TWO CASES OF PRIMARY CARCINOMA OF THE APPENDIX.

By DAVID M. GREIG, C.M., F.R.C.S.Edin.,
SURGEON, DUNDEE ROYAL INFIRMARY; LECTURER ON CLINICAL SURGERY AND SURGICAL DISEASES OF CHILDREN, ST. ANDREWS UNIVERSITY; SURGEON, ROYAL VICTORIA HOSPITAL, ETC.

Primary carcinoma of the appendix is necessarily an uncommon occurrence in any individual surgical practice, hence no justification is required for the publication of isolated cases. Such cases have been collected from time to time by various writers, but as yet have not been numerous enough to justify conclusions as regards symptoms, prognosis, and other valuable clinical data. In both the following cases the patients were operated on in December, 1905, and both are at the present time in perfect health, and show no sign of recurrence.

Case I.

A labourer aged 35 was referred to me by Dr. Lawrence. He was the youngest of twelve, the others being in good health. His father died of cancer of the stomach, but his mother was alive and well. Though married he had no family. He had a comfortable home, and was temperate and a moderate smoker. Twenty years previously he seems to have passed through a mild attack of complete syphilis, and four years later he had an attack of bronchitis. These constituted his only previous illnesses.

History of Illness.

Two months previous to my seeing him he supposed he had strained himself at work, for he was seized somewhat suddenly with a pain in the lower part of the abdomen which shot down into the right testicle. He continued at his employment, however, for about a month, the pain gradually getting worse. The taking of food aggravated it; the bowels were very constipated, and he had pain during defaecation. He then consulted Dr. Lawrence, who recognized it as an atypical case of appendicitis, and under whose directions he restricted his diet to fluids, with the use of enemata every other day to relieve the constipation. Dr. Lawrence was struck with the fact that the pain continued more severe and more constant than the mildness of the other symptoms would have led one to expect, and it was more irrespective of the ingestion of food. His temperature was lower than in typical appendicitis. During three weeks of treatment he improved somewhat, approaching his usual condition of health and becoming almost free from pain. A slight relaxation of diet was allowed, and on the following day the pain returned as violent as ever. There was not with this, however, the usual general symptoms of inflammatory disturbance.

Condition on Admission.

On admission to the Dundee Royal Infirmary he looked a strong man, and appeared to be healthy with the exception of slight pulmonary emphysema. He had slight pain at the end of micturition. Locally a little fullness was visible in the right iliac region, with some discoloration and desquamation caused by hot applications. There was some muscular resistance to palpation and tenderness over the appendix area. An elongated hard swelling was felt a little above and running parallel to Poupart's ligament.

Operation.

On December 13th, 1905, under chloroform anaesthesia, the caecal region was exposed by the usual incision. The appendix was found to be imbedded in an inflammatory mass attached along the line of Poupart's ligament, and, dipping down into the pelvis, was attached to the bladder. To facilitate manipulation it was necessary to make a median incision to supplement the original one, and the mass was dissected out, the stem of the appendix being treated in the usual way. The operation, which was an unusually difficult one on account of the density of the adhesions, occupied an hour and fifty minutes, and the raw surface from which the inflammatory mass had been removed was such that I thought it advisable to introduce on to it a drainage tube from either wound.

After-History.

The wounds were dressed on the following day and daily thereafter until the removal of the tubes, the suprapubic one being removed on the fifth and the iliac on the eighth day after the operation. The wounds healed without any further difficulty, and the patient went home on January 20th. After his discharge from hospital I saw him occasionally until he went to America in the spring of 1907. While there he retained good health, becoming stouter and heavier, until he weighed 12 st. 10 lb., a weight he had never previously attained. His appetite was good, and he had no trouble with the bowels. He occasionally had pain about the region of the right kidney, but nothing abnormal could be made out in connexion with that organ. He returned from America in June, 1909, and was then, as he still is, in excellent health and condition. The cicatrices were strong and showed no yielding, though he wore no belt. An occasional pain about the right loin is complained of, but examination is entirely negative.

Description of Parts Removed.

Professor Sutherland, who examined the growth for me, reported that the lesion was quite definitely cancerous, with marked inflammatory new formation in the parts around. It had originated in the epithelium of the tubules, assumed in places a glandular disposition, but, losing this again, comported itself more after the manner of a scirrhus. There was no doubt whatever that it was not an ordinary cylinder-celled epithelial carcinoma of the intestine.

Case II.

For permission to publish the second case I am indebted to Dr. R. C. Buist.

The patient was a married woman, aged 36, who had been sent into his ward on account of uterine fibroids, for which he did a hysterectomy. During the inspection of the parts after the completion of the hysterectomy it was noticed that the free end of the appendix was the seat of what appeared to be a plum-sized cyst without any adhesions or any inflammatory adjuncts whatever. The appendix was removed in the usual way. Professor Sutherland examined the tumour removed with the appendix and found that it was cancerous, the microscopic examination showing a cylinder-celled carcinoma. The patient made an uninterrupted recovery, and is known to be well at the time of publication.

These two cases fall into very different categories, and for clinical purposes hardly deserve to be classed together. The former proves the danger, the latter merely demonstrates the possibility of the existence, of primary carcinoma of the appendix. In the former the appendicitis, with its pain and its surrounding inflammation, was the dominant symptom; in the latter no symptoms had arisen. Both the patients were about the same age, rather on the young side for malignant disease of the bowels. The variety of carcinoma found in primary affection of the appendix appears to be most commonly of the cylinder-celled variety, and such was present in the latter case. It is much rarer, indeed, to find the appendix the seat of an alveolar carcinoma, and this the pathological examination showed the tumour to be in the former case.

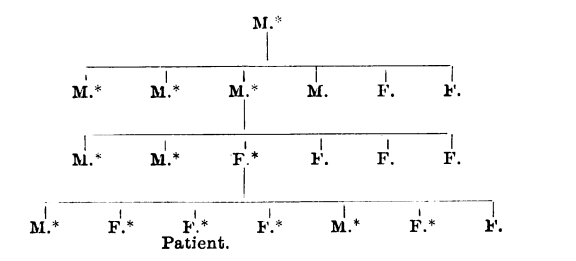
Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

HEREDITARY TRANSMISSION OF SQUINT.

The following particulars of a case may prove of interest: On Thursday, September 23rd, a girl, aged 11, attended Mr. Sydney Stephenson's out-patient department at the Queen's Hospital for Children with a convergent squint of the right eye which measured 35 degrees on the perimeter, the lateral movements of the eye being unimpaired. Right vision $\frac{5}{18}$ partially, left vision $\frac{5}{12}$. It was noticed that the mother also had a convergent squint of the right eye measuring 25 degrees on the perimeter, and there was defective outward movement of the right eye.

On inquiring into the case it was found that on the mother's side the following members of the family had a



M. Male. F. Female. * Affected.

convergent squint: Six out of her seven children—that is, all her children except the youngest, aged 2 months—the mother and her two brothers, her father and two of his brothers, and her grandfather.

The chart, which was kindly got out for me by the sister in charge of the out-patients, gives the tree of this interesting case of hereditary transmission of squint.

Ernest E. B. Landon, M.R.C.S., L.R.C.P.
Acton Vale, W.

In the *American Journal of Clinical Medicine* for October, Dr. George H. Tichenor, of New Orleans, gives an account of the career of William Walker, who, like Thomas Dover, of opium and ipecacuanha powder fame, was a filibuster as well as a doctor. But Walker was a good deal else besides. He was born at Nashville, Tennessee, in 1824. He studied law at the University of Tennessee and afterwards medicine at Edinburgh. After practising as a doctor for a time he took up law as a profession in New Orleans. Whether Themis refused to smile upon him, or whether he wearied of her, he next tried journalism. At that time the gold fever was raging in California, and Walker became associate editor of the *San Francisco Herald*. But his true vocation seems to have been to "extend the area of freedom." He had Napoleonic ambitions, but without the ability—or the luck—to realize them. In 1853, when both the United States and Mexico had troubles enough on their hands to occupy their attention, Walker made a dash into Lower California with fifty-two men, proclaimed a republic, and elected himself president. He gathered some adherents about him, but the Mexicans drove him across the border, where he surrendered to American troops. He was tried, but acquitted of violating American neutrality. In 1854 the last remains of the expedition reached San Francisco, where the ex-president subsided into the editorial chair of a daily paper owned by one Byron Cole, who had some interest in Nicaragua. That same year a revolution broke out in Nicaragua, and Cole obtained a colonization grant, under the terms of which 300 Americans were to be brought in and granted the privilege of bearing arms. This grant was forwarded to Walker, who collected a small force and invaded Nicaragua, where somehow he became commander-in-chief of the army, and a year later President of Nicaragua. Adventurers flocked to his standard from all parts, among them Joaquim Miller, the poet. It was not long, however, before Walker's ambition soared so high as to make it evident to the Central American Republics that if they did not take strenuous action he would soon become emperor of the whole region. They combined against him, and war was declared upon Nicaragua. At that time Walker had 10,000 men, while the allied army numbered 21,000. He might have been victorious but for the hostility of Vanderbilt "the First," who withdrew his ships from Nicaraguan ports, thus cutting off his supplies. He had to leave Nicaragua and return to the United States, where he was received as a hero. But his career as a filibuster was not yet at an end. In a few months he took part in a revolution in Honduras. He was compelled to surrender to the British, who handed him over to the Honduras authorities, and he was executed on May 1st, 1857—a sad end for one whose career was more full of interest than that of the hero of Kipling's story, "The Man Who Would Be King." Walker wrote a part of his own history in a book entitled *The War in Nicaragua*. In it he mentions the stamping out of epidemics of dysentery and cholera among his soldiers, a fact which shows that he had not forgotten his first profession.

The American Western Association for the Preservation of Medical Records was organized in May, 1909, for the purpose of collecting the historical and biographical records of the profession of the West and South of the United States. Its aim is to preserve anything and everything pertaining to Western medicine. Arrangements have been made with the Lloyd Library, Cincinnati, Ohio, for the proper housing of the material collected. This material will be systematically arranged, catalogued, and properly preserved, so that it can be made available for research work. The Association is particularly anxious to obtain (1) medical journals published in the West and South prior to 1880; (2) medical books or pamphlets written or published in the West; (3) manuscripts and autographs of early Western physicians; (4) old diplomas and other documents of a medical character; (5) proceedings of medical societies; (6) reports of hospitals and other medical institutions; (7) catalogues and announcements of Western medical colleges of all "schools"; (8) biographies and portraits of Western physicians; (9) information and material of any kind pertaining to medicine and medical men and affairs in the West; (10) curios of a medico-historical character. An appeal to all persons who may have such documents or objects of the kind described has been issued by Drs. C. A. L. Reed, Chairman, and Otto Juettner, Secretary of the Association. The Librarian is Dr. A. G. Drury, of Chicago. We mention this appeal because it is one among many other evidences of the interest in things connected with medical history that has of late years been aroused, and, as the pages of the JOURNAL show, is steadily becoming keener.

Medical News.

DR. JAMIESON B. HURRY, well known as the historian of Reading Abbey, has been placed on the Commission of the Peace for the Borough of Reading.

THE new hall of the College of Physicians of Philadelphia, described by Dr. Keen in the JOURNAL of last week, page 1161, will be dedicated on November 10th.

THE committee in charge of the testimonial to Professor Ogston desires to intimate that members of the medical profession wishing to contribute should send their subscriptions to the Honorary Secretary, Dr. Mackenzie Booth, 1, Carden Place, Aberdeen, at an early date, as the subscription list must soon be closed.

THE Asylums Committee of the London County Council has granted Dr. T. S. Logan, Assistant Medical Officer of the Epileptic Colony, twelve months' leave of absence without pay in order that he may assist, at the request of the Secretary of Public Health and Charities of the Republic of Cuba, in the remodelling and reorganization of the State Asylum for the Insane in Mazorra, Cuba.

THE members of the Balneological and Climatological Section of the Royal Society of Medicine will dine together at the Imperial Restaurant, Regent Street, on October 29th, Dr. Leonard Williams in the chair. The principal event of the evening will be the presentation to Dr. S. P. Sunderland of a testimonial in acknowledgement of his services as secretary to the late Balneological Society during thirteen years.

THE tenth annual dinner for medical men residing in West Somerset will be held at the London Hotel, Taunton, on Tuesday, November 2nd, at 7 p.m. The chairman will be Mr. Chas. Farrant. The price of the dinner will be 6s. a head, exclusive of wine, etc., and guests, medical or other, will be welcome. Those who wish to be present are requested to intimate their intention by Saturday, October 30th, to the Honorary Secretary, Dr. W. B. Winckworth, Sussex Lodge, Taunton.

THE honorary secretaries of King Edward's Hospital Fund for London have received from the Foreign Office a cheque for £4,775, this being half the net profits of the late Franco-British Exhibition. Under one of the clauses of the charter by which that undertaking was incorporated it was provided that the net profits should be divided equally between France and England and placed in the hands of the respective Foreign Secretaries of these countries for devotion to such public object as they might select. The other moiety has been accordingly sent to France.

A QUARTERLY court of the directors of the Society for Relief of Widows and Orphans of Medical Men was held on October 13th, Dr. Blandford, President, in the chair. Nineteen members of the court were present. A vote of condolence with the family of the late Sir Thomas Smith, Bart., was passed from the Chair. Sir Thomas Smith was elected a member in 1870, had held the offices of Director and Vice-President, had always taken the keenest interest in the welfare of the society, and was a regular attendant at the quarterly courts. The death was announced of one of the annuitants of the charity, a widow, who came on the funds in 1907, and received in grants the sum of £145. The sum of £518 was voted to be distributed among the annuitants as a gift at Christmas, each widow to receive £10, each orphan £3, or the orphans in receipt of grants from the Copeland Fund £5 each. Membership is open to any registered medical practitioner who at the time of his election is resident within a twenty-mile radius of Charing Cross. The subscription is 2 guineas per annum, or a member may become a life member by paying one sum, the amount of which is fixed by the by-laws of the society. Relief is only granted to the widows or orphans of deceased members, and since the last court six letters had been received from widows of medical men asking for relief, but this had to be refused as their husbands had not been members of the society. Application forms for membership and full particulars may be obtained from the Secretary at 11, Chandos Street, Cavendish Square. The next election will be on January 12th, 1910. The invested funds of the society now amount to £100,500.

There is one most important point in Weiss and Joachim's work, the value of which, with all respect, I think Dr. Taylor has not fully appreciated—namely, that in mitral regurgitation the presphygmic *plus* carotid wave interval is increased, almost to double its normal extent—that is to say, that between the onset of ventricular systole and the carotid pulse in mitral regurgitation there is a period of 0.12 to 0.15 second compared with the normal 0 08 second; and what is a crescendo murmur, in my view, but mitral regurgitation? The tracing of an uncomplicated crescendo murmur (Fig. 4) wants a deal of explaining away by the auricular-systole rhythm theory. Fig. 5 is more debatable, but I put it in purposely so that I might not be thought to be hiding difficulties, giving the observer's own comments on the absence of any indication of auricular systole where they expected to find it as meeting criticism of its value from my point of view. Another tracing (their Fig. No. 21) is better evidence for my theory, though not so good as No. 20 (my Fig. 4).

Dr. Taylor does not understand me rightly when he says that, under my theory, the stronger the ventricle is the less able is it to lift the aortic valves without a preliminary mitral regurgitant flow, and vice versa. What I maintain is that, the weaker the ventricle, the less able is it to close competently a mitral valve made more difficult of closure than a normal valve is. Dr. Taylor agrees that in ordinary mitral regurgitation, although it cannot close the stiffened valve, the ventricle can generate sufficient force to open the aortic valve, blood all the time regurgitating through the patent mitral valve, and producing an ordinary systolic murmur of regurgitation. Weiss and Joachim show that in these cases the presphygmic interval is abnormally prolonged, owing to the escape of blood into the auricle delaying the development of sufficient intraventricular pressure to open the aortic valve. A crescendo murmur simply means that the mitral valve is closed during the production of a mitral regurgitant murmur, and that the valve is incompetent for only a portion and not for the whole of ventricular systole, as is the case in an ordinary systolic murmur. It is practically a *presphygmic* murmur in rhythm.

The fact that the crescendo murmur is only heard in the back with extreme rarity presents no difficulties, in my opinion, because it is generally caused by a small regurgitation of blood and under moderate pressure. It arises at the onset of ventricular systole and at a closing valve orifice, as compared with an ordinary prolonged systolic murmur produced at a uniformly patent defective valve by the full force of ventricular systole. It is merely a question of penetrating power of the murmur, for many mitral regurgitant murmurs are not heard at the back.

The difficulty about the reversal of engines is never raised in the practically analogous condition of the see-saw murmur of aortic disease. When a rising-pitch murmur is actually or apparently continuous with an undoubted mitral diastolic murmur, the latter is of a decrescendo or uniform character. We never hear a murmur which begins at the second sound and runs on to be terminated by an abrupt first sound, which is continuously and progressively of rising pitch and crescendo force character. Dr. Taylor will see that rising pitch, meaning a closing valve, is a very important point in my argument.

Sir John Broadbent's answer to my question about the absence of a crescendo murmur in aortic stenosis does not meet the point. In both conditions you have blood passing from one chamber to another chamber or vessel in which it is lower in pressure than in the propelling chamber. True, the pressure in the aorta during ventricular systole is much higher than in the ventricle—which is nearly full and not empty, as he says—during auricular systole, but then the muscular power of the ventricle is proportionately greater than that of the auricle. It would be very hard to prove that the first sound of a heart with diseased auriculo-ventricular valves is mainly muscular in origin, as he contends, whatever may be its cause in the normal condition of affairs.

I should like to have added some further reasons to those in my paper for venturing to doubt some of the deductions from jugular pulse tracings, but the space at my disposal here will not permit of this. I must defer further criticism for the present.—I am, etc.,

Manchester, Oct. 11th E. M. BROCKBANK.

THE CAUSE OF DYSMENORRHOEA.

SIR,—The attention of many members of the profession would be arrested by the report of Dr. McCombie's case in the JOURNAL of October 9th, p. 1072. Personally, I was much interested in the observations therein recorded, supporting as they do the views which I ventured to express in the JOURNAL of May 15th, and to which he refers at the end of his communication.

It seems to me that the interest of this case lies not so much in the condition of the cervix described—for spasm of the internal os is common under such circumstances—but rather in the fact that the cervical spasm, actually demonstrated on palpation as a "constricting band," produced pain of so familiar a type that the patient was led to believe that she was experiencing a recurrence of her painful menstrual periods.

With a past history of dysmenorrhoea, this admission by the patient is significant, since it is but natural to conclude that her former sufferings—similar in all respects to her present sensations—were due to a similar cause, cervical spasm. Moreover, the diminution in the rate of flow of discharge during the acme of pain, and its reinforcement on dispersion of the latter, afford striking testimony to the presence of that relative obstruction in the cervix for the recognition of which I pleaded in my previous letter.

It is mere anticipation to remark that at least one gynaecologist of eminence would interpret the painful sensations of this Bengali patient as manifestations of neurasthenia. Nationality is no deterrent in the eyes of the devotees of this wonderful term—I cannot write disease—for the omniscience of its supporters has bestowed the name upon many diseases in many peoples. Therefore it is but natural that the term "neurasthenia" should haunt every attempt to unravel the perplexing problems of that elusive disease, spasmodic dysmenorrhoea.—I am, etc,

Dukinfield, Oct. 18th. GERALD RALPHS.

Universities and Colleges.

UNIVERSITY OF CAMBRIDGE.

The R. C. Brown Scholarship.

DR. R. C. BROWN of Preston has most generously promised to continue for a further period of two years the Pathological Scholarship of £150 per annum which he founded in connexion with the Committee for the Study of Special Diseases.

ROYAL UNIVERSITY OF IRELAND.

THE following candidates have been approved at the examinations indicated:

FINAL M.B., B CH., B.A.O.—*J. A. Brown, *†J. B. Butler, M.A., *†J. J. Gilmore, *†J. A. Hanrahan, *†E. G. Kennedy, *†E. W. Kirwan, *†J. M. McCloy, *†T. Scanlan, C. Alexander, J. Anderson, J. A. Black, P. M. I. Brett, *B. Byrne, *S. R. Campbell, F. S. Carson, D. S. Clarke, B.A., A V. Craig, *W. Dickey, W. A. Frost, P. Hayes, J. Holland, D. Horgan, *J. C. Houston, D. J. Jackson, B.A., T. Kennedy, H. H. MacWilliam, B.A., W. Magner, T. P. Magnier, T. J. S. Moffett, A. Patton, B.A., S. P. Rea, *J. Reid, D. A. Rice, A. M. Thomson.

M.D.—J. Finnegan, S. J. Killen, C. B. Pearson, S. B. Walsh, B.A. D.P.H., T. Walsh, B.A., D P.H., S. H. Whyte, J. E. Wilson.

† Upper pass. * Qualified to sit for honours in one or more subjects.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

A QUARTERLY Council was held on October 14th, Mr. H. T. Butlin, President, in the chair.

The late Sir Thomas Smith, Bart., K.C.V.O.

The Council recorded its deep regret at the death of Sir Thomas Smith, whose valuable services to the College were highly esteemed, and whose personal character made him an object of affection to all his colleagues. The Council also expressed its sincere sympathy at the loss which his family has sustained by his death.

Examinership in Midwifery.

The vacancy occasioned by the death of Dr. William Rivers Pollock will be filled up at the meeting of the Council in December.

Report to the Fellows and Members at the Annual Meeting.

A draft report, submitted by Mr. Edmund Owen on behalf of the Committee on the Annual Report of the Council, was approved and adopted. This will be presented to the Fellows and Members at the annual meeting on Thursday, November 18th.

University of Sheffield.

Mr. Clement Lucas was appointed representative of the College on the Court of Governors of the above university in place of Mr. A. W. Mayo Robson, whose period of office had expired.

Royal Commission on University Education.

The consideration of a letter from the secretaries of the above stating that the Commission will be prepared to receive information regarding the views of the college upon questions connected with medical education in London was referred to a committee.

Jubilee of the Grant of the Charter enabling the College to confer Diplomas in Dental Surgery.

It was determined to celebrate the above by a dinner given by the college to the leading members of the dental profession. The dinner will be held in the library of the college on Thursday, Deeember 2nd, 1909.

CONJOINT BOARD IN SCOTLAND.

THE following candidates have been approved at the examinations indicated:

FIRST EXAMINATION.—A. I. Clarke, J. J. Dykes, G. W. Fleming, D. B. Cama, R. B. Lilly, C. R. C. Moon, J. Warden, A. T. Kuriyan, P. E. O'Donoghue, G. B. Hanna, F. W. C. Hinings, J. J. Reynolds, O. Brunlees.

SECOND EXAMINATION.—G. A. Macvea, M. F. A. L'Hoste, G. I. Secluna, S. Brennan, J. N. Clark, T. Hardie, S. D. Bridge.

THIRD EXAMINATION.—E. Thorp, Emma C. R. Fisher, J. McManus, E. C. Hamilton, C. S. Owen, J. D. Wright, J. M. Dalzell, J. A. Hutchinson.

FINAL EXAMINATION.—F. B. Carvalho, R. A. Barve, R. D. Neagle, H. H. Field-Martell, M. Remers, A. F. Henriques, K. T. Nath, R. A. Hosegood, W. R. MacKenzie, S. Sharples, Beatrice Coxon, G. B. Moon, R. V. Dias, D. B. Gazdar, Maud T. Féré, H. V. A. Gatchell, F. C. Eberhardt.

CONJOINT BOARD IN IRELAND.

THE following candidates have been approved at the examinations indicated:

FIRST PROFESSIONAL.—J. P. Brennan, B. J. Cusack, J. J. L. Cox, H. A. S. Deane, E. G. Foley, A. B. Foott, R. F. J. Griffith, R. Green, J. F. Lyons, D. McEntire, R. J. May, C. J. O'Carroll, H. V. O'Donoghue, P. Rowan, T. F. Ryan, G. N. Smyth, R. Tivy.

SECOND PROFESSIONAL.—M. J. Ahern, A. J. Best, C. M. G. Campbell, T. J. Kelly, D. Murphy, G. Sheehan, G. A. Shiel, W. Waugh.

Medico-Legal.

WORKMEN'S COMPENSATION.

BAKER'S ECZEMA.

A. M. writes: Is there any case on record *re* compensation to a baker for eczema caused by his employment? It commenced about six months ago, and under treatment seemed to be cured, but it returned again a day or two after he had started to work. This is the third or fourth time he has returned to work after the skin seemed to have recovered its normal condition, but on each occasion the eczema has returned after a day or two at work. Is there any case bearing on his legal position for compensation?

CERTIFICATES IN LUNACY.

J. M.—(1) So far as we are aware, the only cases in which a justice specially appointed under the Lunacy Act, 1890, has to appoint two medical practitioners to certify to alleged lunacy are those which he has to consider under Section 13, Subsection 2, of that Act. (2) In the above described class of cases, even if one of the medical practitioners certifying is not the medical attendant of the patient, it is not clear that there is any legal ground for complaint. (3) We cannot say what is the usual practice for initiating legal proceedings, as it varies in different districts, but we are ready to assume that the provisions of the Lunacy Act are always strictly complied with. (4) Any patient admitted to a public asylum as a pauper, or classified as such on or after admission, can only become classified as a private patient after arrangements have been made for all expenses incurred to be repaid, either from his own resources or by some other means.

GIFTS TO LOCUMTENENTS.

A CORRESPONDENT states that while acting as locumtenent he was presented with £5 by the father of a patient to whom he had given special attention. Later, when the account was sent in by his principal, the father complained of the charges, and mentioned the present to the locumtenent. The principal has since written asking for the £5. Is he legally entitled to it?

*** Although it is a well-recognized rule in the profession that an assistant or locumtenent must not receive a money present from his principal's patients, in the case of a *bona fide* present he might be legally entitled to retain it. In this instance the patient's father appears to have thought the £5 in a sense a set-off against the principal's charges. In these circumstances it would seem that the money ought to be paid to the principal.

MEDICAL WITNESSES.

INQUIRER wishes to know whether, if summoned to attend as a witness the police court or assize court to give evidence as to "facts," and he is there asked for an "opinion" on the matter in question, he can claim an expert's fee before giving the said opinion.

*** A medical witness can only raise a question as to his fees before being sworn. After being sworn he must answer all questions put to him which in the opinion of the judge are relevant to the cause being tried.

THE MIDWIVES ACT.

INDEPENDENT.—(1) Under Section 2 of the Midwives Act, 1902, any woman had the right on application within two years from the date of the Act coming into operation to be certified on producing evidence satisfactory to the Central Midwives Board that, at the passing of the Act, she had been for at least one year in *bona fide* practice as a midwife, and that she bore a good character. The Act came into operation on April 1st, 1903. If a midwife did not obtain certification under the provisions of Section 2, she would by Section 1, paragraph (2), be debarred from practising as a midwife. (2) With regard to our correspondent's other question, we would refer him to a reply published in the JOURNAL of October 9th, p. 1107.

Obituary.

SIR ARTHUR MITCHELL, K.C.B., M.D.,

FORMERLY COMMISSIONER IN LUNACY FOR SCOTLAND.

IN Sir Arthur Mitchell, K.C.B., M.D., who died, as announced last week, in Edinburgh on October 12th, aged 83, has passed away a public official who played a distinguished part in the development of lunacy administration. A Graduate in Medicine of Aberdeen University, he was appointed Deputy Commissioner in Lunacy on the establishment in 1857 of the General Board of Lunacy for Scotland. He was thus present at the very inception of a new order of things which followed upon the Scottish Royal Lunacy Commission's report of 1855. That remarkable document contains the germs of most, if not of all, that has since been done to ameliorate the lot of the insane in Scotland, and Sir James Coxe and the other distinguished men who drew it up found in Dr. Mitchell an enthusiastic supporter of all views tending to rescue the insane from neglect, and to free them from needless restrictions on their happiness and liberty which had grown round them during ages of ignorance and superstition, and had been followed by acquiescence in evils supposed to be irremediable.

In the great reformation of lunacy administration and the influx of new ideas which followed the passing of the Lunacy Act of 1857, the part with which Dr. Mitchell was specially identified was to ascertain the condition of the insane under private care and to guide the Board in taking measures necessary for its improvement. After an experience of six years he embodied the results of his efforts in this direction in a book entitled *The Insane in Private Dwellings* (1864), which yet remains the standard book on the subject. It disclosed a painful story of neglect and misery among the insane under private care when he entered on his duties, but it also put on record the steps taken to remedy the evils disclosed; and at the end of a few years after the passing of the Act it showed the system of caring for the insane in private dwellings established upon the satisfactory footing on which it has since rested.

In 1870 he became a Commissioner, and from that time down to his retirement in 1895 he ever showed himself anxious to support and encourage medical superintendents of asylums and others, on whom rested the burden and heat of the day, in all endeavours which held out a promise of promoting the recovery or adding to the happiness of the insane.

Sir Arthur Mitchell was in 1880 a member of the Commission on Criminal Lunacy in England, and greatly influenced the character of the report of that Commission and of the legislation which followed. In 1889 he became Chairman of a Commission to inquire into Lunacy Administration in Ireland, and in that capacity urged measures which have done much towards improving the condition of the insane in that country.