. In November, 1929, he had a severe attack of what appeared to be typical renal colic, the pain radiating from the left loin into the left thigh and testis. This incapacitated him for about a week. Several minor attacks followed, the last occurring just before admission. The attacks were accompanied by the usual gastric symptoms, but there were no changes in the urine. The man was subject to constipation.

On examination the left kidney could not be felt in its usual position, but an indefinite tumour could be palpated in the left pelvic area. Per rectum a fixed tumour could be felt, pushing the rectum to the right. Before opening the abdomen the diagnosis was not certain, the provisional diagnosis being either an ectopic kidney, or a carcinoma of the pelvic colon involving the ureter. An *x*-ray plate of the upper abdomen showed no evidence of stone, but unfortunately a plate of the pelvic area was not taken.

On February 22nd, 1930, the abdomen was opened by a left infra-umbilical paramedian incision. The right kidney was normal in size and position, the left being absent from the loin. The pelvic colon ran down over the front and right side of the pelvic tumour, and was apparently not connected with it. The peritoneum over the tumour having been incised, the latter was seen to be an ectopic hydronephrotic kidney, 4 by 3 by 3 inches in dimensions, and occupying about two-thirds of the pelvic cavity. The hilum looked upwards and to the left. The renal vessels joined the left common iliacs. The pelvis of the ureter was in front of the vessels, while the ureter ran down over the anterior surface of the kidney and was tightly stretched over it. The kidney was removed without difficulty, and the patient made a good recovery and has enjoyed excellent health since.

COMMENTARY

This case illustrates some important points.

1. Renal colic due to a diseased pelvic kidney closely resembles colic due to a normally placed one. In fact, this man was sent in as a case of left renal calculus.

2. An ectopic kidney may cause no trouble for many years (in this case thirty-two).

3. The gastro-intestinal symptoms, with the presence of a definite pelvic tumour, can easily lead to an error in diagnosis in the absence of typical renal colic or a routine pyelogram.

HOWEL B. PIERCE, M.B., B.Ch.

Cardiff. D. J. HARRIES, D.Sc., M.D., F.R.C.S.

Reports of Societies

THE DIAGNOSIS OF DISEASES OF THE HIP-JOINT

At the meeting of the Medical Society of London on March 21st, with Mr. HERBERT TILLEY, the president, in the chair, a paper was read by Dr. J. F. BRAILSFORD on the diagnosis of diseases of the hip-joint. The paper was illustrated by a very large number of lantern slides illustrating conditions seen on *x*-ray examination.

Dr. Brailsford said that his paper was based on a study during the past five years of patients sent for *x*-ray examination of the hip-joint to various hospitals and infant welfare centres in Birmingham and Warwickshire, and of patients in his own private practice. Save in the case of acute disease, the diagnosis of disease of the hip-joint was almost entirely dependent upon the *x*-ray picture, and even in acute diseases radiography might supply very useful additional evidence. A standard technique should be adopted for all radiographs of the hip-joint, otherwise faulty interpretation was almost bound to occur. The patient should lie on his back, with the lower limbs stretched out and the feet symmetrically inverted. The tube should be centred vertically over a point midway between the anterior superior spine and the symphysis pubis. Both hip-joints should be included on the one film, so that a comparison of density and uniformity of structure could be made. Radiographs permitted of the early recognition of congenital dislocation (which was much more common in the female, in whom the left hip-joint was most frequently affected), and showed that early treatment secured the best anatomical results. Severe trauma during reduction often resulted in a stunted development of the femoral epiphysis and neck. Changes similar to those seen in Perthes's disease of the femoral epiphysis were not uncommon after the trauma attending reduction or attempted reduction. It was not uncommon among children to find a fracture of the neck of the femur, and although this was relatively rare in early adult life, its incidence again increased with age. The fracture might not be detected in children until a coxa-vara deformity had developed, unless, of course, the child was radiographed at the time of the injury. About 50 per cent. of the fractures of the neck of the femur in adults and elderly people failed to unite. Dr. Brailsford was doubtful whether trauma was the cause of slipped epiphysis ; most of the patients with this condition gave no history of trauma, and the radiographic appearances did not support that theory. The epiphysis might be completely reduced, and the best result was a premature effusion of the epiphysis, with a resulting quarter-inch shortening of the limb ; often, however, the epiphysis underwent degenerative changes. Perthes's disease frequently showed more extensive bone changes in the radiograph than the clinical signs would suggest. It had an active phase, during which the bone was plastic and gave way to pressure, and permanent deformity might result. In early tuberculosis of the hip-joint, although the clinical signs might be prominent, the *x*-ray picture might not show any bone changes. On the other hand, a radiograph might show definite evidence of tuberculosis when clinical signs had not suggested the trouble. These apparent contraindications were due to variation in the site and spread of the

He possessed a good all-round knowledge of his profession, and was especially skilful and successful in maternity work. His frank, genial, and kindly nature endeared him to his patients, not only as their trusted medical adviser, but as their personal friend. His work under the National Health Insurance Acts and the Highlands and Islands Medical Service brought him into the homes of the sick poor, to whom he gave of his best in relieving their suffering and helping them in every possible way. There are many who will always cherish a kind memory of him. Dr. Kerr never took a holiday, and it may truly be said of him, "He scorned delights and lived laborious days." His personality and his well-known figure will be greatly missed in the capital of the Highlands. The funeral was attended by a large concourse of people who wished to show their esteem and regard for him.

The following well-known foreign medical men have recently died: Dr. HANS RHESE, extraordinary professor of oto-rhino-laryngology at Königsberg; Dr. A. Le DANTEC, professor of colonial medicine and tropical diseases at Bordeaux; Dr. FRANÇOIS ARNAUD, honorary professor at the Marseilles Faculty of Medicine; Dr. UGO SOLI, a Palermo pathologist, aged 51; Professor JULIUS HELLER, a Berlin dermatologist; Professor CHARMEIL, formerly dean of the medical faculty of Lille; Dr. HENRI GIRARD, formerly inspector-general of the health service of the French Navy; and Dr. EDWARD TYSON REICHERT, emeritus professor of physiology in the University of Pennsylvania.

Medical Notes in Parliament

[FROM OUR PARLIAMENTARY CORRESPONDENT]

Before Parliament adjourned for the Easter Recess the Royal Assent was given to the Veterinary Surgeons (Irish Free State Agreement) Act, the Destructive Imported Animals Act, and the Dangerous Drugs Act. In the House of Commons the Edinburgh Corporation Bill was read a third time, and a Sunday Performances Regulation Bill was introduced by the Government on March 24th.

Public Lotteries

In the House of Commons, on March 22nd, Sir W. DAVISON asked leave to introduce a Bill to authorize the raising of money by means of lotteries for charitable, scientific, and artistic purposes, or for any public improvement or other public object, under conditions approved by the Home Secretary. He said that when he introduced a Bill last year he confined its scope to the provision of funds for hospitals, on the same lines as the sweepstakes in the Irish Free State. In view of representations made to him, he had drawn the present Bill on somewhat wider and simpler lines, although British hospitals would still be within its scope, and could take advantage of it should they so desire. Clause 1 of the Bill provided that, notwithstanding anything to the contrary in any Act of Parliament or rule of law, it should be lawful for the governing body or trustees of any charity, and any trustees or body of persons appointed solely and mainly for the purpose of raising money for any scientific or artistic purposes, or for carrying out public improvements, to hold, with the approval of the Secretary of State, a lottery to raise money for such charity, purposes, or object. Clause 2 provided that no lottery should be held except in pursuance of a scheme sanctioned by the Secretary of State, and for the charity or object named in the scheme. Clause 3 set out certain conditions and regulations, but did not preclude the Secretary of State from making others if he thought fit. The Bill would not apply to Northern Ireland. If it was thought that the scheme of the Bill was too wide, or that it should be confined to hospitals, or that the number of lotteries in any one year should be fixed, that could easily be done in committee. From the Irish sweepstakes just concluded the hospitals received £841,000. Previously they had received over £2,000,000, and in all they had had practically £3,000,000. How much sickness and suffering in this country might have been saved if this money had been kept here? A recent visitor to Dublin, who saw the hospital drum there, stated that when he arrived at Euston on his return he saw in the street a medical student beating a drum, with a procession behind him, asking for alms for a London hospital. Which of the two methods was the more dignified? Another hospital appeal, issued recently, said that 1,000 patients were waiting for beds owing to lack of funds. Those funds could be provided by a lottery. Of the £3,000,000 received in Ireland, over £2,000,000 came from this country. No one imagined that if lotteries for hospitals were established in this country they would maintain the hospitals; the hospitals wanted millions a year. The lotteries would, however, provide funds for urgently needed equipment, and for beds.

Mr. HOPKIN MORRIS asked the House to reject the motion for the introduction of the Bill. He agreed that the betting law was in an anomalous position, and said that a far-reaching inquiry into the whole question was required. Every member would agree that the hospitals were worthy objects, but were they going to support them by questionable means? In London and the provinces last year the sum raised for voluntary hospitals by bequests, subscriptions, savings associations, and paying patients was between £13,000,000 and £14,000,000. That was in a year of acute depression. Of that sum, 50 or 60 per cent. came from voluntary contributions. What was the amount of sweepstakes which would be required to assure an income equivalent to that amount? He would take the figures of a very competent hospital accountant, who said that it would require three sweepstakes a year, each yielding £10,000,000, or in all, £30,000,000 a year. If they assumed—it was a great assumption—that there would be treble the number of subscribers to English sweepstakes there were now to the Irish, the yield would be £15,000,000, leaving a deficiency of £15,000,000. The testimony of the chairman of the Royal City of Dublin Hospital was to the effect that annual subscribers were withdrawing their gifts on the ground that they are no longer needed; that paying patients, generally working-class men and women, were objecting to paying anything for their treatment and keep; that business firms whose employees used to pay a penny or twopence a week to the hospital now refuse to pay anything, and that the loss on this source was 50 per cent.; and that people were not now leaving bequests. That reduction had already taken place, and there was no comparison between the position of the hospitals in this country and those in Ireland. The Irish sweepstakes was a success from the Irish point of view, because Ireland was a small country, and they were drawing English money; but if the hospitals of this country relied on the same position the amount of Irish money which they would draw would be negligible. That was why the governor of Charing Cross Hospital, last May, stated: "Speaking for myself and this hospital, we will have neither part nor lot in any such schemes, and our reasons are not simply moral ones, though they weigh very considerably. Looking at it from a business standpoint, we believe that the gains would be outweighed by the losses." This was the testimony of hospitals, the very institutions which the lottery was intended to support. This was clearly a case where there should be an inquiry first.

Leave to bring in the Bill was given by 176 votes to 123, and the Bill was read a first time.

Silicosis

On March 21st Sir H. SAMUEL told Mr. Neil MacLean that much had been and was being done to get plant installed by employers to prevent silicosis. Regulations to prevent silicosis had been made under the Factory and Workshop Act, 1901, for a number of industries, including the manufacture of silica bricks, cutlery, and edge tools, and the grinding of metals and cleaning of castings. A supplementary code of regulations for the pottery industry had recently been agreed with the industry, and would be brought into force very shortly. All these regulations included requirements involving the installation of plant to prevent inhalation of dust. Further, it was the general practice of the inspectors under Section 74 of the Act to require the provision of exhaust ventilation in any case where the workers were exposed to that risk. The

Hall, I.M.D., and was educated at Edinburgh, where he graduated M.B. and C.M. in 1886. Entering the I.M.S. as surgeon on September 30th, 1886, he reached the rank of lieutenant-colonel after twenty years' service, and retired on May 20th, 1920. Almost all his service was spent in civil employ in Bengal and Assam, where he held for many years the important civil surgeoncy of Dakka, which was the capital of the short-lived province of Eastern Bengal.

Lieut.-Colonel George Maurice Hoblyn Colman, R.A.M.C. (ret.), died suddenly at Victoria, British Columbia, on January 30th, aged 76. He was born at Nassau, in the Bahamas, on January 5th, 1856, and was educated at Cambridge, where he graduated B.A. in 1877, and M.A. and M.B. in 1882, and at St. Thomas's, taking the M.R.C.S. and L.S.A. in 1881. Entering the Army as surgeon on February 3rd, 1883, he became surgeon major after twelve years' service, and retired with a gratuity on August 21st, 1895. During the South African war he was re-employed at Chester, for which he was promoted to lieutenant-colonel on October 18th, 1902.

Universities and Colleges

UNIVERSITY OF LEEDS

The following candidates have been approved at the examinations indicated:

M.D.—Mildred I. Ealing.

CH.M.—A. B. Pain.

FINAL M.B., CH.B.—*Part I*: F. Badrock, G. W. Blomfield, Kathleen S. Bruce, F. L. Cane, Y. Carasik, C. D. Clark, O. E. Fisher, J. Gibson, L. Goldwater, S. I. Leshinsky, Vida L. Liddell, E. Lodge, K. O. Milner, J. T. Rhodes, R. T. Rushton, W. Sharp, D. Thackray, W. H. Tod, N. Wood, W. Zemsky. *Part II*: H. Agar, Doris B. Brown, E. Gledhill, Gwendolen Harrison, H. Hart, F. R. W. Hemsley, Ruth Hooton, A. G. James, E. A. James, F. C. Leach, I. Macpherson, J. Q. Mountain, I. Rosenberg, L. W. Russell, M. Shankhla. *Part III*: E. Gledhill (first-class honours), Doris B. Brown (second-class honours), H. Agar, Gwendolen Harrison, H. Hart, Ruth Hooton, A. G. James, I. Macpherson, J. Q. Mountain, I. Rosenberg, L. W. Russell, C. K. Shain, M. Shankhla.

D.P.H.—J. F. Galpine.

D.P.M.—F. E. Kingston.

The following scholarships and prizes have been awarded: Infirmary Scholarship and Littlewood Prize, J. C. Coates; Scattergood and Edward Ward Memorial Prizes, E. Gledhill; Hardwick and McGill Prizes, Doris B. Brown.

UNIVERSITY OF LIVERPOOL

The following candidates have been approved at the examinations indicated:

DIPLOMA IN PUBLIC HEALTH (*Part I*): F. J. H. Crawford, Rita Henry, E. D. Irvine, G. W. Paton, M. Solomon, Honora J. Twomey.

DIPLOMA IN MEDICAL RADIOLOGY AND ELECTROLOGY.—J. P. Grieve, W. Griffiths, R. B. Guyer, P. T. K. Nayar, E. L. Rubin, J. S. Tomb, Sylvia Wigoder.

DIPLOMA IN TROPICAL MEDICINE.—B. N. Bhandari, P. Dass, J. A. Doherty, R. L. Portway.

DIPLOMA IN TROPICAL HYGIENE.—G. P. F. Bowers, A. Cathcart, T. K. Kurivila, I. C. Middleton, H. J. H. Spreadbury.

UNIVERSITY OF DUBLIN

The following degrees and licences were conferred on March 16th:

M.D.—R. S. F. Hennessey, H. S. Roseman, A. H. Thompson (*stip. cond.*), A. G. Thompson (*stip. cond.*).

M.B., B.CH., B.A.O.—D. B. Bradshaw, Kathleen R. Byrne, H. S. Mason, E. Morrison, A. J. O'Connor, T. J. O'Sullivan, P. H. Peacock, E. S. Samuels, M. A. Shapiro.

LICENCE IN MEDICINE, SURGERY, AND OBSTETRICS.—H. J. Garland.

NATIONAL UNIVERSITY OF IRELAND

UNIVERSITY COLLEGE, DUBLIN

The following candidates have been approved at the examinations indicated:

THIRD M.B.—*Part I* (exempted from further examination in Part I—Pathology and Materia Medica): N. B. Higgins, †A. D. McDwyer, W. J. G. Murphy. *Part II*: †G. Bialkin, P. A. Byrne, D. Coffey, C. Gray, J. F. Hanly, †D. J. Lawless, Mary C. J. McCann, P. McMahon, G. G. McNamee, J. J. O'Byrne, T. J. O'Donnell, Teresa A. O'Donnell, P. J. O'Flynn, J. C. Smyth, *J. F. Sullivan.

D.P.H.—(*Part I*): P. J. Aird, †M. F. Daly (old regulations), E. F. Drumm, F. N. Elcock, †J. I. Heany, *J. J. Keane, T. Langan, *D. F. Macdonald (old regulations), G. T. O'Brien, *M. C. H. Purcell.

* First-class honours. † Second-class honours.

Medical News

The annual dinner of the Cambridge Graduates' Medical Club will be held at the Hotel Splendide, Piccadilly, W., on Thursday, April 14th, at 7.30 p.m., with the president, Sir Humphry Rolleston, Bt., in the chair. The honorary secretaries are Dr. F. G. Chandler and Mr. W. D. Doherty.

The School of Malariology of Rome, directed by Professor G. Bastianelli, is holding the usual two courses this year, the first, on the technico-economic aspects, from March 30th to May 12th, and the second, on the medical aspects of malaria, from July 14th to September 30th. The fee is 100 lire. Further information can be obtained from the secretary, Policlinico Umberto 1, Rome.

The International Office of Documentation in Military Medicine has organized a series of lectures, to be delivered in French at Liége from June 23rd to 25th, by French, Belgian, Dutch, Jugoslav, Spanish, and Mexican authorities.

The forty-seventh Congress of the Balneological Society of Berlin will be held at Bad Salzuflen (Lippe) from April 6th to 10th, under the presidency of Ministerialdirektor Professor Dietrich. The chief subject for discussion will be the importance of carbonic acid in the spa treatment of heart disease. The general secretary is Dr. Max Hirsch, Steglitzerstr. 66, Berlin, W.35.

The tenth Congress of the German Society for Urology, which was to have been held this month, has been postponed until next year.

The annual congress known as the Journées Médicales de Bruxelles will be held in Brussels from June 25th to 28th, under the presidency of Professor Fernand Héger, member of the Belgian Royal Academy of Medicine. The opening address will be given by Dr. Étienne Burnet, the French delegate on the Health Committee of the League of Nations. The other speakers will include Dr. Michaud, professor of clinical medicine at Lausanne, Dr. Marion, the Paris urologist, Professor Marañon of Madrid, Dr. Rohmer, professor of paediatrics at Strasbourg, Dr. L. Carozzi, Italian delegate of the International Labour Office at Geneva, and Dr. Waterman of the Dutch Institute for the Study of Cancer.

An international congress on asthma will be held at Mont-Dore on June 4th and 5th, under the presidency of Professor Fernand Bezançon. The subjects to be discussed include the anaphylactic, nervous, nasal, and endocrine, aetiological, and determining factors in this disease, the different forms of treatment, and the causes, symptoms, and therapy of infantile asthma. Further information may be obtained from the congress secretary, at 19, Rue Auber, Paris IX.

The second International Congress of Tropical Medicine, which was to have been held in Amsterdam next September, has been postponed until financial conditions are more favourable.

During the past year the number of patients attending the London Light and Electrical Clinic in Ranelagh Road, Pimlico, was 120,000, of whom nearly 8,000 were treated free of cost, and the total treatments given were 67,000 in excess of the previous year. Sir Leonard Hill was appointed general supervisor, in addition to his duties as honorary research director. Besides a medical officer for each department, three visiting physicians were appointed for purposes of diagnosis and advice as to treatment. A bacteriological laboratory has been installed, where cases are investigated for infection of the nose, tonsils, lungs, large bowel, etc., and autogenous vaccines made and injections of these given. This new department, while essential for diagnosis and treatment, adds to the running cost of the clinic some two or three hundred pounds a year over and above the fees it earns from patients. The private clinic was closed for two months, but has now been re-equipped, and gives treatment to patients on the recommendation of their own doctors.

At a meeting of the Osler Club held in London on March 24th, Sir Robert Philip gave an address on "Koch's discovery of the tubercle bacillus: some of its implications and results." Dr. W. G. Willoughby, President of the British Medical Association, proposed, and Dr. William Stobie, Mayor of Oxford, seconded, a vote of thanks to the lecturer. An interesting discussion followed, in which there took part Dr. A. S. MacNalty, Dr. R. A. Young, Sir Henry Gauvain, Professor Leonard Findlay, Dr. George Hurrell, and Dr. A. P. Cawadias.

The February issue of *Archiv für Kinderheilkunde* is dedicated as a Festschrift to Professor Rudolf Fischl of Prague on the occasion of his seventieth birthday.

The first two fasciculi of vol. vii of *Acta Psychiatrica et Neurologica* form a Festschrift for Professor August Wimmer of Copenhagen on the occasion of his sixtieth birthday.

A brass tablet was unveiled, and a new sterilizing room opened, at the Louth District Hospital, on March 10th, to the memory of Dr. W. R. Higgins, who died in August, 1930, after twenty-four years' service as medical officer to the institution. The need of a sterilizing room had long been felt; its provision has realized a frequently expressed wish of Dr. Higgins, who took a warm personal interest in improving the surgical facilities at the hospital.

The National Institute for the Deaf is prepared, provided sufficient numbers are forthcoming, to arrange short courses of training in the teaching of lip-reading. The proposed courses will not qualify for teaching deaf and dumb, or for service under the Board of Education. Persons desirous of training as teachers of this subject for professional or voluntary service should communicate with the secretary of the Institute, 2, Bloomsbury Street, W.C.1.

Letters, Notes, and Answers

All communications in regard to editorial business should be addressed to The EDITOR, British Medical Journal, British Medical Association House, Tavistock Square, W.C.1.

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QUERIES AND ANSWERS

An Acid Water Supply

"LATEX" writes: The water supply of my house in the country is from surface springs, issuing from disintegrated and fissured granite rocks. It is collected in masonry tanks and thence pumped to the house. On analysis it is a strongly acid water, and attacks lead, copper, or galvanized iron pipes. Can anyone advise me how best to deal with such a water, or tell me where I can get the required information? I am told that glass or enamel-lined pipes are available, but expensive, and one of the best local plumbers informs me also that the lining is apt to get damaged, either at the joints during fixing, or from accidental knocks afterwards, and that this leads to further exfoliation of the lining subsequently.

Income Tax

Car used for Private Purposes

"A. M. L." uses his car both for professional and for private purposes. He states that some years ago it was mentioned in the *Journal* that "doctors would be permitted to use their cars for other than professional purposes," and asks if there is any change.

*** So far as we are aware there has been no change in the law or practice on this matter. The Income Tax Act, 1918, provides that no disbursements not wholely and exclusively laid out for the purposes of the . . . profession . . . shall be deducted." It might be argued that the maintenance of a car partly used privately is not "exclusively" for professional purposes, and therefore that partial private use negatives the right to claim that cost of such maintenance can be the subject of a claim. That contention is not put forward by the authorities, and therefore private use of the professional car is permissible, and the answer referred to by "A. M. L." (which we have been unable to identify) may have related to that question. But when the car is used for both purposes the total cost must be allocated *pro rata* between them, and only the portion relating to professional use is a proper deduction for income tax purposes.

Change in Proprietorship

"R. T." explains that A and B were in partnership up to December 31st, 1931, as from which date B took over the whole practice. How should B be assessed for 1932?

*** (*a*) As regards the period from January 1st to April 5th, 1932, B will be responsible for the tax on the whole (and not on his share only) of the appropriate proportion of the existing assessment for 1931–32. (This involves a recalculation of the tax payable by each partner on that assessment, and no doubt the inspector of taxes will supply the figures if requested.) For the year 1932–33—that is, ending April 5th, 1933—B will be liable on an assessment the measure of which will be the amount of profits of the practice for 1931. (*b*) If, however, A and B both request the inspector of taxes *in writing* the practice can be treated as having ceased and recommenced. In that case A and B will be assessable for the period April 5th, 1930, to December 31st, 1931, on the basis of their earnings for that actual period, and B will be assessable to April 5th, 1933, on the earnings for that period. That election would, however, probably involve discarding the cash basis for computing the amount of the profits It will be seen that the car renewal allowance to be made in calculating the 1931 profits would under (*a*) affect the liability for the year 1932–33, and under (*b*) the year 1931–32.

LETTERS, NOTES, ETC.

Vacancies and Courtesies

"MEDICAL SUPERINTENDENT" writes in reply to "M.B., B.S." (March 19th, p. 550): The suggested lack of courtesy was in effect merely routine. In many instances the selection committee is a subcommittee of a committee of a large body, and, whilst the action of the subcommittee is often endorsed, legally it is not effective until such endorsement has been made by the council or other governing body. Hence legally the notice of appointment and the replies to would-be candidates are often very much delayed, so much so that the successful candidate may actually have commenced duty before his appointment is in legal form. "M.B., B.S.'s" complaint is reasonable, but apparently, from the town clerk's point of view, not remediable. It could be alleviated undoubtedly if it were not for those young conscienceless practitioners who, having accepted an appointment, in ten days or a fortnight change their minds, and write declining to enter upon the duties. In such cases it frequently happens that from the original list of applications another selection and a fresh appointment is made. Obviously, therefore, notes of regret cannot be issued until the appointment is definite. "M.B., B.S." expects courtesy from an official body, but does such official body always receive courtesy from professional gentlemen? How about the recently qualified man who, being a selected candidate for an appointment, does not appear at the meeting, and does not even take the trouble to send a postcard stating that he will not be able to be present? This is a particularly common experience with regard to candidates from one of the large universities