

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

IDIOPATHIC DILATATION OF THE COLON.

THE great rarity of cases of true congenital dilatation of the sigmoid flexure of the colon, or so-called Hirschsprung's disease, is shown by the fact that out of 16,000 *post-mortem* examinations made at Guy's Hospital, only one such case was discovered.¹ Dilatation of the colon due to obstruction, either by concretions or faeces or by constriction of the bowels below, occurs more frequently, but in such cases the dilatation with the resulting hypertrophy takes place, not in the colon alone, but in other parts of the intestine as well, and is comparable to the dilatation and hypertrophy of any hollow viscus as the result of a stricture below. The following case of true idiopathic dilatation of the sigmoid alone, unassociated with any obstruction, is a condition which occurred in my practice:

W. S., a fairly well-developed Jewish boy, 12 years of age, had suffered from constipation ever since his birth. When one day old, it was found necessary to relieve his unopened bowels by means of a soap-stick. As the child grew up his abdomen was noticed to be always full, and he had a very considerable degree of lordosis as a result of his large abdomen. He was in the habit of going for about a fortnight or more without having his bowels open, and when the distension of the abdomen was getting great the boy found that he could relieve himself of the flatus by putting himself in the knee-and-elbow position. He was treated by several doctors, and on one occasion when he was much distended a doctor at a hospital put a finger up the rectum for the purpose of examination, when there was a sudden gush of faeces and flatus, and the distension disappeared.

I first saw the lad about two years ago for distension and colic, when hot turpentine stupes and a turpentine enema relieved him both of the pain and the meteorism. Recently (early in March) I was sent for again, and found the boy to be suffering from intermittent attacks of severe abdominal pain. His abdomen was unusually large, looking like an inflated balloon. The circumference at the level of the umbilicus was 33½ in., that of his chest being only 27 in. He was not sick, and his pulse, which was rather rapid, was of good volume and tension. His bowels had not been moved for a fortnight, and I again advised turpentine stupes and enema, as well as a tablespoonful of castor oil. I saw him again about six hours later, and was told that he had not yet passed either motion or flatus. The circumference of the abdomen grew to 35 in. The patient looked fairly comfortable in the intervals between the attacks, which were severe but of short duration. There were no visible peristaltic movements, and the liver dullness was impaired. Any attempt on the part of the patient to relieve himself of flatus in his own way being unsuccessful, I passed a rectal tube, which went in 11 in., but no wind came out. On withdrawing the tube, the tip was found to be slightly blood-stained. I gave him another turpentine enema, which was returned without any faeces, but was followed by a little flatus, the abdominal circumference being reduced by ½ in., and the patient felt much relieved. A few hours after the symptoms became very severe, and the patient was removed to the German Hospital, where the bowels were punctured, and the patient died immediately after.

Post mortem the sigmoid flexure was found to be exceptionally dilated and hypertrophied. There was also a volvulus of the flexure which was probably the immediate cause of death.

The symptoms of Hirschsprung's disease as described by Dr. Hale White are distension, shortness of breath, lividity, and palpitation on account of interference with the action of the diaphragm and heart respectively, obliteration of liver and spleen dullness, and in bad cases oedema of legs and scrotum, and albuminuria. Additional symptoms mentioned in Nothnagel's *Practice of Medicine* are malnutrition and dyspeptic symptoms, and the fact that a finger or tube in the rectum may promptly relieve the condition.

The important symptoms in my case—which seem to be diagnostic—were the constipation, distension, and relief of both by means of a finger in the rectum, or on the part of the patient himself by putting himself in a certain position. This last sign would seem to show that there is some kind of valve mechanism at work, which, indeed, is a theory put forth by Marfan to explain the etiology of the disease. No such valve has, however, ever been found *post mortem*.

It has been suggested that the dilatation is a result of the constipation, which, causing an accumulation of impacted faeces, sets up a kinking of that part of the bowel. This theory, however, is not tenable, since neither

is constipation a constant symptom nor can such a rare disease be the result of such a common symptom as constipation. Rolleston's view is that such dilatation and hypertrophy of the colon without obstruction is analogous to dilatation of the stomach without pyloric constriction. The most probable theory, however, is that of Hirschsprung—that it is congenital. This seems, at any rate, to have been the case in my patient, since he suffered from constipation from birth.

The disease is more frequent in boys than in girls; most of the cases end fatally before the age of 12, death being due in the majority of cases to perforation of an ulcer. The cause of death in my patient seems to have been a volvulus.

As regards treatment, several things have been suggested:

1. Enemata and purgatives. These, while they may relieve for the time being, do not cure the condition.
2. The same criticism applies to a rectal tube; and
3. Puncture of the intestine. Moreover, a rectal tube often fails to give even temporary relief.
4. The best treatment—one which was suggested by Hale White a few years ago—is colotomy above the dilated part, so as to give the affected part a rest. This treatment has been followed by good results. Unfortunately, however, it is seldom that a correct diagnosis is made in time.

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London, E.

TWO CONSECUTIVE CASES OF STRANGULATED INGUINAL HERNIA IN THE FEMALE.

THE points of interest in the following cases are that (1) inguinal hernia in the female is rare; (2) that femoral hernia was diagnosed by a surgeon of great experience, and though I must admit to making no thorough examination before making the incision, I also thought it to be a femoral hernia, which had pursued its usual upward course towards Poupart's ligament after escape from the saphenous opening; and (3) the fact that healing by first intention under the circumstances took place.

CASE I.—On April 1st, 1908, I was asked to operate on J. L., an imbecile woman of 78, for slight strangulated "femoral" hernia. The operation had to be performed in the patient's cottage, and as she was a pauper its condition as regards asepsis may be imagined. She had further undergone absolutely no preparation. An incision over the swelling was made, and as soon as the neck of the sac was defined the hernia was found to be of the direct inguinal variety. It was reduced and treated in the usual way, the wound healed by first intention, and the old lady made a rapid and uneventful recovery.

CASE II.—On March 25th, 1908, I was asked to see M. L., a woman of 65, with a view to operation for strangulated inguinal hernia on the right side. The patient was a delicate woman who "had had a rupture for about twenty-five years, which often came down, but which she could always replace." On this occasion she had failed to replace it, but "it had gone back when she woke that morning." Her symptoms had not been typical of strangulation, though there had been a fair amount of vomiting, but no obstruction to the passage of faeces. There was no trace of a hernia, though the region was tender to touch, and the external abdominal ring appeared to be occupied by a small body about the size of a pea, and to the touch resembling a gland. As the patient appeared to be considerably better than she had been I did not consider an operation expedient. I next saw her at 5 p.m. on April 11th on the operating table in our hospital, the hernia having again come down on the 10th and become strangulated. There was now a large, extremely tense, and hard swelling the size of a big orange in the right inguinal region; over this I made a fairly long incision and attempted to find the neck of the sac; in this, however, I was unsuccessful, the sac appearing to be directly continuous with the abdominal muscles and all the tissues in the vicinity being of a fibrous nature. I next made various attempts to peel off the sac by means of incisions over its extremity, but again without success. As by this time the patient's strength was commencing to fail, I resolved to cut into the sac; this proved to be fully a quarter of an inch in thickness and to contain an elongated structure about the size and length of one's two fingers placed together, and I took it to be the appendix. This structure was withdrawn from the abdominal cavity and removed; the sac ligatured and cut off at its neck and the wound hurriedly closed in the usual way. The patient made a perfect and uneventful recovery.

The laboratory report is as follows: "Thickened hernial sac with much unstriated muscle in its wall. The thickening is the result of a very chronic inflammatory process leading to lymph effusion and subsequent organization. It is not tuberculous. The appendix is much thickened by the formation of young fibrous tissue outside the muscle coat and in the mesentery. There is very little inflammatory change to be seen, and the thickening appears to be rather the result of slight strangulation."

¹ See Hale White's article on Diseases of the Colon in Clifford Allbutt's *System of Medicine*, second edition.

I cannot understand how such a hernia, which must have existed very many years, could at times become absolutely unrecognizable. From the appearance of the appendix in the sac immediately the latter was laid open, it seemed to have occupied this resting place for some time, the walls of the sac being permanently indented by the nodosities on the appendix. Moreover, the stony hardness of the swelling before operation and the great size of the mass when exposed make it inconceivable that such a mass could be "coming down and going back again" as the patient described.

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CONSUMPTION AND OZONATED AIR.

DURING the last two years I have treated under great disadvantages two patients by ozone, who were suffering from pulmonary phthisis in an advanced stage, with large development of tubercle bacillus. But besides other disadvantages, my ozone apparatus was defective, and the results were only partially successful. However, I perfectly satisfied myself that the treatment so far as it went was on right lines. The patients felt better while using the ozone; the dyspnoea was relieved, hectic fever and night sweats less, coughing and expectoration less, pulse slower, and arterial tension improved; and whenever the production of ozone ceased, the patients complained of feeling worse, all the worst symptoms becoming aggravated.

My hope was that by bringing the patient night and day into an atmosphere in as far as possible resembling really good air, and, so far as the antiseptic ozone is concerned, an atmosphere far excelling the finest natural air in any health resort in the world, not only would all germs in the sick-room be destroyed, but the ozonated air breathed by the patient would sooner or later overcome the bacilli in the lungs and blood, thus giving the patient a chance to recover. From what I have seen, it appears to me, at least where this treatment is resorted to in the earlier stages of the disease, there is every encouragement to expect perfect recovery in the patient's own home, and under the care of his own medical attendant. It will be observed, too, that all danger of infection to the members of the household is obviated by the germicide action of the ozone.

Larbert.

JOHN A. MACKENZIE, M.B., C.M.Edin.

Reports

ON

MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF THE BRITISH EMPIRE.

NORTHAMPTON GENERAL HOSPITAL.

TWO UNUSUAL ABDOMINAL CASES.

(Under the care of Dr. P. S. HICHENS and Mr. N. B. ODGERS.)

THE following two abdominal cases, from the difficulties they presented in diagnosis and their unusual nature, seem worthy of record:

1. *Internal Hernia*.—A married woman, aged 40, who had been an in-patient three years earlier for gastric ulcer, was readmitted on September 21st, 1907, for a recurrence of gastric symptoms, which had commenced four months previously. She had much pain in the epigastrium and frequent vomiting, but no hæmatemesis. Under suitable dieting and treatment she made a good recovery, and was about to be sent home when, on the evening of October 22nd, she was suddenly taken with severe abdominal pain and vomiting, for which in the course of the night a small injection of morphine was given. On the morning of October 23rd she was collapsed; her pulse was feeble

(160), and she was continually sick. She was carefully examined by both of us. There was some distension of the abdomen in the epigastrium, and the abdominal muscles were somewhat rigid. The liver dullness was not obliterated, and there were no signs of free gas or free fluid in the abdomen. The area of stomach resonance could be mapped out, and showed moderate distension. These physical signs, accompanied as they were by a continuance of vomiting, made a diagnosis of gastric perforation doubtful, although the previous history of the case suggested it. Immediate exploratory operation was decided on. The abdomen was opened through the left rectus muscle, close to the middle line above the umbilicus. There was no escape of gas or free fluid; the stomach was moderately distended, and had numerous adhesions about the pylorus. No perforation could be discovered. Immediately below the stomach and beneath the omentum several coils of distended small intestine presented. The incision was prolonged downwards; the transverse colon, which was quite collapsed, lifted up and a hernia of small intestine into the duodeno-jejunal fossa was found. With a little manipulation this was readily reduced; it consisted of the upper 3 ft. of the jejunum. The orifice of the fossa readily admitted three fingers. No attempt was made to sew up the opening, as a large branch of the middle colic artery ran along its free margin. The abdomen was rapidly sewn up. The patient, though much collapsed, rallied well and made an uninterrupted recovery.

2. *Gangrene of the Appendix (?)*.—A youth, aged 19, was admitted on October 9th, 1907. Two and a half weeks earlier he was seized with abdominal pain and then had an illness of doubtful nature. He was sick off and on and had fever; the bowels were well open with purgatives; a few doubtful spots were seen on the abdomen, and at one time a diagnosis of enteric fever was suggested. His condition remained much the same until the day before his admission, when he was seized with very intense abdominal pain, severe vomiting and collapse, and was then sent to the hospital.

He was given an enema immediately after admission, and a large quantity of dark red blood came away in the resulting motion.

When seen by both of us he looked extremely ill, pale, and in a cold sweat, and was very restless. The temperature was subnormal and the pulse small, 160. He constantly vomited small quantities of brownish-green material. The abdomen was somewhat distended, rather rigid, and hardly moved with respiration. There was no evidence of free gas in the abdominal cavity, but shifting dullness in the flanks pointed to the presence of free fluid. A rectal examination revealed clots of blood in the rectum. The real nature of the case seemed very obscure, but a diagnosis suggested as conceivable was enteric fever accompanied by hæmorrhage and perforation, which was a possible explanation of blood in the motions and also in the peritoneal cavity.

As a last resort, at the request of his mother, an operation was undertaken. The abdomen was opened to the right of the middle line below the umbilicus, with a view of inspecting the lower part of the ileum. The peritoneal cavity was full of dark faeculent-smelling blood. There was no free gas or sign of peritonitis. The grave condition of the patient prevented any further examination; a drainage tube was inserted and the patient hurried back to bed as soon as possible. He died about an hour later.

At the *post-mortem* examination the abdomen and large intestine were found full of blood. There were many adhesions about the appendix region, but no trace of that organ could be found corresponding to the probable site of its attachment in the caecum; there was, however, a ragged ulcerated perforation about the size of a sixpence. There was no evidence of ulceration in the bowels or into any considerable abdominal vessel. The *post-mortem* examination was made by the house-physician, Dr. Milton, in our unavoidable absence.

It is difficult to explain the sequence of events in this very extraordinary case. Presumably the termination of it, at any rate, was due to gangrene of the appendix and hæmorrhage from the appendicular vessels.

A somewhat similar case was reported in the *BRITISH MEDICAL JOURNAL* of December 14th, 1907, by Mr. G. S. Thompson.

* Communicated by the Director-General, Royal Navy.

simple, cannot be as efficient as we would like to have them." Twenty-three centres have therefore been selected where there are universities and large civil hospitals, and the Director-General desires to place on record the response which the medical profession has made to the call for aid in connexion with them. In not one of the twenty-three centres has that call been heard without evoking an enthusiasm which, in itself, is a sufficient indication of the patriotism of the profession to which he belongs. Sir Alfred Keogh says it is with no little pride that he is able to announce the approaching enrolment of 368 physicians and 368 surgeons as officers of the Territorial Medical Corps. In the case of St. Bartholomew's Hospital, London, and at the very commencement of the organization of the Territorial Medical Service, the physicians and surgeons volunteered *en bloc* to join as the staff of the 1st City of London General Hospital. A patriotism no less marked has been displayed at each of the twenty-three centres.

NURSES.

As regards the nursing profession, the Director-General has reason to think that nurses will prove no less patriotic than the members of the medical profession. Matters were now sufficiently far advanced to proceed to the formation of an Advisory Council upon which the nursing profession is fully represented by matrons who belong to London hospitals, and are, therefore, in a position to attend frequent meetings. This council has been charged with the framing of rules and advising as to the best method of procedure to be adopted in forming a Territorial Force Nursing Service, in accordance with the following requirements: A matron will be required to join the administrative staff of each general hospital, and control an establishment of 30 sisters and 88 nurses. Every two years she will be given an opportunity of studying for one week the administrative duties of matrons in large military hospitals. For each general hospital 91 sisters and nurses will be required in time of war. They will be enrolled by local committees at each of the twenty-three general hospital centres, in the formation of which county associations are concerned. The establishment in excess of the actual numbers required will be enrolled in order to allow for reliefs and casualties.

VOLUNTARY AID SOCIETIES.

Dealing with the part to be taken by voluntary aid societies in the formation of the general hospitals, the Director-General says the British Red Cross Society has now organized itself on a plan corresponding somewhat to that of county associations, in so far that county committees exist whereby county effort is focussed. In 1907 a conference was held with the Executive Committee of the the society, as a result of which the Army Council has given its assent to proposals made by the society, of which the following is a brief summary:

The Territorial Force proposes to be self-contained so far as the first and second lines of medical assistance are concerned, but in rear of the field ambulances—that is, in the line of communication zone—the Red Cross organization will play a great rôle.

It is first concerned in the transport of the sick and wounded from the head of the line of communication to the various hospitals along the line, and their dispersal and distribution throughout the country. As the field army must have first lien on any available transport, the function must be performed in close communication with and subordinate to the superior military authorities, but the society can be of great assistance in adapting surplus transports to the needs of the sick, either by road, rail, or water. It will equip and organize ambulance trains, either permanently fitted or improvised, on the various railway lines; fit out, where waterways exist, boats and barges for the same service; establish along these routes rest and refreshment stations where convoys are likely to pass or be detained.

At certain centres the society proposes to select and prepare plans to adapt buildings found suitable for hospital accommodation, and to consider beforehand the questions of sanitation and supply to which the organization of these hospitals will give rise. Where suitable permanent buildings do not exist, they will work out schemes for the provision of temporary structures.

The society undertakes to deal with the question of medical stores, certain clothing and furniture necessary for the hospitals, to take stock of the local resources, and to work out schemes for the rapid purchase of articles necessary on mobilization.

Further, though the Territorial Force will train in peace a nucleus of men to carry out the administration and the more specialized duties in these hospitals, the Red Cross Society's assistance will be invaluable in providing the balance of male

personnel required, the men to whom those duties which do not demand a very special training could be allotted.

Finally, the Society undertakes to provide and organize convalescent homes throughout the country to lessen the strain on the hospitals, and give shelter to the sick and wounded when no longer in need of hospital attention.

SUMMARY OF SCHEME.

When thus completed the medical arrangements for the army for home defence will consist of:

1. Sanitary and medical establishments of battalions under the officers commanding the battalions.
2. Ambulances, under divisional and mounted brigade commanders, in the proportion of three field ambulances to a division and one cavalry ambulance to a mounted brigade.
3. Sanitary companies for the sanitation of camps of concentration and similar camps under the local commanders.
4. Administrative medical officer, with staff medical officer and sanitary officer to co-ordinate and supervise the work of the above formations.
5. Evacuation of sick and wounded from the field units to the general hospitals by road, rail, or water, under a line of communication organization in which the British Red Cross Society will play a large part.
6. Establishment of general hospitals, under administrative officers of the Territorial Medical Corps, with a staff of physicians and surgeons from the large civil hospitals in the locality, with a nursing staff from a Territorial Force Nursing Service, with other subordinate personnel from the Territorial Force and voluntary aid societies, and with the preparation and equipment of the buildings undertaken by the British Red Cross Society.
7. Convalescent homes, organized by voluntary aid societies.

THE PATRIOTISM OF THE MEDICAL PROFESSION.

In conclusion the Director-General says:

I cannot attempt here to describe the tasks which have been placed on the shoulders of the members of the medical profession. All the efforts connected with the organization of a medical service of the Territorial Force have been made by men who are leading busy lives while undertaking these additional and heavy burdens. It is on principals and professors of universities, lecturers in medical schools, physicians and surgeons of great civil hospitals, and more especially on the general practitioners throughout the country, that the whole burden of training to equip themselves for the work now falls, and for this purpose they are devoting both time and money. I feel it to be my duty, therefore, to draw your special attention to the aid which I have received from these most patriotic men, the whole body of the medical profession.

Universities and Colleges.

EDINBURGH UNIVERSITY COURT.

THE Edinburgh University Court met on Monday, July 20th. The Court approved of the following minute: "The resignation of the Chair of Chemistry by Professor Crum Brown will render vacant the seat on the University Court, which he has occupied as a representative of the Senatus since the Court was enlarged by the Act of 1889. The University will lose a Professor whose long experience as a teacher and whose scientific reputation have added to its renown. His colleagues on the Court regret that they will cease to have the benefit of the services rendered by him so ungrudgingly during so many years, and they desire to record in their minutes their great appreciation of his genial nature and high personal character."

Subject to the approval of the Senatus, the Court appointed Dr. T. S. Clouston and Dr. George M. Robertson to be joint lecturers on mental diseases for a period of two years, the systematic lectures to be delivered by Dr. Clouston and the clinical lectures by Dr. Robertson.

The Senatus reported that Mr. Francis Caird, M.B., C.M., F.R.C.S.E., on having presented his commission as Regius Professor of Clinical Surgery, has been duly inducted as a member of the Senatus.

Recommendations made by the Senatus with regard to the requirements of candidates for the degrees of M.B., and Ch.B. in Practical Midwifery, etc., under Ordinance No. 16, Section vii, II, were approved.

There was laid before the Court a deed of gift by the Right Hon. William McEwan, formerly Member of Parliament for the Central Division of the City of Edinburgh, establishing a fund to be called "The McEwan Hall Endowment Fund," amounting to £6,450, the annual income of which shall be applied towards meeting payment of the ordinary annual expenditure incurred in connexion with the maintenance and repair of the said Hall, and for no other purpose. The Court, in accepting the deed of gift, resolved to record in their minutes their deep sense of the manifold obligations which the amplitude of Mr. McEwan's generosity towards the university has laid on it; this instance of his regard for its interests having been preceded by the still more munificent gift of the McEwan Hall itself, together with other large contributions towards university purposes.

The Court had before them a communication from a minority

of the Court of the Scottish Association for the Medical Education of Women, and also from the lecturers for the Medical Education of Women in Edinburgh. The Court agreed to grant individual recognition to each of the aforesaid lecturers in accordance with the provisions of Ordinance No. 18, Section iii (4) for next academical year.

UNIVERSITY OF EDINBURGH.

THE following candidates have been approved at the examination indicated:

FIRST M.B., CH.B. (*Practical Chemistry*).—J. A. Andrews, S. H. Arthur, W. R. Bayne, A. J. Bennet, A. G. Biggam, H. F. Blacklee, J. R. Boyd, F. D. Cairns, L. D. Callender, W. J. Candlish, A. L. Christie, J. H. Cuthbert, A. Eprile, H. Evans, F. R. Fraser, B. A., K. A. Gilchrist, R. G. Gordon, R. A. Greenwood, S. J. Linzell, D. J. McAfee, A. M. Mackay, E. F. W. Mackenzie, J. S. S. Martin, W. P. Murray, H. S. Palmer, M. P. Paton, L. T. Poole, S. D. Reid, G. Richardson, H. A. von Rönne, R. B. Rutherford, C. E. H. Smith, J. Scott, H. W. Webb, T. C. Welsh, L. B. Willox, D. M. Wilson.

UNIVERSITY OF ABERDEEN.

DEGREE DAY.

AT a meeting of Convocation on July 22nd, honorary degrees in the Faculty of Law were conferred on Sir Henry Adamson, the Earl of Cromer, and General Sir J. R. L. Macdonald. The ordinary degrees conferred in the Faculty of Medicine were as follows:

M.D.—A. Alexander, E. Barnes, *R. M. Gunn, *S. C. Howard, *J. McIntosh, *G. Milne, A. S. Niven, B. R. G. Russell,† D. Sive-wright, C. A. Soovong.

* "Honours" for thesis.

† "Commendation" for thesis.

‡ "Highest Honours" for thesis.

M.B., CH.B.—W. S. Angus, W. M. Badenoch, W. Bain, J. G. Christie, W. Y. Davidson, R. E. Flowerdew, D. S. Garden, S. Goodbrand, G. F. Hunter, P. S. Hunter, E. Jane Innes, W. K. Irwin, J. B. Macallan, *W. G. MacArthur, F. MacRae, B. W. Martin, J. G. Muterer, W. J. Pirie, D. E. Rae, W. B. Rennie, A. Robertson, K. Ross, M. A., A. J. W. Stephen, W. R. Stephen, R. F. Twort, E. Walker, J. H. Will, C. C. Wood, J. H. Yule.

* Passed Final Examination with "Distinction."

JOHN MURRAY MEDAL AND SCHOLARSHIP.—Distinguished graduate (M.B.) of 1908, J. Watt, M.A.

On the same occasion Diplomas in Public Health were distributed to:

*W. S. Clark, A. Noble, M. W. Renton, R. W. A. Salmond, A. W. O. Wright, Captain, I.M.S.

* Passed with "Credit."

ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH.

AT a quarterly meeting held on July 21st, Dr. Playfair (President) in the chair, the following candidates were admitted to the Fellowship and Membership of the College respectively:—To the Fellowship: W. E. C. Dickson and C. J. Shaw. To the Membership: C. M. Campbell and T. B. Hamilton.

Admission to the Licence.

The Registrar reported that since the last quarterly meeting of the College fourteen persons had obtained the Licence of the College by examination.

Curriculum and Examinations.

The regulations regarding the Single Licence and Membership and Fellowship of the College for the ensuing year were approved.

The Secretary intimated that Dr. W. Allan Jamieson had been appointed as a representative of the College on the Governing Board of the School of Medicine.

ROYAL COLLEGE OF SURGEONS OF EDINBURGH.

AT a meeting of the college on July 14th the following gentlemen were elected Fellows:

W. M. Bergin, W. A. Burr, V. A. P. Costobadie, T. E. Coulson, H. J. Dunbar, T. Edwards, R. S. Godsall, M. P. Kerrawalla, W. C. Mansfield, H. F. Marshal, H. M. Newton, D. G. Perry, R. J. Rogers, J. Taylor, A. Verge, and J. Young.

CONJOINT BOARD IN SCOTLAND.

THE following candidates have been approved at the examinations indicated:

FIRST EXAMINATION.—J. M. Chrystie, W. I. Jones.

SECOND EXAMINATION.—J. G. Buchanan, A. R. Henry, J. McCusker, M. B. Motafram, J. B. Michie, F. P. Quirk, M. W. Rees, E. W. Wilburne, S. H. Noble.

THIRD EXAMINATION.—U. J. Bourke, G. E. Carto, R. M. Danks, R. J. Helsby, R. A. Hosegood.

FINAL.—O. R. Belcher, G. E. Carto, A. R. F. Douglas, A. Baxendale, A. D. Macfie, P. C. Mukherji, H. H. Bradley, A. N. Palit, R. Roberts, R. M. Blair, C. Homer, D. Das Gupta, K. J. L. Banner-man.

Obituary.

HENRY JULIAN HUNTER, M.D.,

FORMERLY OF SHEFFIELD.

THE death of Dr. Hunter in his 85th year occurred at Oldfield Park, Bath, on July 11th. He belonged to a Sheffield family, his father being the Rev. Joseph Hunter, the archaeologist, who wrote the histories of Hallamshire and South Yorkshire, and was for some time assistant to the Commissioners of Public Records.

Dr. H. Julian Hunter was born at Bath in 1823. He was educated at King's College School, London, and subsequently studied medicine at the hospital connected with that college. He took the degree of M.D. at Aberdeen in 1855, and settled down in practice at Sheffield. There he was appointed Lecturer in *Materia Medica* at the Sheffield School of Medicine, now affiliated with the Sheffield University, and also Surgeon to the West Street Dispensary and Hospital, at that time having about fifty beds.

He carried on an extensive practice for some years, but having no children he retired in 1861, and, with his wife, spent some few years in travelling about Europe and in visiting various parts of England. Eventually, at the suggestion of his lifelong friend Sir John Simon, he joined the medical department of the Privy Council, for which his great medical knowledge and intellectual capacity rendered him specially fitted. On account of his health he retired in 1875, and spent several years abroad. Ultimately, after living for a time at Penzance and Bournemouth, he returned to Bath in 1893, and there spent the remainder of his days. He interested himself much in the Bath Royal Literary and Scientific Institution, of which his father was one of the founders; he read various papers on literary and antiquarian subjects, and published several pamphlets. For the last few years he suffered a good deal, but his intellectual vigour continued to within a short time of his death.

A former pupil thus writes: "I was one of the last pupils under the old apprentice system, and was articled to Dr. Hunter when only 16. Our home life was very simple; his recreations consisted in reading, gardening, and chess, at which he was an excellent player. These were varied with an occasional visit to the theatre, to which he recommended my going once a week. Dr. Hunter was peculiarly well fitted to teach a pupil, and infused me with his own spirit of enthusiasm and love of his profession."

His wife died three years ago, and Dr. Hunter has left the greater part of his property to the Sheffield University.

SIR THOMAS NAGHTEN FITZGERALD, C.B., of Melbourne, whose death at the age of 70 was announced recently, was consulting surgeon to the Melbourne, St. Vincent, Austin and Queen Victoria Hospitals. He was admitted Licentiate of the Royal College of Surgeons in Ireland in 1857 and a Fellow in 1884. He was an ex-president of the Medical Society of Victoria, and in 1889 was President of the Intercolonial Medical Congress of Australasia. Sir Thomas Fitzgerald, who had a great reputation throughout Australia, served as a consulting surgeon to the Imperial Forces during the Boer War, and received the decoration of Companion of the Bath for his services.

DEATHS IN THE PROFESSION ABROAD.—Among the members of the medical profession in foreign countries who have recently died are Dr. Friedrich Janeczek, founder and first President of the Imperial Austrian Medical Association, aged 40; Sanitary Privy Councillor Dr. Zimmermann, said to be the oldest member of the medical profession, aged 98; Dr. Leonard Gigli, of Florence, one of the leading gynaecologists of Italy, aged 45; Dr. A. K. Belousow, Professor of Anatomy and Physiology in the University of Charkoff; Dr. Moreau, Professor of Hygiene and Forensic Medicine at the Medical School of Algiers; and Dr. Deneffe, sometime Professor of Operative Surgery and Ophthalmology in the Medical Faculty of Geneva, and a man of great erudition, shown in a number of contributions to medical history, aged 73.