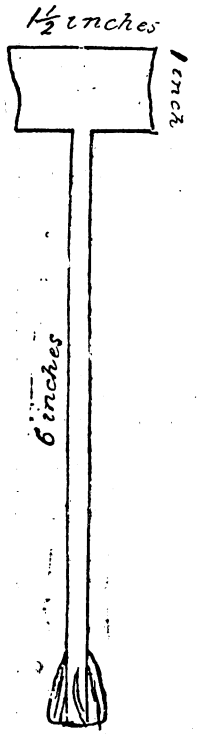
Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

HYSTERECTOMY FOR CANCER OF THE UTERUS OR CERVIX: A SUGGESTION.

To render the division of the vaginal walls more easy and rapid I have had an instrument made locally which acts very satisfactorily. It is practically a vaginal "director," and consists of a straight handle which carries at one end a flat plate 1½ in. wide and 1 in. in length.



Vaginal "director."

This plate is slightly curved like a duckbill. Before opening the abdomen the operator pushes the plate into the anterior fornix, and leaves the instrument lying there.

As soon as the uterine arteries are ligated the instrument is pushed upwards by the nurse and defines sharply the anterior wall of the vagina. Upon this support the wall can be divided by knife or thermocautery without the least trouble. When the anterior wall is divided the instrument is passed into the posterior fornix, and the uterus being pulled forward, the posterior wall is seen very well defined, and division is easy.

A second suggestion I would like to make is the treatment of a diseased cervix.

To avoid any infection of the abdominal cavity it has hitherto been imperative that the ulcerated surface should be scraped or cauterized.

A method I think much simpler is as follows: A volsella is clamped upon the cervix before the abdomen is opened. The instrument described above is pushed into the anterior fornix. The abdomen is then opened and the usual steps of a hysterectomy performed. When the uterine arteries are ligated the uterus is amputated above the cervix, care being taken to protect the surrounding parts with sponges. The walls of the vagina are then divided upon the little instrument I have described, and the cervix is withdrawn per vaginam by traction on the volsella. By this procedure no infection of the abdominal cavity can occur.

I am not aware if I am suggesting any procedure already adopted, but I think the above will perhaps be of value to operators, like myself, who have not unlimited assistance at hand.

P. CLENNELL FENWICK, M.D., F.R.C.S.E.,
Honorary Surgeon to Christchurch Hospital, New Zealand.

TWO CASES OF ACUTE TETANUS TREATED BY ANTITETANIC SERUM: RECOVERY.

A. M., aged 38, female farm servant, was placed under my care in the Western Infirmary by Dr. Love, of Cumbernauld, on November 13th, 1908.

Ten days before admission, while driving a horse at the mill, her right foot was caught in the wheel and badly lacerated. On examination I found the right foot had a large lacerated wound over the dorsum and another across the sole, extending upwards on the outer aspect of the foot and leg. She complained of stiffness in her jaw, the following day she complained of stiffness in her back, and in the afternoon she had a distinct attack of opisthotonos. The discharge from the wound was examined by Professor Muir, who found the bacillus. Antitetanic serum was injected once in the twelve hours, but no improvement took place in two days, and, after consultation with Professor Muir, I used Parke Davis's serum, which rapidly produced a marked improvement, and she gradually recovered.

H. S., aged 5, was admitted on March 10th, 1909, with a history that three weeks previously she had the ring and little fingers of the left hand injured with a reaping machine. Half of the little finger had been amputated. Four days before arriving at the infirmary she developed symptoms of tetanus. On examination the stump of the ring finger was found to be in an unhealthy condition, and it was therefore amputated. Opisthotonos and trismus were well marked in her case also. Parke Davis's serum was used, as in the case above, and the patient's recovery was quite satisfactory.

REMARKS.—Cases of tetanus are so frequently fatal that it seems right to record the above two in which recovery took place. In lacerated wounds it is important to have any discharge examined, in order that, if the tetanus bacillus is found, doses of serum ought to be given; indeed, in every lacerated wound where healing is not progressing favourably a prophylactic dose of serum ought to be administered, as the bacilli might be absorbed before they could be discovered in the discharge.

J. CRAWFORD RENTON, M.D.
Surgeon and Lecturer on Clinical Surgery, Western Infirmary, Glasgow.
Glasgow.

DYSTOCIA DUE TO VENTRIFIXATION OF UTERUS TREATED BY CAESAREAN SECTION.

ON August 17th, 1910, at 2 a.m., I was sent for to assist Dr. J. C. Galloway at a difficult case of labour. The patient is the wife of a farm labourer resident some two and a half miles from Banff. She is 27 years of age, and her obstetrical history is as follows:

Her first three pregnancies were in rapid succession, were quite normal, and three living children were delivered without any interference whatsoever. In October, 1907, she aborted at the third month, and after that she had a certain amount of prolapsus uteri, in connexion with which she consulted Dr. Galloway. Dr. Galloway advised her to go into Aberdeen Infirmary, where ventrisuspension was advised and performed by Mr. Marnoch on August 1st, 1908. The patient came home after this operation on August 22nd, and had one menstrual period after her return, when she again became pregnant. In May, 1909, she gave birth to a very small premature child, which was stillborn, and was born before Dr. Galloway arrived. She informed me that it came "feet first." During the pregnancy which resulted in her most recent labour "she did not feel at all like she had done in previous pregnancies," but did not consult Dr. Galloway until she had to send for him on June 12th for sudden haemorrhage, which came on while she was lying in bed at midnight. This haemorrhage was very severe, but stopped soon after Dr. Galloway's arrival, without any treatment, and is explained by the fact that at the subsequent Caesarean section the placenta was found to be lying well down in the lower uterine segment. She stayed in bed till June 16th, and was then able to do light housework till August 16th, when she fell into labour about 11 a.m. She did not send for Dr. Galloway till about 10 p.m., and on his arrival he found on examination a transverse position, the membranes intact, the os very high up and dilated sufficiently to admit two fingers. He attempted version, and, the membranes rupturing, the liquor amnii drained away. He got hold of the left foot, but could not get the child turned round at all, the head lying persistently in the left iliac fossa. He sent into town at 2 a.m. and I went out. I gave the patient chloroform, and he again endeavoured to turn, without avail. He then asked me to attempt to deliver, which I did, he giving the anaesthetic. I found the uterus very much thinned out and firmly adherent to the abdominal wall, in the line of the ventrisuspension scar. The os was well dilated and the cord prolapsing and pulsating strongly. I worked away for a long time, but could not get the child delivered.

After talking over the case, Dr. Galloway and I agreed that to persist in attempting the delivery by version or even by embryotomy would probably lead to rupture of the uterus. Her pulse was now very weak and running at 130 per minute. We accordingly decided that Caesarean section was the safest course to adopt, and the house

being merely a labourer's cottage, we arranged to remove her immediately to Chalmers Hospital, some two and a half miles distant. She stood the drive into hospital fairly well, arriving shortly after 6 a.m. On admission her temperature was 100° F., her pulse 140, and very weak. Before putting her on the table she was given $\frac{1}{30}$ gr. strychnine and $\frac{1}{100}$ gr. digitalin hypodermically and a rectal saline with brandy. With Dr. J. H. Stephen giving chloroform and Dr. J. Anderson assisting me I opened the abdomen; the uterus was found fixed to the abdominal wall by a strong fibrous band not more than 1 in. in length, about $\frac{1}{4}$ in. thick and 1 in. broad, about $1\frac{1}{2}$ in. to 2 in. above the pubes. The uterine wall above the adhesion was very much thinned out and followed every contour of the fetus, but below the adhesion it was much thicker. On opening the uterus there was a good deal of haemorrhage, which was soon checked by very hot saline after the removal of the child and placenta. The child was quite full time, weighed fully 8 lb., but unfortunately could not be revived. Owing to the woman's exhausted condition I decided to leave the uterus, but ligatured and cut both Fallopian tubes and finished the operation as quickly as possible, suturing in the usual manner.

An intramuscular injection of Parke Davis's aseptic ergot was given and repeated every four hours for four doses. Rectal salines with brandy were given frequently. Four hours after operation $\frac{1}{4}$ grain of morphine was given hypodermically, which effectually stopped the sickness which was very severe.

The temperature remained at 100° F. for eight hours and then fell below normal and remained there and the pulse-rate gradually diminished in frequency. Involution followed a normal course and the lochia remained quite pure, in fact the patient made an uninterrupted recovery. I have reported this case at length for several reasons: First, because I have never heard or read of such a troublesome case following ventrisuspension; secondly, that I have never heard of Caesarean section recommended should such a case occur; thirdly, because of the remarkably good recovery made by this patient from Caesarean section, performed as it was at 7 a.m., some twenty hours after the outset of labour, and even then after considerable vaginal manipulations, which says a great deal for the aseptic precautions taken by the medical attendant, Dr. Galloway. I would like to take this opportunity of recording my thanks to Dr. Stephen for his administration of the anaesthetic to such a bad case, and to Dr. Anderson for his very able assistance at the operation.

W. Manson Fergusson, M.B., Ch.B.,
L.M.Rotunda;
Assistant Surgeon, Chalmers Hospital, Banff, N.B.

Reports of Societies.

THE ROYAL SOCIETY.

Thursday, December 8th, 1910.

Mr. A. B. Kempe (Treasurer and Vice-President) in the Chair.

The Trichromatic Theory of Colour Vision.

Sir W. de W. Abney, continuing his papers on colour blindness and the trichromatic theory of colour vision, made a contribution on incomplete red or green blindness. In Part I he had treated of complete colour blindness, and in this paper of incomplete colour blindness. He argued that the amount of incompleteness could be accurately determined from the luminosity curve of a colour-blind person both red and green blind, and that the amount of incompleteness could be determined from observations made by the red or green blind at any part of the spectrum, if someone with normal vision made observations at the same place using unchanged white light for the comparison. He adduced evidence that the three sensation components of the different colours of the spectrum, as determined by himself, were verified by the results; and that the trichromatic theory accounted for all cases of incomplete colour blindness which he had measured.

Enumerative Studies in Malaria.

The object of researches reported by Professor Ronald Ross and Dr. David Thomson was to make a minute co-ordinated study of cases of malarial infection occurring in the tropical ward of the Royal Southern Hospital at Liverpool. A measured quantity of blood was made into a dehaemoglobinized thick film, and the organisms contained in it counted. Almost daily estimates of the number of parasites, with frequent estimates of the leucocytes, the haemoglobin and the excreted urobilin, were made since the beginning of this year in 24 cases of *Plasmodium falciparum*, 8 cases of *P. vivax*, and 1 case of *P. malariae* and *P. falciparum*. Correlation, with minor deviations, was found between the number of asexual parasites present and the degree of fever. If the asexual forms did not number more than several hundreds per cubic millimetre they were not numerous enough in these cases to produce fever. The asexual forms did not disappear between relapses as usually thought, but tended to diminish. It was roughly estimated from these cases that quinine reduced the asexual forms by 50 to 80 per cent.

Haemoglobin Metabolism in Malarial Fever.

In a preliminary note Dr. G. C. E. Simpson said that in the pyrexia of malaria there was a marked fall in the haemoglobin of the blood, and further investigation of this question was undertaken in the hope that it might throw light on the relationship of malaria and blackwater fever. In benign tertian malaria a slightly increased output of urinary urobilin occurred; in malignant tertian malaria, a greater increase; and in the malignant form, marked urobilinuria was sometimes found. More urobilin was excreted in the faeces than in the urine, a fact which had been largely neglected by previous observers. In benign malaria faecal urobilin was excreted in amounts comparable to those in other pyrexial diseases; in malignant malaria a higher output was the rule, and might represent as much as 25 per cent. of the total blood. This showed that the haemoglobinometer readings recorded an actual destruction of haemoglobin. The number of corpuscles destroyed was larger than the number infected by parasites. It appeared that in malignant tertian malaria the removal of free haemoglobin by the liver prevented haemoglobinaemia of sufficient grade to produce haemoglobinuria. A remarkable excretion of urobilin was found in a case of blackwater fever, representing the destruction of an amount of haemoglobin equal to the whole of the circulating blood, the amount of haemoglobin passed unchanged in the urine being negligible in comparison. Haemoglobinuria in this case was not due to failure of the normal mechanisms to deal with an amount of haemoglobin such as was set free in ordinary malaria, but to a slight overflow of haemoglobin through the kidneys owing to the exceptional amount of haemolysis.

Sleeping Sickness.

Professor Ronald Ross and Dr. David Thomson reported further observations on a case of sleeping sickness studied by precise enumerative methods. (1) The trypanosome cycle recorded in their previous paper continued till the patient's death. (2) The amount of fever was greater during the trypanosome increase. (3) The total leucocytes increased coincidently with the trypanosome increase. The mononuclears increased relatively more than the polymorphonuclears. During the trypanosome fall the leucocytes continued to increase in number. The number then decreased rapidly to normal and under when the trypanosomes again commenced to increase. A very marked mononuclear increase, coincident with a decrease of trypanosomes, was accompanied by a remarkable clinical improvement. (4) Atoxyl in small doses, 2 to 4 grains, and quinine and methylene blue in large doses had no appreciable trypanocidal action. (5) Subcutaneous injection of vaccines of trypanosomes obtained from heavily infected rats seemed to cause a premature rise in number of the patient's trypanosomes; the effect depended upon the time of injection in relation to the cycle. (6) Subcutaneous injection of leucocytic extract caused a marked leucocytosis on the day after the injection, and on one occasion this leucocyte increase was coincident with a marked clinical improvement. The conclusions drawn by the authors were as follows:

bacteria, like other bacteria, vary according to circumstances.

From the epidemiological standpoint, it is most important to realize that the cholera vibrio may exist for days, even for a fortnight, in the intestines, not only of persons who have recovered from cholera, but also in quite healthy subjects. Although the vibrios of such "vibrio-carriers" are not very virulent, and such people are not so likely to spread the germs of cholera as are genuine cholera patients, there can be no doubt that the former are capable of disseminating cholera. It is quite possible that of the people about a cholera patient 5 to 7 per cent. may be bacteria carriers, and yet appear perfectly healthy. The germs may also be carried by flies, in which, it has been proved, the fibrios may exist for days and may be inoculated into food. This is an important point if we remember that in the summer vibrios propagate most luxuriantly in foodstuffs. According to recent investigations the vibrio-killing capacity of the contents of the stomach depends not only upon the concentration of the hydrochloric acid, but upon other factors, such as the general gastric contents. Dr. Preisz proved this by pumping out the contents of a stomach after a test meal; in this way he found that it took much longer to kill the vibrios when the stomach contained 0 2 per cent. of hydrochloric acid than when it contained nothing more than a glass of water containing 0.03 per cent. of hydrochloric acid alone. Peptone, albumose, and mucus all weaken the vibrio killing property of the gastric juice to a considerable extent. An interesting epidemiological fact is the variety of circumstances which explain the abatement or complete disappearance of cholera during the winter, such as the decrease in the use of river water for such purposes as drinking, bathing, etc.; the lower temperature, which is unfavourable for the propagation of vibrios both in water and elsewhere; the diminution of traffic; and the far smaller quantity of raw fruit which is consumed during the winter months. But that the cholera germs do remain alive during the cold weather is an established fact, and with the advent of summer they begin to propagate once more on a larger scale; and should their virulence increase and circumstances be favourable, another epidemic may break out. Moreover, the vibrios may remain alive for over three months in the excrements of cholera patients. But one question remains to be solved, What happens to the vibrio when the cholera is really in a dormant state? Does it actually die, or does it by losing its virulence, become an innocent bacillus which cannot recover its pathogenic properties in our climate? It is equally important to discover whether, in places where the cholera is endemic, the vibrios live permanently in the human body or outside it? Serumtherapy has hitherto been useless in cholera since, although serums do kill bacteria the infected body does not in consequence of this get rid of the poison contained in the vibrios; and the serums called antitoxic have been proved to be only vibrio-killing. Recent investigations seem to show that inoculation by means of dead vibrios is an efficacious method of prevention. The recent cholera epidemic in Hungary chiefly ravaged the districts lying along the banks of the Danube; and considering the large number of infected villages the hygienic authorities ought to be very active in enforcing preventive measures if they do not desire to go through some unpleasant experiences.

DEATHS IN THE PROFESSION ABROAD.—Among the members of the medical profession in foreign countries who have recently died are Dr. Nathaniel Pendleton Dandridge, Professor of Surgery at Cincinnati, aged 64; Dr. Ulrich Krönlein, Professor of Surgery in, and Director of, the Surgical Clinic in the University of Zürich; Dr. Stanislaus von Kostanecki, Professor of Organic Chemistry in the University of Berne, aged 50; and Dr. N. Manolesco, sometime Professor of Clinical Ophthalmology in the Medical Faculty of Bucarest.

Correspondence.

STATE SICKNESS AND INVALIDITY INSURANCE.

SIR,—In his letter in the JOURNAL of December 17th Dr. Buist observes: "The rapidity with which Dr. Cooper and I approach each other . . ." If he means by this that we are nearer together because *both* of us have moved from our original positions, the implication is quite erroneous. I stand precisely where I have always stood as the steadfast opponent of the principle of contract practice and the earnest advocate of payment according to work done in medical attendance under any State sickness and invalidity insurance scheme. I cannot see how any language of mine can be twisted into any other meaning. If therefore there be any convergence in our views it must be that Dr. Buist is coming round to the principle I advocate, but I see little evidence of this in the remainder of his letter.

To another statement of Dr. Buist I must take emphatic exception. He says: "Dr. Cooper seems almost to admit that, whether advisable or not, a *per capita* rate of 10s. would be adequate over a parcel of 2,000." I certainly never "almost" admitted any such thing. I said: "I have very little doubt that a good many of the profession might be induced to adopt contract practice and put up with all its drawbacks for a guaranteed income of £1,000 a year"; but I never said that *I* would, and I strongly repudiate Dr. Buist's erroneous inference. In fact, I went on definitely to say that I was opposed, on principle, to contract practice, *whatever the remuneration.*

I think I succeeded in showing that Dr. Buist's tempting bait of £1,000 per annum for medical practitioners, under a capitation fee of 10s., was wide of the mark. On his own showing (p. 1944), and even including the whole of the population of these islands, the average gross income only works out at £562 10s., which is very nearly one-half of Dr. Buist's original figure. (Possibly that is where the convergence alluded to by Dr. Buist comes in. I admit that a drop of nearly 50 per cent. in one week on his part is a considerable step nearer to my estimate.)

But, unfortunately both for Dr. Buist and Dr. Flemming, who takes up the cudgels on his behalf, we cannot include the remaining 30 millions of the population in such a calculation, *for from 10 to 15 millions of these are actual or potential paupers*, who are separately provided for by the Poor Law, and it is certainly not the Government's intention at present to include these in a State sickness and invalidity scheme, so where is the 10s. a head from these to come from? It must, further, be remembered that any income derived from *per capita* payments would be a *gross* income—that is, all professional expenses, cost of premises, conveyances, assistance, and all medical and surgical equipment—would have to be deducted from this, so that the *actual net income* would be very much less than this.

Dr. Buist suggests that we can make up our incomes by attending those who are not included in the State grant. It is only too certain, however, that a very large number of practitioners in the poorer districts would get very few of these outsiders. Further, the amount of time they would have to give to their contract patients, who would certainly have the first claim upon their services, would permit very little, if any, time for outside work.

As Dr. Fothergill points out, the attendance on a parcel of 1,500 beneficiaries would mean at least fifty visits a day, apart from attendances at the surgery. Anyone who knows anything of medical attendance must admit that it is quite impossible to attend to such a large number of cases, spread over a large area. with anything like adequacy, so that a gross annual income of £750 would be a practical impossibility to maintain.

Dr. Buist objects to my reference to exceptional cases. It is just because I know what a lot of exceptional cases there are that I mentioned one, and because the *per capita* system takes no note of exceptions. It merely pushes all the risks of such exceptions on to the already overburdened shoulders of the profession. Indeed, where it is intended that we should take over actual cases of chronic illness requiring constant attendance the whole principle of insurance drops out: it is no longer a possibility or contingency but a certainty of work to be done, which we

great personal comfort. Any form of gymnastics has been unsuitable for this patient up to the present.

Minor degrees of adiposis dolorosa are perhaps not very uncommon, if looked for. The "dolorosa" is always regarded as rheumatic by the patient; the "adiposis," when very slight, has commonly not been observed, or no importance has been attached to it; it is, perhaps, most common in the upper arms.—I am, etc.,

Leamington, Dec 3rd. PHILIP HICKS.

THE TREATMENT OF MORPHINOMANIA BY THE "COMBINED" METHOD.

SIR,—Having read with the greatest interest Dr. Crichton Miller's paper on the above subject in the JOURNAL, p. 1595, I shall be glad if you will give me space for a few remarks thereon. I wish particularly to emphasize the necessity of treating the psychical side of the disease, while fully appreciating, as does Dr. Crichton Miller, the physical side also. It is the physical rather than the psychical side that has been treated in the past, and very well treated, and it is the absence of the psychical side of the treatment that has prevented the physical treatment of the past being the complete success it should have been had psychic treatment been combined with it. I have treated morphinists by the gradual withdrawal method of Jennings, with the help of his "therapeutic triad," and by the more rapid method of Crothers under bromides, and I have found that in both there has been something wanting, and that something, like Dr. Crichton Miller, I am satisfied is to be found in rightly-applied hypnotic suggestion. There is a physical crave and a psychical crave, and, although without psychic treatment or such conscious psychic treatment as is given by hypnotic suggestion, the suppression of the morphine can be accomplished in most cases with a small amount of distress by either Jennings's or Crothers's method, it can be accomplished in most cases with far less distress—for there is mental as well as physical distress—when psychic treatment by hypnotic suggestion is employed in conjunction with physical treatment.

It is, however, in the after-treatment of morphinomania, the period that begins on the completion of the withdrawal of morphine, that psychic treatment becomes of paramount importance, and it is exactly here where treatment without such psychic treatment has failed in the past and led so often to relapse. Jennings and others have realized the cause of relapses to be the want of what they call re-education, but have not seemed to realize the value of hypnotic suggestion in bringing about this re-education. My experience in the use of hypnotic suggestion in these cases is, like Dr. Crichton Miller's, not of long enough duration to make my records of any great value; but I can certainly say that the cases I have treated by combined psychic and physical treatment have done far better than those which in the past I treated by physical measures only. My tendency has been to rely more and more on bromidization in effecting the withdrawal of the morphine, on account of the possibility of a rapid withdrawal, under conditions less distressing to the patient than a long drawn out gradual withdrawal even when symptoms are relieved to the utmost.

My experience is that except in such cases where it is obviously contraindicated by organic disease of the heart or lungs, rapid withdrawal in a few days under sufficient sedation is without any real danger, heart tonics (sparteine and digitalis) together with alkalis, and other drugs, being given to allay physical symptoms as they arise, and will arise, during morphine suppression. I have never reached the height of sedation and the complete withdrawal of morphine in three days, having contented myself hitherto in attaining my object in from six to eight days after the first dose of bromide was given.

My practice has recently been to commence treatment with hypnotic suggestion for about a fortnight, with the object of training the suggestibility of my patient, and gaining his complete confidence, by full explanation of the treatment, and getting him to understand that I want his complete co-operation, and that I shall do everything I can to assist him to co-operate. During this preliminary treatment the morphine is gradually withdrawn with the patient's complete knowledge and consent; when the suppression begins to be in any way distressing, the bromide treatment is commenced, and when it begins to be effective the morphine is more rapidly withdrawn in proportion to the bromide sedation produced. At the end of from six to eight days the patient is in the semicomatose condition described by Dr. Crichton Miller, and both bromide and morphine are then withdrawn completely, and as soon as the patient becomes again sensible enough, hypnotic suggestions are resumed and continued in decreasing doses during the remainder of the treatment.

While appreciating Dr. Miller's opinion that the treatment should be as short as nine weeks if possible, I think it is a mistake to attempt to make any hard and fast rule, as so much will depend on the physique of the patient, upon his mental health, and the response he makes to therapeutic suggestion. I fully endorse the importance which Dr. Miller gives to the teaching of autosuggestion to the patient as a stand-by when he is left once more to his own devices, and to accustoming of the patient to see and handle the syringe and drugs he has been accustomed to abuse before the completion of his course of treatment. I wish to advocate the preliminary preparation of the patient by hypnotic suggestion before commencing the rapid withdrawal of the morphine under bromides as of value when suggestion has again to be resorted to after the bromide and morphine withdrawal. The patient then knows what is required of him, and is more likely to respond to suggestions, when quick and thorough response to suggestion is of the greatest importance.

Dr. Bérillon, I believe, prepares his morphine patients for treatment in this way before commencing reduction at all, or at all events before carrying it to any extent.

It is as unscientific and irrational to treat morphinomania by physical measures without psychic measures as it is to treat it by psychic measures without physical measures.—I am, etc.,

J. W. ASTLEY COOPER, L.R.C.P.Edin.

Ghyllwoods Sanatorium, near Cockermouth, Cumberland, Nov. 22nd.

"INDUCED CELL DIVISION AND CANCER."

SIR,—In a volume just published by Messrs. John Murray and Sons, entitled *Induced Cell Division and Cancer*, by Mr. H. C. Ross and Dr. J. W. Cropper, our names are quoted either in the preface or in the body of the work. We desire to say that, having had no opportunity of seeing the work previous to publication, either in manuscript or in proof, we think it only fair to disclaim any responsibility for the statements made and the conclusions arrived at by the authors.—We are, etc.,

R. J. HARVEY-GIBSON.
W. A. HERDMAN.
B. MOORE.
J. REYNOLDS GREEN.
C. S. SHERRINGTON.

Liverpool, Dec. 19th.

Universities and Colleges.

UNIVERSITY OF OXFORD.

THE following candidates have been approved at the examinations indicated:

FIRST M.B. (*Organic Chemistry*).—W. G. V. Blogg, K. G. Bowes, L. R. Broster, L. G. Brown, W. H. Butcher, J. B. Cavenagh, R. W. J. A. Cushing, J. F. Haynes, R. J. Inman, O. G. Parry-Jones, P. P. Reitlinger, S. W. F. Underhill, H. St. H. Vertue, D. M. P. Whitcombe.

FIRST M.B. (*Human Anatomy and Physiology*).—A. C. Ballance, C. H. Carlton, J. C. Davies, A. W. Dennis, C. H. L. Harper, A. L. Pearce-Gould, T. O. Thompson, T. A. Townsend.

SECOND M.B. (*Materia Medica and Pharmacology*).—H. T. Evans, R. A. Fawcus. D. P. McDonald, W. R. Reynell, R. C. Wingfield.

SECOND M.B. (*Pathology*).—H. C. Bazett, W. H. Bleaden, N. G. Chavasse, P. L. Gibson, E. G. Martin, G. E. Neligan, W. J. Pearson.

SECOND M.B. (*Forensic Medicine and Public Health*).—A. R. Chavasse, W. A. Cooke, G. E. Downs, H. J. B. Fry, A. D. Gardner, P. L. Gibson, G. W. Johnson, G. E. Neligan, E. O'Connor, E. L. Pearce-Gould, J. F. Penson, R. C. Wingfield.

SECOND M.B. (*Medicine, Surgery, and Midwifery*).—R. F. B. Bowes, A. W. Donaldson, G. E. Downs, G. W. Johnson, E. P. Poulton, A. S. Roe, R. C. Wingfield.

UNIVERSITY OF LONDON.

LONDON (ROYAL FREE HOSPITAL) SCHOOL OF MEDICINE FOR WOMEN.

Building Debt.

THE Council has received the following sums towards the repayment of the building debt: The Goldsmiths' Company, £100; The Mercers' Company, £52 10s.; Miss S. A. Turle, £200;

F. C. N., £52 10s.; The late Mrs. Isabel Thorne, £50; Dr. May Thorne, £50; F. C. T., £50; Sir Charles Burt, £10 10s.; collected by Mrs. Starling, £74 1s.; and smaller sums amounting to £10 10s.

Demonstrators.

The Council has appointed Miss N. Laycock, B.Sc., to be demonstrator in Biology, and Miss I. Pendlebury, B.Sc., to be demonstrator in Physics for 1910–11.

Exhibition and Scholarship.

The St. Dunstan's Exhibition of £60 a year for three years has been awarded to Miss Lilian A. Clark of the City of London Girls' School, and the School Scholarship of £30 to Miss C. I. Fox, of the Mount School, York; Miss K. Lloyd, of the Welsh Girls' School, Ashford, being named *proxime accessit.*

VICTORIA UNIVERSITY OF MANCHESTER.

THE following candidates have been approved at the examinations indicated;

FIRST M.B. (*Organic and Bio-chemistry*).—Gwendolen Birch-Jones, D. R. Garrett.

SECOND M.B., CH B. (*Anatomy and Physiology*).—*L. B. Baird, A. Barrett, F. A. Bearn, J. G. Bennett, E. S. Brentnall, F. S. Charnock, H. F. Hutchinson, H. Kempsey, E. Leahy, *F. L. Newton, W. L. Nicholson, T. P. Robertson, H. A. Sandiford, *E. Talbot, †H. Taylor, C. Thompson, F. K. Tomlinson, C. H. Whittall, H. W. F. Williams, G. W. Wood.

THIRD M.B. (*Pharmacology, Therapeutics, and Hygiene*).—W. Barnes, ‡C. T. G. Bird, L. S. Daly, R. B. Gorst, C. L. Graham, H. Harrison, G. B. Horrocks, T. P. Kilner, F. Oppenheimer, W. J. A. Quine, H. Sheldon.

THIRD M.B. (*General Pathology and Morbid Anatomy*).—F. S. Bedale, §B. B. Berry, §A. G. Bryce, G. C. Dixon, G. Fildes, W. H. Kauntze, J. A. Lees, §P. H. Midgley, §T. H. Oliver, §S. B. Radley, L. W. Sparrow, C. F. White, §A. G. Wilkinson, H. D. Willis.

* Anatomy only. † Physiology only.
‡ Pharmacology and Therapeutics only.
§ Distinction in Pathology.

UNIVERSITY OF LIVERPOOL.

Dutton Chair in Tropical Entomology.

IN 1905 the late Dr. Dutton lost his life in the Congo from spirillum fever, a disease which he, together with the other members of the twelfth expedition of the school were investigating. In view of the many great services that Dr. Dutton had rendered to the investigation of tropical medicine, although he died at the early age of 28, the Liverpool School of Tropical Medicine set about collecting a sufficient sum of money to endow a Professorship in the University of Liverpool connected with Tropical Medicine, to commemorate the sacrifice of his life.

The school has recently been able to offer the university the sum of £10,000 for the establishment of a Chair in Tropical Entomology. This offer has duly been laid before the university, and at a meeting of the council held on December 13th, it was resolved gratefully to accept the offer of the school.

This makes the second Chair given to the university by the Liverpool School of Tropical Medicine, the first being the "Sir Alfred Jones Chair in Tropical Medicine."

Associate Professorship of Pathology.

On the recommendation of the Faculty of Medicine and the Senate, the council has conferred the title of Associate Professor upon Dr. Ernest E. Glynn; for the last six years he has been Lecturer in Pathology in the university.

Tropical Medicine.

The following candidates have been approved for the diploma in Tropical Medicine:

E. Brabazon, L. Castellino, J. A. Caulcrick, W. E. Haigh, H. F. Hamilton, W. St. M. Hefferman, A. Hipwell, J. Homer, W. M. Houston, D. P. Johnstone, A. G. Macdonald, C. C. Murison, P. D. Oakley, I. C. Pratt, E. L. Sieger, P. J. de Sousa, J. H. Waterhouse.

THE JOINT MATRICULATION BOARD.

THE annual report of the Joint Board of the Universities of Manchester, Liverpool, Leeds, and Sheffield, which conducts the matriculation examinations on behalf of the four universities, has just been issued. The report shows that 1,954 candidates presented themselves for the matriculation, which is almost the same number as last year, but the number of those who satisfied the examiners fell from 1,067 to 855. In the previous year the number of failures was less than usual, and the fall in the percentage of passes was partly to be accounted for by the requirement of prose composition in Latin, though the failures were above the average in nearly every subject. While undue strictness in the examination was not desirable, it was felt that it would not be to the advantage either of the candidates or the universities if persons were passed who would not be likely to qualify for their first university examination at the end of their first year of study. It was noted that many candidates had not been well advised in presenting themselves for papers in the higher subjects. These papers were not adapted for candidates for the ordinary subjects, and presupposed at least one year's advanced study. They were intended rather for the best candidates from the higher forms in schools, or for those who intended to enter the honours schools of the universities.

Under the regulations for the inspection and examination of schools, examinations had been held for school certificates, and also form examinations and inspections. The Board had also conducted on behalf of a large number of education authorities in Lancashire, Cheshire, and Yorkshire examinations on which recommendations for the award of scholarships were made, as well as examinations for certain entrance scholarships in some of the universities.

Revised regulations for school examinations will shortly be issued, and will be obtainable from the Secretary at the offices of the Board, 24, Dover Street, Manchester.

UNIVERSITY OF SHEFFIELD.

Chair of Surgery.

MR. R. J. PYE-SMITH has resigned the Professorship of Surgery. The Council has adopted the following resolution:

That the resignation of Mr. Pye-Smith as Professor of Surgery in the University be accepted with great regret. Mr. Pye-Smith, who is the senior member of the teaching staff, has been a teacher of surgery for thirty-four years, first in the old medical school, next in the University College, and finally in the University, and the Council desire to place on record their appreciation of the distinguished services which he has rendered to the cause of medical education in Sheffield.

Lectures in Materia Medica.

Mr. E. W. Adams, M.D. (London and Sheffield), has been appointed to the post of Lecturer in Materia Medica and Assistant to the Professor of Materia Medica, Pharmacology, and Therapeutics.

The Services.

DIFFICULTIES IN CONNEXION WITH THE MEDICAL ADMINISTRATION AND ORGANIZATION OF THE TERRITORIAL FORCE.

[FROM A CORRESPONDENT.]

JUDGING from recent articles and discussions in the lay press, there is undoubtedly a somewhat widely prevalent belief that there are many matters concerning the administration and organization of the Territorial Force as a whole which call for prompt remedial action on the part of the authorities. The present seems to be a suitable opportunity, therefore, for indicating some of those which more particularly affect the medical service of the Force, and while the following summary does not claim to be exhaustive, it is thought that it covers the more salient points involved.

It will be convenient to deal with the subject under the several heads given below.

General Considerations.

General officers and their staffs of the regular service at divisional and command head quarters often fail fully to realize the difficulties under which Territorial officers labour, and the result is that the latter do not always receive that specially sympathetic and considerate treatment to which they are entitled in virtue of their disinterested services to the State. The hectoring attitude not infrequently adopted in the regular army by seniors towards juniors is by no means uncommonly employed by the regular staff towards Territorial officers. There is too great a tendency also to hustle the latter with letters marked "urgent" and "pressing" (often quite unnecessarily) and demanding the immediate submission of replies and reports; and to issue orders calling for action within a period entirely inadequate for the purpose. Medical officers of the Force have their share of these worries, and as most of them are busy practitioners, it will be readily understood that procedure of this nature is apt to prove extremely vexatious to them.

Administrative Medical Officers.

The responsibilities and duties devolving on these officers are very onerous, continuous, and increasing daily. The work is, however, cheerfully done, though it is very discouraging to them to have to make bricks without straw—that is to say, to carry on with insufficient funds the medical administration of their divisions, together with that of such mounted brigades, army troops, territorial units of coast defences, general hospitals, and R.A.M.C.(T.F.) schools of instruction as may be within the divisional areas.

A serious blow to the prestige of A.M.O.s has recently been dealt by the orders conveyed in paragraph 354, Regulations for the Territorial Force, 1910, which places on Command Principal Medical Officers the duty of carrying out the greater and more important part of the annual inspection of field ambulances (including that directed to test their readiness for war and mobilization arrangements), and the whole of that of general hospitals

YET another Crimean veteran has passed away in the person of Deputy Surgeon-General JOHN MEANE, who died at Bournemouth at the age of 82. He obtained the diploma of M.R C.S.Eng., in 1850, and entered the Army Medical Service in November, 1852, attaining the rank of Brigade Surgeon in March, 1880, and retiring with the honorary rank of Deputy Surgeon-General in 1881. He went to the Crimea in 1855, and was present at the siege and fall of Sebastopol, where he was wounded, and at the attacks on the Redan on June 18th and September 9th. He was mentioned in dispatches, and received a medal with clasp and the Turkish medal. He also served in the Afghan war in 1878–80, was again mentioned in dispatches, and received a medal.

DR. HENRI HUCHARD, one of the leading physicians of Paris, has just died at the age of 66. His clinical treatise on diseases of the heart and blood vessels (1889-1893) is a classic, and he wrote much also besides—on caffeine, antipyrin, strophanthus, rheumatism, dyspepsia, etc. He was also the author of a well-known work, entitled *Consultations Médicales*, published in 1901. Dr. Huchard was a man of strong personality and a strenuous advocate of the reform of medical education.

Public Health AND POOR LAW MEDICAL SERVICES.

LAVATORY ACCOMMODATION AT RAILWAY STATIONS AND TEASHOPS.

IN the JOURNAL of January 8th, 1910, pp. 89 and 109, we called attention to the question of the lavatory accommodation for ladies at railway stations, and we are glad to find that the matter has been taken up by a conference of representatives of the Royal Sanitary Institute, the National Health Society, the Women's Imperial Health Association, and the Women's Sanitary Inspectors' Association, held on November 21st. Mrs. Oxley Grabham, who has conducted an extensive investigation into the subject, was also present. The following resolutions were carried:

1. That in the opinion of this meeting sufficient sanitary accommodation for women's use should be provided free of charge by sanitary authorities, railway companies, and in places of public entertainment and resort.
2. That in the opinion of this meeting it is essential in the interests of public health and decency that there should be an attendant in charge of the sanitary convenience provided for women's use in public places.
3. That, in the opinion of this meeting, all sanitary conveniences provided for the use of women should be subject to periodical inspection by women sanitary inspectors appointed by the local sanitary authorities.
4. That this meeting desires to call the attention of the railway companies, and managers of theatres and other places of public resort, to the unsatisfactory character of much of the sanitary accommodation provided for women, and to the necessity for having only sanitary conveniences of good modern type and construction.

With regard to Resolution No. 1, it is pointed out that, although the system now so largely adopted by the railway companies of providing lavatory carriages on long-distance trains has proved an enormous benefit to both men and women travellers, still there is considerable evidence that the accommodation for women at railway stations all over the country is often insufficient and insanitary, whilst the necessity for payment, which is still universal for women at railway stations, operates harshly on the travelling public of the more necessitous classes.

Appropriate communications on the subject of the aforesaid resolutions have been addressed by the Council of the Royal Sanitary Institute to the Local Government Board, the Board of Trade, the London County Council, and the principal railway companies.

A CLEAN MILK SUPPLY.

IT has been pointed out more than once that a pure and clean milk supply will be provided as soon as milk consumers realize its necessity and formulate a demand for it. In the meantime, every effort should be made to educate the milk producer as well as the milk consumer in the right methods to be adopted to secure cleanliness and purity. With this object in view, a series of three leaflets have been issued jointly by the National Health Society and the National League for Physical Education and Improvement. The first of the series is addressed to farmers and other milk producers, the second to distributors and retailers of milk, and the third to housewives and all consumers of milk. The advice given in each case is altogether admirable, and is contained in language of the simplest and most understandable. One piece of advice which we do not remember to have seen in any similar pamphlet is very appropriately included. It is, that no child should be allowed to take any part in handling the milk or milk utensils, as children often suffer from unrecognized forms of infectious disease. The printing of the leaflets is excellent, and by a frequent interspersion of thick block type prominence is given to important statements.

DUTIES OF M.O.H. AND SCHOOL MEDICAL OFFICER.

X. Y. Z. will find a great deal of useful information relating to the duties of a medical officer of health and of a school medical officer in the *Public Health Service Directory*, published by Hodgetts, 36–38, Whitefriars Street, Fleet Street, E.C. The duties of a medical officer of health are referred to at some length in Whitelegge and Newman's *Hygiene and Public Health* (Cassell). With regard to the duties of a school medical officer, our correspondent might consult *The Medical Inspection of School Children*, by W. Leslie Mackenzie, assisted by E. Matthew (Edinburgh and Glasgow: Wm. Hodge and Co., 1904. 10s. 6d.), and *Medical Examination of Schools and Scholars*, by T. N. Kelynack (London: P. S. King and Sons, 1910. 10s. 6d.).

DUTIES OF COUNTY SCHOOL MEDICAL OFFICER.

F. W. P.—The county school medical officer is entitled to ask as to the probable duration of a child's absence from school. It might be argued that the education authority should pay a fee to the practitioner for such information, but we believe that medical men have hitherto been in the habit of giving the information as a matter of courtesy and in the interests of their patients. As the inquiry objected to by "F. W. P." refers to a certificate signed by himself, it is difficult to see how the district school medical officer can be involved. As a matter of fact, such questions are dealt with by the school attendance officer, and may not come under the notice of the school medical officer at all.

Medical News.

A SCHOOL of tropical medicine has recently been established in Brussels by Royal decree.

THE King Edward Memorial Fund at Ealing is to be devoted to completing the new hospital in that locality.

THE Berkshire memorial to His late Majesty is to take the form of a children's ward, now in course of erection at the Royal Berkshire Hospital.

THE Duke of Connaught during the course of his visit to Sierra Leone received a telegram from the King containing the following passages: "From the reports of the Governor, Sir Leslie Probyn, who has just relinquished his post after several years of successful administration, I am glad to know of the progress of the Colony and the Protectorate both in civilization and in wealth. It is particularly gratifying to notice that the efforts of the medical staff, supported by the chiefs and the people, have resulted in a marked improvement in the health of the community. I ask you to make it known to my subjects throughout the Colony with what interest I watch over their welfare, and that I trust they may be blessed with peace, happiness, and prosperity."

WE are glad to observe that the Hospital for the Study of Obscure Diseases, Cambridge, has received a legacy of £200 from Miss Marian Julia James, of Hindhead, who died on November 10th. We have several times called the attention of our readers to the work done by this hospital, which is of the highest value from the practical as well as from the purely scientific point of view. Most of its work hitherto has been devoted to that indeterminate condition known as rheumatoid arthritis. It is from the medical profession that the greater part of the contributions towards the upkeep of the institution have hitherto come; but if sufficient support is forthcoming from the public, it is hoped to enlarge the scope of its activity and to include other obscure diseases within the range of its researches. Miss James has also left £500 to the paying patients' ward of St. Thomas's Hospital, and it is directed that in certain circumstances the residue of her estate, which would appear to be over £50,000, shall be devoted to the maintenance of hostels and the making of grants of money for the benefit of educated persons of the professional class of limited means who are in need of a holiday.