immense advantage in the economy of energy both for the individual and the species as against most pronograde competitors in the struggle for existence. The chief change producing maximum vertical elevation of the head is the bringing the axis of the vertebral column and of the lower extremities into the same vertical line. This is rendered possible by man's increased power of extension of the hip and knee joints. The necessary distancing is effected by the willed extension of the vertical axis in which are the centre of gravity of the cranium, the vertebral column, the pelvis, and the lower extremities.

The weight of the body being borne entirely by the lower limbs, the upper limbs, freed from the task of aiding in station and progression, become available for prehension and movements involving delicacy of touch and manipulation, such as writing—that is, making distinct signs to represent sounds or things, and setting free the jaws, teeth, and mouth for other purposes. These latter, eased of their functions as weapons of offence and defence against enemies, and from the duties of seizing food, are left free for the duties of speech—that is, the modification of the laryngeal voice to make distinct articulate sounds to represent different things and the better expression of the emotions. Hence the erect posture gives man advantages as to sight, sound, smell, touch, and delicate manipulation, voice, and speech, which are represented structurally in the increased intricacy and quantity of his brain structure. These increasing powers demand increased attention to man's early training. Man's education does not always demand conscious instruction. In the absence of unfavourable circumstances, he can learn by unconscious imitation of good models.

While natural selection was bringing about maximum vertical elevation of the head, *pari passu* man was learning to secure maximum stability of bodily equilibrium in the most erect posture. To do this with the minimum expenditure of energy involved much redistribution of the weight of the skeletal and visceral structures around the new vertical axis, in obedience to gravitation, so that the plumb-line through the centre of gravity might fall within the diminishing area of support now restricted to the feet.

Among the changes promoting maximum stability of equilibrium are:

(*a*) The structure and strength of the foot and ankle-joint.

(*b*) The inclination of the pelvis to the spine.

(*c*) The anterior convex lumbar curve of the spine.

(*d*) Shortening of the antero-posterior diameter of the thoracic cage as compared with the transverse.

(*e*) The balancing of the head on the atlas by the occipital condyles coming to lie in the median fifth of the base of the skull: (*b*), (*c*), (*d*), and (*e*) help to bring the centre of gravity of the trunk over the hip joints.

Further changes to save power are:

(*a*) The adhesion of the central tendon of the diaphragm to the fibrous pericardium and so to the deep fasciae of the thorax and neck so as to aid in mechanically supporting the viscera.

(*b*) The fixation of the intestine to the abdominal wall by additional mesenteric adhesions forming mechanical supports.

(*c*) The maximum use of the passive skeletal structures (bones, cartilages, and ligaments) to resist gravitation and maintain the form and posture of the body, the equilibrium being automatically controlled by the cerebellum so as to minimize expenditure of energy on both cerebral and muscular accounts.

(*d*) The increased complexity of brain organization and development.

The tendency of all these modifications in structure is to promote economy in the expenditure of power in the working of the human machine. Nature exemplifies this "principle of optimum efficiency" in all her works, and man's structure and function are "normal" in as far as he is educated to habitually conform to this ideal or standard.

Applying these considerations to the present problem, the normal orthograde posture may be defined as that in which:

1. The centre of gravity of the head is vertically over the centre of the base of support.

2. The vertical plumb-line joining these points bisects the median transverse occipito-condyloid axis, and also the intercotyloid axis, passing through also the centre of gravity of the mass made up of the trunk and upper limbs.

3. The centre of gravity of the head, that of the trunk, and the centre of the base of support, are actively distanced as much as possible from each other by fullest possible extension of the vertical axis in which the above points lie with each in-breath until the extension becomes automatic and unconscious.

This posture should be the basis of all physical education for the young. It is the ideal we should seek for every child, the one we should endeavour to get stereotyped by growth in form and structure, the one to which such child should automatically return after action or relaxation. The subject trained thus has an easy and graceful carriage, a straight back, well-poised head, a raised, expanded, and mobile thorax well distanced from the pelvis, a flat abdomen, and all the internal organs in constant correct position for best work. The postures permitted and taught by some physical culturists with retracted head, stiff neck, protruded abdomen, hollowed back, and bent knees, do not comply with my definition, and are absolute caricatures of the normal erect posture, and directly produce deformity and disease. Moreover, the normal erect posture is the fundamental essential for all efficient respiration, correct voice production, and speaking. Lastly, the influence of the normal erect posture in the prevention and treatment of disease is of a potency as yet but barely suspected. Limits of time and space prevent my entering into details here, and I must refer readers to other papers on the subject. For the present I venture to invite scientific experts to consider my definition of the normal orthograde posture.

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[1] Scanes-Spicer, *Clin. Journ.*, October 18th and 25th, 1893; *St. Mary's Hosp. Gazette*, June and July, 1897; President's Address, Section of Laryngology, BRITISH MEDICAL JOURNAL, vol. ii, 1900. [2] Spencer, *Principles of Biology*, vol. ii, p. 126. [3] Scanes-Spicer, A New Cardinal Principle, etc., *Medical Press and Circular*, February 9th, 1909. [4] Schäfer, *Textbook of Physiology*, vol. ii.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

COLLAPSE IN A BABY.

THE following case seems to me of interest from the cause of the attack compared with its severity:

A few months ago I was called in to see a baby who was said to have had a "fit." He was a male baby, 5 months old, was farmed out, and had only been with the present people about a month. So far as could be made out the following was his history. He was bottle-fed after the first month, but had always been healthy except that for the last six weeks the bowels had been irregular, chiefly constipated, though for a week previous to the attack he had had slight diarrhoea and seemed to have pain when his bowels acted. About 5.30 p.m., when he was having his bottle before being put to bed, he took a little of the feed and then cried, took a little more and cried again, and then finished the bottle. Almost immediately he became sick and brought up most or all of the feed, which was said to be in the same state as when swallowed. As this had soaked his nightdress he was laid down to have it changed, but he suddenly became pale and unconscious.

While the people were waiting for a doctor to come he was put in a warm bath and then rolled in a blanket, but he did not show any signs of reviving and gradually got colder. Once or twice he was supposed to be dead, and they were not quite certain if he were alive when I came.

On my arrival, about half an hour after the attack commenced, I found him quite limp, the head and limbs falling about when he was moved; he was cold all over, extremely pale, no pulse to be felt; the eyes were partly open and the conjunctivae insensible to touch. There were slight sighing respirations at intervals, but no other signs of life. I do not remember auscultating the heart.

I put him in a hot bath and splashed cold water in his face, while a blanket and flannels were being heated, and when they were ready he was dried and laid on a warm

blanket in front of a fire and rubbed with a hot flannel. At this time his tongue and the inside of his mouth felt cold and clammy and were quite pale, and on putting my finger in as far as the epiglottis to see if I could stimulate the breathing there was no sign of sensation and the whole region felt cold.

I had no hypodermic with me, but had some sal volatile, so I dropped a mixture of that and peppermint water on the back of his tongue. In ten to fifteen minutes this stimulated the throat sufficiently to cause swallowing, and, continuing with the sal volatile, fire, and hot flannels, he slowly revived. In a few days' time he seemed all right again.

This case evidently was not a fit, but a faint, due seemingly to some stomach irritation. Instead, however, of relief having been given by the bringing up of the stomach contents, this seems to have been the cause of the collapse.

It is rather interesting to find so long a collapse from so seemingly trivial a cause, for the baby must have been nearly an hour without a pulse that could be felt, and with sighing respiration, and when the pulse did appear it went again unless sal volatile was given freely.

I have no reason to doubt the history of the attack, and poisoning can be excluded, as two other babies in the same house were not affected in any way.

I have never seen such a case of collapse in a baby before, and for some time did not expect him to recover—a dead faint for nearly an hour, and mouth and tongue cold and clammy, seemed hopeless. I should be grateful if any of your readers who have had a similar case could let me know what the mouth or rectal temperature fell to, as I did not take it, and do not think an ordinary thermometer would register it.

RONALD T. HERDMAN, M.B., C.M., D.P.H.Camb.
London, N.

FRACTURE OF THE FEMUR AT BIRTH.

IN April, 1909, I was called in to attend the confinement of a primipara, and on examination found a breech presentation with the legs extended. The labour was protracted, and the patient considerably weakened. Attempts at version and at bringing down a leg were made, but without success. It was also found impossible to effect delivery with the fillet or the finger in the groin. At this stage it was thought that the child could not be born alive, and the patient being anaesthetized, a blunt hook was used. Considerable force had to be exerted before delivery could be accomplished. The child was a large boy, and was alive, but the upper part of the shaft of the left femur was found to be fractured, and there was some laceration and considerable bruising of the soft parts in the groin. The question of treatment was a difficult one, for the conditions of the groin precluded the use of most of the recognized methods of treatment. For example, it was soon found impossible to maintain the limb flexed against the abdomen, according to Credé's original method, on account of the difficulty of looking after the wound complicating the case. Suspension in a special frame, with the legs vertical, has been tried with success in these cases, but I soon abandoned it as unsatisfactory.

The extension seemed quite unnecessary, and there was constant trouble and difficulty in keeping the limbs in proper position without interfering with the circulation. Feeding and bathing were also rendered very difficult by this apparatus. Whilst beset with all these difficulties in looking after the case, Dr. Isbister of North Sydney published an account of a splint which he had used with success for similar cases. In the BRITISH MEDICAL JOURNAL, April 17th, 1909, is a complete account of his apparatus with illustrations. Messrs. Maw and Sons made a similar splint for me and the treatment of the case was comparatively simple by its employment. It is made of aluminium, only weighs about 2 oz., and consists of a band which surrounds the abdomen, an angular splint which keeps the knee and hip joints flexed, and a connecting band between the two parts. From my experience of its use I have nothing but praise for it. The mother and nurse were extremely pleased, for the infant was quite comfortable in this splint; he could be fed at the breast without any difficulty; he could be bathed and dressed quite easily, and could be taken out in the perambulator without attracting any special attention. The result was quite satisfactory. Union took place with fragments in good position. After about six weeks the splint was discarded and gentle massage begun. There was considerable formation of callus but this gradually disappeared. There was no deformity and a shortening of only about ¼ in. The case was seen about six months after birth by Mr. G. Lenthal Cheatle, who wrote:

I am sure you are to be much congratulated on the result, as it was a most difficult case.

I attribute the successful issue in great measure to the splint which was used, and am happy to add my experience of its success to that of Dr. Isbister.

East Sheen, S.W. CECIL JOHNSON, M.B., Ch.B.Vict.

ACUTE POISONING BY *TRACHINUS VIPERA* IN NORMANDY.

A FEW days after our arrival at Les Grandes Dalles, Normandy, I caught a number of prawns and small fish with a prawning net, and had placed the catch in a fisherman's basket, when my son, a Merchant Taylors boy, aged 15, handled the contents of the basket and seized a small fish, which happened to be a small *Trachinus vipera*. The fish stung the boy on the index finger of the right hand about the middle of the second phalanx. Immediately after the injury had taken place the boy complained of severe, nauseating pain going up the hand, arm, and up to the shoulder. I was not cognizant at first of what had happened, but on being told by an old sailor that the wound of this fish, called in Normandy "vive," was considered to be very dangerous, I at once went some three-quarters of an hour's distance with the patient to a chemist, no medical man being in the vicinity, who told me that to his knowledge four persons who had received similar wounds had died from the effects. In the meantime, about one hour after the accident, the finger had swelled up, and was of a dark blue colour and very painful; the hand was swollen up to the wrist, and the boy felt very faint and ill. I had seen cases of snake bite in the West Indies, and had seen good results from alcoholic stimulation (brandy and wine), and injections of permanganate of potash solution into the wound; but as the boy was in great agony—in fact, he said he felt he was going to die—I decided at once to get rid of as much venous blood from the affected area as possible, and accordingly made a deep and long incision into the swollen tissues of finger with a scalpel which the chemist lent me. Bleeding from the incision was encouraged by rubbing the arm and forearm in a downward direction. After about one hour's interval less pain was experienced, and the finger, which before had been perfectly stiff, could be slightly bent.

Treatment afterwards consisted in bathing the hand and forearm continuously for days with 1 in 600 permanganate of potash solution and 5 per cent. carbolic acid alternately—the carbolic seemed to give the greatest relief—and giving quinine in small doses internally. The finger and hand remained swollen for quite a fortnight after the injury, and close upon six weeks have elapsed, and the wound has only just healed. On the day following the sting an axillary gland became painful and enlarged, but subsided gradually as the symptoms of swelling in hand and finger lessened. During the whole course of the case the temperature was below normal.

Description of Trachinus Vipera.

This fish is about 4 to 6 in. in length, about the size and colour of a large sardine, with a rather broad head and the eyes close together. The black dorsal fin possesses three sharp, long spines. The operculum on each side has a sharp spine projecting backwards—the defensive and offensive weapon—and the chemist at Sassetot told me that zoologists have discovered a poisonous gland in the floor of the mouth, from which poison is ejected from under the gill simultaneously when the fish inflicts the wound. The fish are very good eating, either fried or boiled, but the fishermen cut off the heads immediately after catching

them, as the cooks decline to touch the fish unless the heads have been severed from the body. I read in Leuni's *Synopsis* that these fish were much feared by the ancients.

London, E.C. JOHN H. SPITZLY, L.R.C.P., M.R.C.S.Eng.

Reports

ON

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

ROYAL VICTORIA HOSPITAL, DOVER.

THREE CASES OF STRANGULATED EPIGASTRIC HERNIA.

[Reported by J. C. RIDGWAY, M.B., B.Ch., B.A.O., Trin. Coll., Dublin, House-Surgeon.]

As the occurrence of an epigastric hernia is somewhat rare, I venture to record the three following cases, which came under my notice during the past one and a half years, and which were operated on by Mr. C. E. Murphy, Visiting Surgeon to the Hospital, with whose permission I now publish them.

CASE I.

A. P., a labourer, aged 60, was admitted on March 11th, 1909, with the following signs and symptoms: He had a painful tumour situated in the epigastric region, and had had persistent vomiting for two days, no flatus or faeces being passed during that time; his temperature was 100.4° F. and the pulse 120 on admittance. In size the tumour was about that of a large turkey's egg, being situated in the middle line midway between the ensiform cartilage and the umbilicus. The skin over the tumour was normal. The tumour was tense and elastic to the touch, and gave no impulse on coughing. A rather interesting coincidence was that he had another tumour in his right groin, which was an old-standing inguinal hernia, and which on examination proved to be non-reducible. It had been present for about forty years, but had up to a year of his admittance to hospital been kept in place by the use of a truss. Then, however, he left off wearing it. An impulse on coughing was easily elicited, and it was plainly evident that the symptoms of strangulation were confined to the epigastric tumour.

A strangulated epigastric hernia being diagnosed, the following operation was performed. A vertical incision was made through the skin over the tumour extending for about 4 in. On opening the hernial sac, fluid blood-stained in colour escaped, in all about 1½ oz. A loop of transverse colon, measuring 3 in., was found very adherent to the sac; the bowel was purple in colour, but the peritoneal covering had not quite lost its lustre. It was found that the loop of intestine was tightly constricted by the neck of the sac. The neck was ½ in. in diameter. A director was passed through the constriction and the neck of the sac divided in a vertical direction upwards; the constriction then being relieved, the loop of intestine was drawn down into the wound and the point of constriction carefully examined. As the peritoneal covering above was intact, the bowel was carefully reduced into the abdomen again. The sac was then excised. The edges in the linea alba were freshened and the aperture then closed by interrupted silk sutures. In bringing the recti together the right was brought across the middle line and united to the anterior aspect of its fellow, thus forming a flap over the site of the previous hernia. The skin was then sewn up with salmon gut.

The patient was greatly relieved by the operation. Flatus being passed twenty-five hours later, and a normal action of the bowels occurring forty-six hours after leaving the table. Good progress was made until the morning of the fifteenth day, when he complained of feeling unwell, and stated that he felt pain in his right groin. On examination, the impulse which was clearly elicited before had now gone. His temperature, normal since operation, had risen to 99.8° and the pulse to 116. The skin was normal, but great pain was complained of on touching the tumour. As his condition became worse, it was decided to operate the same evening. On opening the sac, it was found to contain a mass of adherent omentum. This was transfixed, ligatured in two places, divided, the ligatured stump being reduced into the abdomen and the adherent omentum and sac removed, the abdominal wall being closed by a modified Bassini. He made a good recovery and left hospital on April 25th. When seen on July 6th last, he was in excellent health.

CASE II.

M. W., a woman aged 58, was admitted on August 8th, 1909. She related that she first noticed a lump in the epigastric region over thirty years ago, but, although it had latterly become larger, it had never given her any trouble until three days before being admitted, when, in endeavouring to move a heavy sideboard, she felt something give way in the site of the tumour. The same evening she vomited after taking her tea, and her symptoms becoming worse a doctor was called in, who advised immediate removal to hospital. When seen in the ward on admittance she was in a collapsed condition; vomiting had been constant for fifteen hours previous. A clammy sweat covered her face. The pulse was 134 and the temperature 97.8°. A tumour somewhat resembling a lipoma was seen situated in the middle line between the ensiform cartilage and the umbilicus, in size about that of a large Java orange. No impulse was felt when she coughed. The skin over the tumour was tense and of a darkened colour.

Immediate operation was decided on. On opening the sac, which contained very little fluid, three coils of small intestine were found closely matted together; these were freed from one another with great difficulty. It was doubtful whether the bowel should be excised, owing to its condition bordering on gangrene, but as the patient was in a collapsed state the constriction was relieved, and the bowel returned into the abdomen, the recti being brought together with two layers of Japanese silk and the wound closed, a Kocher drainage tube being inserted. Before leaving the table 1 pint of hot saline was injected into the rectum and retained. The patient came round from the anaesthetic, but three hours after signs of severe collapse set in. The pulse was 160 and the respirations 42. The foot of the bed was raised, the limbs bandaged, and saline injected into the axilla up to 1½ pints. Strychnine and digitalis being also given hypodermically. She gradually came round and made a satisfactory recovery. She left hospital on September 22nd, and was last seen in January, when she was attending as an out-patient with bronchitis, but unfortunately in April she contracted pneumonia, to which she succumbed.

CASE III.

H. F., a farm labourer, aged 66, was admitted on February 16th, 1910. For over forty years he had been in the habit of putting staves into the ground for netting rabbits by leaning on them and using his body as the driving force. He first noticed a swelling at a point about 2 in. above the umbilicus in the site of pressure about thirty years ago, but as it never troubled him he did not pay much attention to it. It had remained the same size for several years, namely, that of a hen's egg, but latterly he said that it had gradually become bigger. He stated that when in the act of sneezing he felt as if something had given way, and the same evening on endeavouring to lean on a stave, felt great pain in the tumour. On retiring to bed he examined the tumour and found it had become much larger. Next day he had increasing pain, and that evening vomited his food. His condition becoming worse a local doctor was called in and ordered his admittance to hospital, which, however, was delayed until the evening of the day following. His condition then was most serious. The pulse recorded 122, the temperature 100.2° F. The skin over the tumour was in an inflamed condition, being thin and upon the point of ulceration. The tumour itself was spherical in shape and 3 in. in its longest diameter. No impulse was present, and well marked signs of intestinal obstruction were in evidence. Immediate operation was performed. On opening the sac a loop of transverse colon 2½ in. in length and a mass of adherent omentum were found, the bowel was of a darkish colour, but the peritoneal covering retained its lustre. The omentum was exised, and the same proceeding followed as in Case I. His further progress was most satisfactory. He left hospital on March 12th. When seen in July, 1910, he was in good health.

In all three cases the skin was painted before and after operation with a 2 per cent. solution of iodine in rectified spirit; chloroform was the anaesthetic used.

THE Rural Housing and Sanitation Association was formed in 1902 for the purpose of improving the condition of housing and sanitation in country working class homes throughout England, so as to prevent the rural population from being driven into towns by the inadequacy and unwholesomeness of their habitations. It is sought to attain these objects by educating public opinion as to the need for reform, by advising as to the carrying out of the Public Health and Housing Acts, by inducing sanitary authorities to enforce remedial measures in specific instances brought to their notice, and in other ways. In the last annual report of the association it is urged that the public body administering the Public Health and Housing Acts in rural districts should be drawn from a wider area than is the case at present, and that there should be an improvement in the qualifications and the positions of rural health officers, for it is contended that the terms on which these officials hold their posts are not calculated to encourage them in the efficient performance of their duties. At the foot of page 7 of the report there is displayed a singular want of knowledge of the duties of a county medical officer of health, who is referred to as an official who supervises the carrying out of the Public Health and Housing Acts in rural districts. The carrying out of these Acts is still in the hands of the district councils, whose executive officers are the district medical officers of health.

Bégouin holds that his cases represented milder attacks of the same disorder. Infection from leucorrhoeal discharge ascended the genital tract and attacked the Fallopian tubes, which fortunately became obstructed, so that peritonitis, fatal in Riedel's subjects, did not occur.

RENAL SURGERY AND PREGNANCY.

THIS interesting theme—the effects of an operation on the kidneys during pregnancy and its effects on future pregnancies—was made the subject of a discussion at a recent meeting of a French Congress.[1] Pousson of Bordeaux found that patients subjected to nephrectomy fared about as well as most women when they became pregnant. Out of 66 such cases, 59 were delivered at term, leaving but 7 miscarriages, and most of the patients suckled their children, one actually becoming a professional wet-nurse. Pinard made an important statement. Tuberculous disease of the kidney is a malady which we associate with very sickly young women. Yet it may be cured by nephrectomy, and the patient, should she conceive, may pass through a normal pregnancy. Israel has reported no less than 15 pregnancies in a series of 8 of his own cases from whom he had removed a tuberculous kidney, and declared that in none were there any of the complications of pregnancy, and that in all labour was normal. Hartmann, who quoted Israel in the course of the discussion, read an instructive communication on 113 cases of renal operations, 35 during pregnancy and 78 followed sooner or later by pregnancy. In the 35 he included Cragin's vaginal nephrectomy for the removal of a displaced cystic kidney in the pelvis obstructing labour; normal delivery occurred on the next day. In Twynam's case certain complications, hitherto absent, made the induction of labour necessary three weeks after a nephrectomy. Twenty-six more nephrectomies during pregnancy were included; 2 proved fatal, but one patient had uronephrosis and died of eclampsia on the second day, and the other had phlebitis already before the removal of the kidney. Out of the remaining 24 the pregnancy continued till term in no less than 22. In 4 out of 5 nephrotomies in pregnancy gestation continued to term, but the remaining case died on the second day after premature labour. One nephropexy and one incision into a perinephritic abscess during pregnancy were not followed by premature delivery or any other complications. Hartmann also recorded his collection of 78 cases where pregnancy followed renal operations. Out of 74 nephrectomies 72 became pregnant to term from one to four times and 2 aborted. Two only died in the puerperium, one with eclampsia, the other with anuria, without convulsions; thus, in seventy instances a single kidney did very well throughout gestation, which was sometimes repeated. Out of three women who had undergone nephrotomy, one had a miscarriage, one became pregnant twice to term, and one three times, also to term on every occasion. The last case was a bilateral decapsulation, and it is interesting to bear in mind that the patient afterwards became pregnant once, and was delivered at term. A good special report of the after-histories of patients treated after Edebohls's method is much to be desired. What supplies the place of the capsule, and how does the deputy capsule answer in respect to the renal functions? Altogether, renal surgery seems distinctly favourable to normal gestation.

[1] Report of the Congrès National de Gynécologie, etc. Toulouse. 1910. *Annales de gynéc. et d'obstét.*, October, 1910, p. 674.

LEBANON HOSPITAL FOR THE INSANE, ASFÛRIYEH.

IN this week's SUPPLEMENT (page 458) is printed an abstract of the annual report of Dr. H. Watson Smith, the Medical Superintendent of this international, Christian and philanthropic institution, which was founded by Theophilus Waldmeier, and opened in August, 1900. Till then there was no asylum in the whole of Palestine, nor, indeed, between Constantinople and Cairo. Beliefs in devil-possession prevailed, and to this day, Mr. Waldmeier says, there are no other words for mental diseases than *sikuy* (possessed) and *majnoon* (demon-possessed). Exorcism was practised, the patients kept bound in chains, and closely confined in convents and elsewhere. For the history of this beneficent institution we would refer readers to the successive annual reports, which may be obtained from the Secretary of the Lebanon Hospital for the Insane, 35, Queen Victoria Street, E.C.; but, as showing the growing estimation in which the work is held in Syria, it may be mentioned that the receipts for patients have risen from £153 for the year 1900–1 to £2,007 for the year 1909–10. Side by side with this increasing appreciation of its value, however, the demands made upon the institution are growing also. As Dr. Sandwith said at the last annual meeting, the asylum can never become self-supporting unless it become a private institution for the wealthy instead of for the poor. As it receives no financial help from the State, it is likely to remain largely a charitable institution, and as such we cordially commend it to the notice of our readers.

"LOCAL ANAESTHETICS IN DENTAL SURGERY."

IN a paragraph under this heading published in the JOURNAL of November 26th, page 1734, discussing a recent action at the Bolton County Court, it was stated that the witnesses for the defence "maintained that neither the preparation of the gum nor sterilization of the instruments was either necessary or usual." We are informed that the medical witnesses for the defence did not take up this position, and did not state that the sterilization of the instruments was neither necessary nor usual. We have therefore to express our regret that the statement above quoted, which we are satisfied is incorrect, should have appeared in the JOURNAL.

GENERAL ELECTION.

MEDICAL MEMBERS OF PARLIAMENT.

THE following are among the list of successful candidates possessing medical qualifications whose elections have been announced up to the time of going to press:

England.

*Dr. Christopher Addison (L.), Hoxton.
*Mr. C. H. Dixon (U.), Boston.
*Sir G. H. Pollard (L.), Eccles.
*Sir R. J. Price (L.), East Norfolk.
*Sir G. Scott Robertson, K.C.S.I. (L.), Central Bradford.

Scotland.

*Dr. W. A. Chapple (L.), Stirlingshire.
*Sir Robert Finlay, K.C. (U.), Edinburgh and St. Andrews.
*Dr. A. R. Rainy (L.), Kilmarnock.

Ireland.

*Mr. J. Dillon (N.), Mayo East.
*Mr. A. Lynch (N.), West Clare.

* Represented the same constituency in the last Parliament.

COLIN MACKENZIE, M.B., C.M.ED., D.P.H.R.C.S.ED.,
TRINITY, EDINBURGH.

WE regret to record the death, from enteric fever, of Dr. Colin Mackenzie, which took place at his residence on the morning of December 4th, 1910. Dr. Mackenzie was born at Ullapool, Ross-shire, on December 6th, 1854, and received his early education first at Dingwall, and afterwards at Daniel Stewart's College, Edinburgh. He then proceeded to the study of medicine in the University of Edinburgh, where he graduated M.B., C.M. in 1877. In 1890 he took the Diploma of Public Health of the Royal College of Surgeons of Edinburgh. After graduation he was appointed House-Surgeon to Leith Hospital, and he acted as assistant to the late Dr. Murray of Leith. Later he settled at Tain, where he quickly built up a large practice, and was held in high esteem. Fourteen years ago he moved to Trinity, one of the suburbs of Edinburgh, and soon established himself as one of the leading practitioners of the district. As a doctor he was very successful, endearing himself to his patients not only by his efficiency and skill, but by his kindly ways and his tender solicitude for the welfare of his patients. He was much respected by his fellow practitioners.

With his fine physique, Dr. Mackenzie was essentially an outdoor man, and an ardent lover of all manly sports. Latterly his chief recreation was golf, in which he became so proficient that he carried off many prizes. Formerly he was a Lieutenant in the Volunteer Battalion of the Seaforth Highlanders, and was awarded the long service medal. He was an enthusiastic Freemason, and held the office of R. W. Master of Lodge St. Duthus at Tain. After coming to the Edinburgh district he was one of the founders of Lodge Trinity, and was elected its first R. W. Master. He leaves a widow, a son, and a daughter to mourn his premature death.

WILLIAM HALL, M.D., J.P.,
LANCASTER.

WE regret to record the death in November of Dr. William Hall, of Elmsfield, Lancaster, a town with which he had been connected all his life, and in which he had been in practice for some forty years. After completing his general education at Lancaster Grammar School, Dr. Hall went to Edinburgh, where in 1871 he became L.R.C.P. and S., and then joined his father in practice. Later on he became F.R.C.S.Edin. and M.D.Brux. At the time of his death he was Senior Surgeon to the Lancaster Infirmary; his services to it were long and great, for besides holding a post on its staff for over thirty years, he had taken a large part in its management, being elected President of the Governing Body in 1904 and again in 1905. His father had held a like position, and the services to the institution of son and father together aggregated sixty-seven years.

Besides carrying on a large practice, Dr. Hall at one time played a part in the municipal affairs of the locality as a member of the Town Council. For several years he was Chairman of the Tramways Company, and he held a commission in the Artillery Volunteers long enough to obtain the rank of Surgeon-Colonel. He was an old and active member of the British Medical Association, and at one time President of its North Lancashire Branch. He had also been President of the Lancaster Medical Book Club, and held a considerable number of appointments, including the Surgeoncy of the London and North-Western Railway.

Dr. Hall, who was in good health up to within two or three days of his death, is survived by a widow and five daughters. Some ten years ago his name was added to the Commission of Peace for the borough.

BRIG.-SURG.-LIEUT.-COLONEL JOHN ROSS MURRAY, M.D., F.R.C.S.E.

ON November 17th, at Gipsy Hill, an old officer of the medical service of the army passed away in the person of Brigade-Surgeon-Lieutenant-Colonel John Ross Murray, who graduated M.D.Edin. in 1858, and F.R.C.S.E. in 1889.

He joined the army as a Staff Assistant Surgeon in June, 1861, his commission being antedated in recognition of valuable services rendered during the New Zealand war as an acting Assistant Surgeon. He was gazetted to the 107th Foot in 1863, and to the Royal Artillery in 1868, in which regiment he remained until the introduction of the unification scheme in 1873. In 1875 he was promoted Surgeon-Major, and shortly after this his services were specially mentioned by the Commander-in-Chief in India for good work done during a cholera epidemic at Lucknow. In 1889 he was promoted Brigade-Surgeon-Lieutenant-Colonel. He served in India and Bermuda with distinction, and during the New Zealand campaign was present in three actions, receiving the medal. He retired in 1892. He was a member of the British Medical Association for many years.

DR RICHARD LORD, who closed a long and honourable career at Ealing in his seventy-third year, on November 5th, received his medical education at Edinburgh, where he took the degree of M.D. in 1862, choosing as the subject of his thesis "Synovial Membranes, with Especial Reference to the Bursae Mucosae." In the following year he was admitted a Member of the Royal College of Surgeons of England. He practised principally in Crewe, where he was Medical Officer of Health, and made his name as a skilful, devoted, and conscientious practitioner. Later he came to London, and practised at Notting Hill. Some years ago he gave up his general practice for laboratory and similar work, and acted as medical adviser to a large firm of manufacturing chemists. His death after a brief illness has deprived Dr. Lord's family of an affectionate, devoted parent and his many friends of a capable counsellor and a cheerful, unselfish companion.

DR. JAMES T. MOORE, 27, Buckingham Terrace, Glasgow died on December 7th at his residence, in his seventy-sixth year. Dr. Moore came with his brother, the late Dr. Samuel J. Moore, from the North of Ireland, and, after teaching for some time in Paisley, the brothers took up the study of medicine at Glasgow. Dr. James graduated in 1869, and two years later became M.D. He first practised on the south side of the city, subsequently removing west. He was for thirty-five years a prominent member of the profession in Glasgow, but owing to his health he retired from active work five years ago. He is survived by two sons and two daughters, one of his sons, Dr. S. J. Moore, being in practice in Glasgow.

DR. STEVEN, who died on December 5th at the age of 81, was the senior member of the Association in Dundee. Dr. Steven was a native of Dundee, and served his apprenticeship to Dr. Cocks there, acquiring then the bent which later made him for so many years Surgeon to the Dundee Eye Institution. Dr. Steven had retired from practice some time ago, but was brisk and active to the end. He was much liked by his colleagues, though of a retiring disposition. He was unmarried.

Universities and Colleges.

UNIVERSITY OF CAMBRIDGE.

THE following degrees have been conferred:

M.D.—G. H. A. C. Berkeley.
M.B.—L. S. T. Burrell, R. Crawford, G. Graham, A. Hamilton.
B.C.—L. S. T. Burrell, R. Crawford, A. Hamilton.

GLASGOW UNIVERSITY COURT.

AT a meeting of Glasgow University Court held on December 8th, Principal Sir Donald MacAlister presiding, Professor Phillimore was welcomed as the assessor appointed by the Senatus. A recommendation that Professor Bryce be appointed honorary curator of the anatomical collections in the Hunterian Museum was confirmed.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

AN ordinary council was held on December 8th, Mr. H. T. Butlin, President, in the chair.

Issue of Diplomas.

Diplomas of Fellowship were granted to twenty-four candidates found qualified at the recent examination.

Diplomas of the Licence in Dental Surgery were granted forty-two candidates found qualified for it.

Annual Meeting of Fellows and Members.

At this meeting, held on Thursday, November 17th, a resolution was passed affirming the desirability of admitting Members to direct representation on the Council. To this resolution the Council returned the answer that, as the matter referred to in the resolution was fully considered by the Council during the present year, they are not prepared to reopen the discussion.

Vacancy on the Court of Examiners.

The President reported that a vacancy had occurred, which would be filled up in January, 1911. Any Fellow wishing to become a candidate must apply in writing to the Secretary.

General Medical Council.

The thanks of the Council were given to Sir Henry Morris for his services as representative of the College on the General Medical Council.

Memorial to King Edward.

A letter was read from the Right Hon. the Lord Mayor announcing the opening of the Mansion House Fund for providing a memorial to King Edward in London, and asking the President to bring the appeal to the notice of members of the College living in London.

Scale of Medicines in Mercantile Marine.

A letter of November 29th was read from the Secretary of the Marine Department of the Board of Trade stating that the Board propose to revise the scales of medicines and medical stores issued by them for merchant ships, and to entrust the revision to a committee consisting, as on the occasion of the last revision in 1888, of members of their medical staff and representatives of the Royal College of Surgeons, Royal College of Physicians, and Pharmaceutical Society of Great Britain, with the addition, this time, of a representative of the shipping interests concerned; and asking the Council to nominate a representative of the College to act on the committee.

Mr. Clinton Dent was appointed to represent the Royal College of Surgeons.

Fellowship Examination.

The following candidates have been approved at the examination indicated:

FINAL FELLOWSHIP.—T. G. Fenton, Krishna M. Pardhy, W. B. Ainger, E. E. Maples, G. E. O. Fenwick, G. W. Thomas, J. M. Wyatt, E. T. H. Davies, J. B. F. Wilson, C. W. G. Bryan, J. B. Macalpine, P. J. Verrall, A. Richardson, H. Blakeway, H. D. Gillies, E. L. M. Lobb, H. Chapple, M. Muthu Kumarasamy, J. F. O'Malley, E. Mapother, C. A. Pannett, R. N. Porter, B. Quick, P. B. Roth,

In all there were 67 candidates, of whom 26 were approved and 41 were referred. Messrs. E. M. Cowell and A. K. Dalal passed the examination, but cannot be admitted to the Fellowship until they have reached the requisite age of 25 years.

Medical News.

THE income of the Surgical Aid Society as reported at the annual meeting on December 6th was £28,380, which is an increase of over £1,800 on the income of the previous year, The number of surgical appliances issued was 40,401, an increase of nearly 1,200.

A COURSE of instruction in hospital administration for the diploma in public health will be given by Dr. J. MacCombie, medical superintendent of the North-Western Hospital, Hampstead, on Mondays at 3 p.m., and Thursdays at 11 a.m., beginning on January 9th, 1911. The fee is three guineas, and further particulars can be obtained from the Clerk of the Metropolitan Asylums Board, Embankment, E.C.

IT appears from the report of the council of the Metropolitan Hospital Sunday Fund for the year ending October 31st that the collections in various places of worship on Hospital Sunday amounted to £40,778. This is an increase of some £1,600 over the collection of the previous year. The largest collection was made at St. Paul's Cathedral—£4,483.

THE Friday evening meetings of the Royal Institution of Great Britain will be resumed on January 20th, when Sir James Dewar will give an address on Chemical Change at Low Temperatures. Among other lectures before Easter will be one on Grouse Disease by Mr. Arthur E. Shipley, on Digestive Activity by Professor H. E. Armstrong, and on Water Supply by Mr. J. H. Balfour-Browne, K.C.

IN the report of the libel action against Halifax doctors which was dismissed at the Leeds Assizes, published in the JOURNAL on page 1896 of last week's issue, we omitted to mention that the local solicitors, Messrs. Hirst and Whitley, Halifax, whose names were given, acted as agents for Messrs. Le Brasseur and Oakley, solicitors, of London, and that the latter firm represented the London and Counties Medical Protection Society, Limited, in this case.

Letters, Notes, and Answers.

☞ *Queries, answers, and communications relating to subjects to which special departments of the* BRITISH MEDICAL JOURNAL *are devoted will be found under their respective headings.*

QUERIES.

IGNORAMUS asks how to destroy "worm" which has attacked oak furniture.

A. M. asks for a manual on nursing such as would cover the syllabus of lectures prescribed by the Red Cross Society.

*** The following books would probably answer our correspondent's requirements: *Our Sick, and How to take Care of them*, by Miss Stacpoole. Cassell's Home Handbooks. 1s. *Nursing at Home*, by R. J. Collie and J. D. E. Mortimer. London: G. Gill and Sons. 1906. 8d. *Handbook for Untrained Nurses*. Published by the National Health Society, 53, Berners Street, W. 3d. *Hints and Help for Home Nursing and Hygiene*. Published by the St. John Ambulance Association. 1s.

HOME FOR TROUBLESOME BOY.

L. E. M. asks for advice in finding a school or institution for a troublesome and unruly boy who has got beyond the control of his widowed mother who has slender means.

*** It is difficult to recommend a school without knowing more of the boy's peculiarities. If morally defective the best plan would be to write to the Secretary, National Institutions for Persons Requiring Care and Control, 14, Howick Place, Westminster, S.W., who might be able to indicate a suitable institution.

CONSUMPTIVE SCHOOL CHILDREN.

A MEDICAL CORRESPONDENT, who has been appointed a member of a subcommittee of a county council to report as to the best means of dealing with cases of tuberculosis in children who have been forbidden to attend school, asks what is being done by other county councils, his own view being that the best solution would perhaps be to allow the children, who number some 80 to 100, to run wild. On the other hand, some members of the county council think that should the children recover, they will join the ranks of the unemployed.

*** The latest information as to what is being done by various county councils in dealing with cases of tuberculosis in school children may be obtained from the Annual Report for 1909 of the Chief Medical Officer of the Board of Education. (Open Air Schools, page 144. Schools for Consumptive Children, page 148.) It will be seen that, at present, very little is being done in this direction. The objections to allowing such children to "run wild" when excluded from school are: That they need medical supervision; that the home conditions are often unfavourable to recovery; that the disease tends to be of long duration, so that the children may miss their chance of education. Children excluded from school for tuberculosis at say 10 years of age sometimes never return to school at all, though they may be quite fit for school work under proper special conditions. The National Association for the Prevention of Consumption (20, Hanover Square, W.) published a pamphlet on tuberculosis in school children (Leaflet No. 6) which gives some suggestions as to the provision which may be desirable for such children.

FERTILITY OF WOMEN.

A. B. C. asks to be referred to statistics or literature bearing on the relative fertility of women at different ages.

*** See Matthews Duncan, On the Variations of the Fertility and Fecundity of Women according to Age, *Transactions of the Royal Society of Edinburgh*, vol. xxiii, p. 475; also the same author, On the Laws of the Fertility of Women, same *Transactions*, vol. xxiv, p. 287; and also in vol. xxiv, p. 481, a remarkable monograph by Professor Tait, entitled, Note on Formulae representing the Fecundity and Fertility of Women.

"STILL'S DISEASE."

DR. JOHN W. TAYLOR writes: In the review (JOURNAL, December 3rd) of Dr. Cautley's *Diseases of Children* the reviewer mentions: "On careful perusal we can find no subject of importance omitted;" and, further, it is stated "the most recent works on the subject are laid under contribution." Still's disease has been dealt with of late, but no notice of it whatever occurs in Dr. Cautley's work. It would be interesting to know if your reviewer has overlooked this omission, or whether Still's disease is not regarded by the profession generally as a distinct disease. For my part, I believe