at all, and all had recovered with simple drainage of the abscess. In two of the cases he removed some tiny flakes of bone three or four months later. Before chemotherapy extensive operations would have been done, in his experience disappointing and mutilating.

Mr. F. C. W. CAPPS referred to the dangers of chemotherapy when used without adequate clinical observation. He had tried to impress on practitioners that the subsidence of symptoms was not sufficient, and that until the drum-head was seen to return to its clinical normal the case must not be regarded as cured. If the drum was still bulging and reddened, even though symptoms had subsided, there was need for resort to paracentesis.

Mr. R. G. MACBETH asked if the sulphonamides were of any prophylactic use in tonsil excision and laryngeal operations.

Colonel WHITBY, on this last question, considered that a reasonable prophylactic course occupying two or three days was justifiable. The risk was very small, and the course could always be expanded to full treatment if required. If he had any reason to anticipate septicaemia he would employ these drugs prophylactically. As to the danger of prolonged courses of minimal doses, there were certain people who were sensitive to these drugs and unable to tolerate more than a gramme or two without exhibiting skin rashes or granulocytopenia or even agranulocytosis. Ordinarily the course was of seven to ten days and the total amount between 50 and 60 grammes. Intolerance was a question not so much of the amount as of the time. People became sensitized when even minimal amounts were given for prolonged periods. With a course of 50 grammes occuying ten days there was less likely to be trouble than with the same total amount spread over a month. As to antibody production in patients treated with chemotherapeutic drugs, there appeared from experiments on mice to be a certain, though not very durable, resistance to pneumococcal infection but not to streptococcal. There was something to be said for active immunization with vaccines, though against the streptococcus this was extremely transient.

The annual meeting of the Cardiac Society of Great Britain and Ireland was held at Oxford on April 18 under the chairmanship of Dr. A. G. Gibson. Dr. J. B. Herrick (Chicago) and Dr. Frank N. Wilson (Ann Arbor) were elected honorary members, in addition to Dr. Paul White (Boston), elected in 1938. Accommodation was kindly provided at Merton College, where books and records of William Harvey were on view. At the morning session there was a debate on the early signs of cardiovascular disease. In the afternoon the treatment of coronary thrombosis was discussed. Original communications, as arranged by the honorary secretary, Dr. Maurice Campbell, included papers on the right pectoral electrocardiogram in auricular fibrillation, the collateral circulation in coarctation of the aorta, the haemic factor in angina pectoris, the electrocardiogram of the Stokes-Adams attack, and a criticism of the term "chronic myocarditis."

The Ministry of Food announces that while the sale of milk to consumers is reduced to six-sevenths of the quantity sold during the first week in March, members of the National Milk Scheme, children receiving milk in schools, and inmates of hospitals, maternity homes, and nursing homes will continue to receive their full requirements. In addition, on the advice of the Special Diets Committee of the Medical Research Council, persons suffering from active tuberculosis, silicosis, affections of the mouth, throat, or gullet which prevent swallowing, gastric, duodenal, or anastomotic ulcer, illnesses characterized by high fever, and post-operative conditions may obtain a daily supply of milk up to a maximum of two pints on production of a medical certificate. This certificate is to be given on a form obtainable from the local Food Offices of the Ministry, which will ordinarily be supplied only on the request of a medical man. Criticisms of the procedure have appeared in our *Supplement*, and the British Medical Association is making representations to the Ministry of Food.

Local News

INDIA

Health of the Army in India

The annual report for 1939 on the health of the Army in India gives a satisfactory account of the British and Indian troops during the year which saw the outbreak of war in Europe. There were no serious epidemics, although civilian areas amidst which troops were placed suffered extensively from cholera, plague, small-pox, dysentery, malaria, and enteric fevers. Among British troops the hospital admission rate of 666 per 1,000 of strength during the year seems very large, and, indeed, it was an increase on the rate for the year before, but the death rate of 2.75 per 1,000 and the invaliding rate of 9.14 per 1,000 were lower, and all these rates during the last quinquennial period continue to show the fall which has been progressive since the last war. Among the Indian troops, though the death rate was down, the hospital admission and the invaliding rates were up, but it is stated that the increases can be fully accounted for by the conditions of war service, and the return or influx of large numbers of men potentially infected with malaria and other prevalent diseases. Malaria and dysentery—the percentage figures are exactly equal—share the top place in the list of principal causes of sickness among officers of the British Army in India, and these are followed by catarrhal jaundice and cellulitis. Among the soldiers malaria has first place, followed by cellulitis, and—a good way down—tonsillitis, but dysentery comes sixth, and is only half as frequent as a cause of admission as malaria. Malaria, sandfly fever, and dengue between them are responsible for just over 90 per 1,000 admissions. Before the last war and for a year or two afterwards the malaria admission rates among British troops were considerably higher than among Indian, but during the last ten years the Indian rate has been very much higher than the British, and in 1939, while the admission rate for British troops was 58.1 per 1,000, for Indian troops it was 118.3. It is a different story with the dysentery-diarrhoea group. Before the last war the admission rates were higher among Indian than among British troops, but since 1919 they have been considerably lower, and in 1939 the admission rate for Indian troops was only half the figure for British, and the British figure was the highest for twenty years. Comments from commands and districts indicate that the prevalence of dysenteric infection is due to the lack of sanitation surrounding the troop areas. The seasonal incidence of these diseases appears to be different among the British and among the Indian troops: last year for the former the peak month was August and for the latter May. Respiratory diseases have been little in evidence, and there have been no epidemics other than minor outbreaks of mild influenza and pharyngitis. Nor is there any sign among the military populations of the steady increase in tuberculosis which appears to be occurring in the civilian population. Seventy pages of the report are occupied by contributions on the preventive and curative work carried out by the military medical services. A detailed account of the pathological work undertaken seems specially useful.

Public Health in Burma

The outstanding figure in the vital statistics given in the report for 1939 on the state of public health in Burma is the infant mortality rate (203.85 per 1,000 births), which is higher than in any of the Indian provinces except the Central Provinces, and three and a half times higher than in England and Wales. One explanation is that infant mortality in Burma is primarily due to malnutrition. Owing to Burmese customs and prejudices most mothers, even of the middle class who could afford a better diet, try to starve themselves during pregnancy, believing that if they live strictly on a rice diet with some dried fish they will escape the ailments from which people who take plenty of fresh and rich foods may be expected to suffer. The major epidemics in Burma are cholera, plague, and small-pox. A good deal of systematic anti-cholera work seems to be undertaken, including the purification of water supplies, control of the sale of food and drink, and

protection by means of inoculations, nearly a quarter of a million of which were performed during 1939. The most important measures against plague are those which deal with the administration of the bazaars, the storing of grain, and the enforcement of building by-laws. The number of deaths from small-pox (125) is the lowest ever recorded. The law of the country gives district councils and municipal committees power to frame rules for compulsory vaccination, and out of 105 of these local bodies ninety-three have done so. Malaria is one of the most widely prevalent diseases of the country, but its incidence cannot be exactly gauged because the registration of deaths is carried out by village headmen, who are apt to include all fatal cases of malaria as "fevers." Not only are malarious areas being reclaimed, but other measures are being undertaken, including the introduction of larvivorous fish into ponds and wells. Prof. Lyle Cummins recently visited Burma to study measures necessary to control tuberculosis. He found the incidence very low except in Rangoon. As a result of his report the Burma Tuberculosis and Leprosy Relief Association has offered Rs. 2½ lakhs (say, £18,000) to the Government towards a tuberculosis hospital in or near the capital.

ENGLAND AND WALES

London Hospital in Essex

The London Hospital, following the example of Guy's and St. Thomas's, has opened a country branch. During the last week of April an annex in Essex was taken over for the accommodation of, to begin with, 130 "London" patients, the number eventually to be 360. Sufficient staff and equipment have been provided to furnish in the country environment all the services of the mother hospital. There are four resident doctors at present, two registrars, and seventy-five nurses, but the number of nurses will eventually be increased to 180. A nurses' home is being built, and is expected to be completed in about ten weeks' time. The services of the consultants attached to "The London" will similarly be available for the Essex patients. The annex consists of twelve brick and steel huts, linked by canopied concrete paths which afford protection against the worst weather conditions. A modern operating theatre and other facilities have been put in, as well as adequate kitchens. Should the building in Whitechapel be rendered untenable by enemy action—it has already had bombs and incendiaries—the Essex institution will become the headquarters, but in the meantime the whole administration will be carried on from "The London," on the spot where the hospital has carried out its work for two hundred years. There are 350 beds in Whitechapel, and with the 360 to be presently available in Essex "The London" still claims to be England's largest voluntary hospital.

The Hospital Almoner in Wartime

The war has revolutionized the setting of the almoner's work and created a new demand for it. In a large voluntary hospital she may now find herself serving not a local district but a region. Patients from a London hospital may be distributed over a wide area of the Home Counties. One county council has appointed a travelling almoner to work in several hospitals under the E.M.S. scheme. The bombing of London and other cities has created a need for just such social service as the almoner can render. Her work has extended beyond voluntary hospitals to municipal and county; it also seems to be developing in connexion with the needs of old people evacuated to public assistance institutions. Hospitals which at the beginning of the war closed or restricted their almoners' departments have found it necessary to reinstate the almoner and extend her work. In 1939 there were fifty almoners out of work, now there are practically none. Last year seventy-five students received the certificate of the Institute of Hospital Almoners, and at the close of the year there were about 100 women in various stages towards qualification. During the first ten weeks of this year twenty-one new posts were notified, as against thirty-one during the entire year 1940. The impetus to the movement was given by the Minister of Health when at the end of last year he strongly recommended all hospital authorities in the E.M.S. to employ almoners, and intimated that part of the expense of establishing new almoners' departments might be met by Government grant. Although the work has extended from one department to another there are still one or two fields—notably venereal diseases clinics—where there is reluctance to develop almoner's work. The Countess of Limerick, speaking at the annual meeting of the institute the other day, said that the registration of women was creating some misgiving among those responsible for the training of almoners, and she felt that it was of the utmost importance that there should be a steady flow of well-educated girls for training for this important work. In view of the Ministry's encouragement to hospitals to employ almoners, it is very unlikely that suitable girls who seek this profession will be prevented from doing so by demands to do other national work.

Correspondence

Chemotherapy in Acute Otitis Media

SIR,—I have been deeply interested in two recent publications in the *Journal* on chemotherapy in acute otitis media, the first by Dr. J. B. Jessiman (March 15, p. 399) and the second by my old chief, Mr. Lionel Colledge (March 22, p. 455).

Dr. Jessiman records a series of cases of acute otitis media (all in children) which responded well to chemotherapy, though not without anxiety in some instances. I have felt reticent in expressing enthusiasm for this form of treatment, and the reason is perhaps not far to seek. I do not see so many cases of acute otitis media nowadays in their initial stages, as they are treated by my colleagues in general practice by chemotherapeutic means with marked success. But the ones I do see are those which for some reason or another have either failed to respond to the drug or are left "sitting on the fence." By this I mean that complete resolution has not occurred, yet the usual clinical picture of otitis media is scarcely recognizable. In these cases the residual affection seems to vary: in one it may be persistence of pain; in another, persistence of temperature (often without a corresponding rise of pulse rate). Where the drum has ruptured spontaneously or has been incised there may be persistence of discharge and deafness. The appearance of the patient is striking: he looks as "sick" as he feels, and following the usual clinical picture of toxic absorption he looks and feels worse when the discharge is scanty, but often with only a mild pyrexia or even none at all. Even our old friend the state of the tongue is a less reliable guide as to the need for surgical intervention.

The conduct of a case of acute otitis media after chemotherapy had apparently failed is not always as straightforward as might be expected, even though it might reasonably be assumed that half the battle had already been won. Two recent cases may be quoted.

A middle-aged man failed to respond satisfactorily to sulphapyridine after an attack of acute otitis media. A paracentesis was performed and the culture grew haemolytic streptococci. Discharge after paracentesis was scanty. There was little indication for intervention except persistent deafness and pain at night only, which was sufficient to keep him awake. I drained a mastoid full of pus, after which the whole condition cleared up rapidly.

The second case was in a man of about 30 years who was successfully treated with sulphapyridine for an attack of acute otitis media, and in spite of spontaneous rupture of the drum and discharge he had a dry ear in five days. After a week it flared up again, and when I saw him four days later he looked fairly well, but spoke like a man with a quinsy, due to a generalized oedema of his pharynx. His temperature was swinging up to 104° F., but his pulse was slow in comparison. He had a central perforation in the drum, through which was coming a copious flow of pus. He had no mastoid tenderness. His tongue was fairly clean but he felt shivery. At operation his mastoid was found to be full of pus, which welled up from the region of the tip

It is obviously desirable that the court trying a personal injury action—or any other—should have the best evidence obtainable. It is not desirable that medical men should feel compelled to reach an agreement against their true judgment. Their Lordships' remarks applied, of course, to a case where there was no agreement. When an agreed statement is before the court the judge would doubtless be satisfied if one medical man were present to clear up any uncertainties that might arise.

FALSE DECLARATION IN WORKMEN'S COMPENSATION

A workman was incapacitated by nystagmus, and when examined by a surgeon on behalf of the employers he disclosed that he had previously suffered from the disease. The surgeon made a note to this effect in his report, and the employers began to pay compensation at the full rate of 30s. a week, although when he had first been employed by the firm in 1928 he had signed a declaration that he had never had nystagmus. He signed another similar declaration in 1933. In fact, as he admitted at the hearing, he had suffered from nystagmus at various times, had been incapacitated for various periods lasting over seven years, and had been medically certified five times as suffering from it. Section 43 (i) (*b*) of the Workmen's Compensation Act, 1925, lays down that if it is proved that the workman has at the time of entering the employment wilfully and falsely represented himself in writing as not having previously suffered from the disease, compensation shall not be payable. The county court judge found as a fact that his false declarations had been wilfully made. Nevertheless, he held that the payment and receipt of compensation constituted a "binding and concluded agreement" under the Act whereby all questions of liability between the parties were settled. The firm appealed,[1] but the Court of Appeal upheld the judge's award. There is, by Section 21, no difference in effect between an agreement and an award of a county court judge, and if an award or an agreement is recorded and registered in the county court they have precisely the same validity. An unrecorded agreement (such as this) is just as effective as an unrecorded award, and precludes both parties from raising anew any question which would have been relevant when it was negotiated.

[1] Pease and Partners, Ltd., *v.* Birch (1941). 1 All E.R. 343.

The Services

MENTIONS IN DISPATCHES

Lieut.-Colonel A. H. Whyte, D.S.O., Lieut. (Temporary Major) P. H. Newman, D.S.O., and Lieut. J. M. Muir, D.S.O., R.A.M.C., have been mentioned in dispatches for distinguished services in the field.

EFFICIENCY DECORATION, TERRITORIAL ARMY

The Efficiency Decoration of the Territorial Army has been conferred on Colonel F. R. Sandford, M.C., and Lieut.-Colonel A. Swindale, R.A.M.C., T.A.

CASUALTIES IN THE MEDICAL SERVICES

ROYAL ARMY MEDICAL CORPS

Captain ALFRED ANTHONY FERRO died of wounds on March 19. He was born in Malta in 1914 and was educated at the Royal University of Malta, graduating M.D. in 1937. He joined the R.A.M.C. soon afterwards, and was promoted captain in May, 1939.

Captain WILLIAM BRADFORD FOSTER died in Middlesex Hospital on April 15. He was born at San Francisco in 1913, the eldest son of Mr. and Mrs. W. D. Foster of East Molesey, and was educated at Cranleigh School and St. Bartholomew's Hospital, qualifying M.R.C.S., L.R.C.P. in 1937. In the following year he graduated M.B., B.S. of the University of London. He had held the posts of resident surgical officer at Worthing Hospital and resident medical officer at the Kent and Canterbury Hospital. He joined the R.A.M.C. early in 1939. He leaves a widow and one son.

The name of Captain CHARLES EDWARD MCCLOGHRY is included as "Died" in an Army Council casualty list published on April 30. He graduated M.B., B.Ch., B.A.O. of Queen's University, Belfast, in 1936, entered the R.A.M.C. as lieutenant in April, 1937, was promoted captain a year later, and saw service in Palestine. He had been a member of the British Medical Association since 1937.

The death from wounds of Lieut. JOHN MURDOCH MCKILLOP is announced in an Army Council casualty list published on May 2. He was educated at the University of Glasgow, where he graduated M.B., Ch.B. in 1938. His home was in Glasgow.

INDIAN MEDICAL SERVICE

A list of casualties in the Indian Army, published by the India Office, records the death of Captain GILBERT CHARLES RETZ, aged 28. He was born on September 10, 1912, and was educated at Trinity College, Dublin, graduating M.B., B.Ch., B.A.O. in 1937. After holding the post of house-surgeon at Macclesfield General Infirmary he entered the I.M.S. as lieutenant in 1938, being antedated one year. He joined the British Medical Association in 1938.

DEATHS IN THE SERVICES

Wing Commander FRANK PAUL SCHOFIELD, R.A.F. (ret.), lost his life by enemy action in London last month. He received his medical education at St. Bartholomew's Hospital, and qualified M.R.C.S., L.R.C.P. in 1920. Four years later he took the degrees of M.B., B.S. of the University of London. He had held the post of house-physician at St. Bartholomew's. In 1926 he entered the R.A.F. as flight lieutenant, was promoted squadron leader in 1934 and wing commander in 1937, retiring in 1939.

Captain GEORGE WHARTON KENDRICK, late R.A.M.C., died at Cheddar on April 26. He was the son of the late Dr. Kendrick of Bilston, and received his medical education at St. Thomas's Hospital, taking the M.R.C.S., L.R.C.P. in 1932. Entering the R.A.M.C. soon after qualifying, he became captain in 1934. He had recently served in India and was stationed at Benares, but had to leave the Service owing to ill-health.

Universities and Colleges

UNIVERSITY OF CAMBRIDGE

The Linacre Lecture will be delivered by Sir Walter Langdon-Brown, M.D., F.R.C.P., Emeritus Regius Professor of Physic, on Friday, May 30, at 5.15 p.m., in the lecture room of physiology, St. John's College. The title of the lecture is "From Witchcraft to Chemotherapy."

Applications for the Marmaduke Sheild Scholarship in Human Anatomy are to be sent to the Registrary by May 20. The award will be made towards the end of June. The persons eligible are such undergraduates of not more than three years' standing from matriculation, and such Bachelors of Arts of not more than four years' standing from matriculation, as have completed the first examination for medical and surgical degrees and are qualified in anatomy and in physiology to proceed to the Final M.B. Examination, and have also obtained honours in Part I of the Natural Sciences Tripos with anatomy as one of their subjects. Women also are eligible. The scholarship is normally tenable for one year from the date of the award, but a scholar may be re-elected for a second year. The emolument is £100 a year.

UNIVERSITY OF WALES

Nancy G. Rogers has satisfied the examiners in Part II and has qualified for the Diploma in Public Health.

SOCIETY OF APOTHECARIES OF LONDON

The following candidates have passed in the subjects indicated:

SURGERY.—C. A. Anderson, D. V. Bateman, G. H. Miles.

MEDICINE.—S. Hashim.

FORENSIC MEDICINE.—S. Hashim.

MIDWIFERY.—D. V. Bateman, A. H. Evans, P. R. Green, J. H. C. Hill, R. L. Skea, H. A. Worthy.