production of dental destruction. The President had inquired whether beet sugar had been used in the experiments. The speaker had used sucrose, glucose, maltose, lactose, beet sugar, as such had not been employed, and, in reply to Dr. Bostock Hill, he pointed out that it was citric acid in "acid drops" which made the saliva more acid, and was glad that there was some control over the sale of sweets by the Local Government Board through the various county councils. He had been able to create in the crown of sound teeth, kept in the incubator in a mixture of saliva and chocolate, soft spots or small cavities in the enamel, which showed decalcification of the enamel but which he could not yet affirm was actually dental caries. This occurred both with regard to saliva from the mouths of the immune and non-immune.

DEMONSTRATIONS.

DURING the course of the meeting some cases of special interest were demonstrated.

Mr. A. W. WELLINGS showed a young woman, aged 18, who presented *Hypertrophy of the gingival and alveolar margins*, and brought forward reasons for believing the condition to be due to associated pyorrhoea alveolaris. The precise nature of the condition was proved by skiagrams taken from both within and without the mouth, and by microscopic sections. At the time the patient was shown the investigation of the case was not entirely complete, and the exhibitor was still engaged in work upon it.

Professor JOHN HUMPHREYS (Birmingham) demonstrated the chief contents of his dental museum, and in the course of his remarks drew attention to the imperishable nature of teeth. It was a point which rendered them invaluable to the geologist in estimating climatic and geographical conditions in past ages; as also to the palaeontologist in reincarnating dry bones and in tracing the facts of evolution.

Professor A. E. UNDERWOOD showed and described two dried specimens showing *Abnormalities of the maxillary sinus*. The specimens had been sent to the speaker by Professor Jamieson of Leeds University. The first specimen was a right maxilla, in which the portion corresponding to the wisdom tooth was divided from the rest of the cavity by an almost complete bony septum. This septum was one of the largest yet recorded. In the front part of the cavity were two septa carrying newer vessels and arising from the infraorbital canal. The second specimen showed both antra and the intervening bony tissue *in situ*. On the right side there was an obvious bony swelling caused by a sort of blowing outwards of the inner wall of the sinus in the region of the lower termination of the nasal duct. The morphological interest of this specimen was that it showed in a less degree the condition normal in the gorilla, in which anthropoid this cavity is so large as to equal the sinus proper in size, and to look at first sight like a large anterior chamber belonging to the antrum. The surgical interest of this specimen was the great difficulties it would present to the operating surgeon in approaching the cavity from the nose.

Professor HUMPHREYS, in a comment on the demonstration, related the history of a case of antral trouble, which was rather remarkable. The patient, a doctor, aged about 45, with a comparatively perfect set of teeth, related his experience of considerable suffering, apparently from appendicitis, and arrangements had been made for an operation. He complained of nasal catarrh, but as the teeth were sound and healthy, there was no suspicion of antral trouble at the time; but a later examination showed a considerable amount of pus in the right antrum, in which an opening was made and drainage effected. The operation, however, did not effect a cure, and subsequently the left antrum was found to be similarly affected, and a second operation and drainage gave but slight relief. Later on it was discovered that the mischief arose from the frontal sinus, drainage from which infected both antra, and the septic matter swallowed produced the gastric trouble supposed in the first instance to arise from appendicitis.

Professor F. E. HUXLEY (President) remarked that any one who had to do with cases of antral disease had probably at some time been puzzled by certain obscure conditions. These rare specimens might explain one of the unsuspected complications one might meet with.

At the conclusion of the meeting the following resolution, suggested by Sir VICTOR HORSLEY, was proposed by the PRESIDENT OF THE SECTION. seconded by Mr. C. WALLIS, and carried unanimously:

The Section of Odontology request the Council of the Association to urge upon the Board of Education the need of pressing the local education authorities to establish school clinics as being the only means whereby the dental and medical requirements of the elementary school children can be adequately and economically treated.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

A FATAL CASE OF MELAENA NEONATORUM.

THE following case, which occurred in my practice, resembles the two cases reported in BRITISH MEDICAL JOURNAL by Drs. W. J. Lord and C. M. Rolston on January 14th and April 8th, 1911, respectively:

On June 13th, 1911, I attended Mrs. P., a primipara and native of this town, who came to consult me when she was seven months pregnant, having been told by a midwive that the pelvis was rather narrow. However, I satisfied myself by examination and by taking some pelvic measurements, which I regret I did not keep, that the pelvis was not contracted, and told her that probably everything would come off naturally.

When the confinement took place, labour started very indefinitely, the pains coming on spasmodically about the abdomen and at very irregular intervals, and at times there would be no pain for several hours at a time. On placing the hand on the abdomen, the regular contractions of the uterus could be felt, some being very painful and others quite painless, which came on and passed off quite unperceived by the patient. There was no dilatation of the os. This sort of thing went on for about three days, during which time I had to give several injections of morphine, as a mixture of bromides and chloral had very little effect, and the patient was getting worn out.

On the evening of the third day dilatation of the os had fairly well started and the liquor amnii had been coming away all that day, and the contractions of the uterus were fairly strong and regular. I thought the case would come off that night, however. Secondary uterine inertia came on about 3 a.m., and the patient went off to sleep with a good slow pulse and, there being no symptoms of distress as regards the fetus, I went away, leaving instructions to be called as soon as the pains restarted.

On my arrival next morning about 10 a.m., I found the pains fairly strong, dilatation was complete, and meconium coming away with the occiput presenting, I hurriedly sent for my colleague, Dr. Trumbull, who administered $CHCl_3$, and I delivered with forceps a healthy female child with asphyxia pallida. I rapidly severed the cord and handed the child to my colleague, who started doing artificial respiration while I attended to the patient who was bleeding rather freely, and as stimulation of the uterus would not stop the *post-partum* haemorrhage, I forcibly expelled the placenta by pressing down the fundus, the placenta and membranes complete landing on the floor one and a half yards away from the bed. All haemorrhage ceased straight away and I turned to help Dr. Trumbull with the child, keeping up artificial respirations helped by cutaneous stimulation and injections of ether and brandy. The child was brought round after some difficulty, and when I left it was breathing perfectly well, also crying out strongly now and then. I went back the same evening and found mother and infant doing well.

Next morning, however, the baby had vomited a little red-coloured froth and there was also some clotted blood about the nostrils. I had the child undressed to examine it, and on looking at the diapers there was a good deal of dark coloured blood together with clots. I could find nothing else physically wrong.

On seeing the child again that evening, some blood was also coming from both ears. I was told that the vomiting of frothy blood had continued all day long and the melaena had also persisted. The child died early next morning.

On looking at my notebook I find I put down at the time that the child died with symptoms of fractured base, but evidently the blood started coming first from the bowel and the blood from the ears did not come till several hours after the first symptoms of haemorrhage.

I have reported this case at length as there may be some connexion of these cases of melaena in the newborn with protracted labour, as in Dr. Rolston's case and my own, and I do not find any mention in any of the books I have with me of such a condition, and during the nine months I was doing maternity work at the Rotunda

Hospital, Dublin, six months of which I acted as extern maternity assistant, no case of this sort came under my notice.

STANLEY M. WELLS, F.R.C.S.E., L.M.
Valparaiso, Chile, South America.

A CASE OF TRAUMATIC TUBERCULOSIS.

THE patient in the following case, a man aged 33, a farmer and mill-owner by occupation, had a sister who was said to have died of consumption, but otherwise his family history was good.

In September, 1908, he consulted me for pain in the right wrist of a rheumatic character, following an injury received three weeks previously. He remained under treatment for some time, but no improvement occurred. He then saw a local specialist, who placed the diagnosis between gonococcal rheumatism and commencing tuberculous disease. (The first was out of the question, as the patient had never had gonorrhoea.) I put him on syrup ferri iodi, with a Scott's dressing and splint applied locally.

While under this treatment, which lasted four weeks, and produced no improvement, he developed a slight evening rise of temperature, but careful examination of chest revealed no signs of tuberculous mischief. His further history was as follows:

On November 13th a soft fluctuating swelling was made out between the metacarpal bones of thumb and first finger. The supratrochlear gland became slightly swollen, but no tenderness or enlargement of the axillary glands occurred. Hot boracic poultices were applied for two days, followed by a free incision with an escape of flocculent pus.

November 20th. The local condition gradually became worse. Pain more severe, and aggravated by the slightest movement. He was unable to sleep. Failed in his general health, and became weak and thin. Had a regular evening rise of temperature.

December 2nd. A thorough examination under chloroform revealed extensive disease of carpus. A few incisions were made, and a quantity of pus escaped; the carpal bones were found to be diseased.

Operation.—December 4th. Amputation was performed at the junction of middle lower third of forearm. Dissection of the hand revealed tuberculous disease of os magnum trapezoid, together with base of metacarpal bones of thumb and first finger. Bones soft and friable. Trapezium and scaphoid practically destroyed by caries. On opening up the wrist-joint pus exuded, and the articular surfaces were found destroyed by granulations.

Result.—For a time the patient improved; his temperature fell, and the stump was fairly healthy, but about January 14th he developed a cough. No definite physical signs of actual disease could be made out, but examination of the sputum revealed a slight trace of tubercle bacillus. Evening rise of temperature to 101° and 102°. A slight pocket formed in stump on radial side, discharging a thin watery pus.

At the end of January he was sent to a sanatorium, where he remained for some five weeks, but became rapidly worse. He returned home in a grave and critical condition: marked emaciation, regular rise of temperature, night-sweats, cough very distressing, and tuberculous disease in both lungs. Early in May he died.

The interesting points in this case are as follows:

1. What part did the traumatism play in this particular case, where no tuberculous disease could be made out by the ordinary clinical methods? Previous to the injury, I may say that the patient had been under my care for eighteen months for many slight ailments, but had never any lung trouble.

2. The tubercle bacilli could not have been introduced from without, and that they must have existed in the system before the trauma was received.

3. Was there some later focus of disease in the carpus which became aggravated by the injury, which may have caused active mischief and dissemination of the bacilli which were carried by the venous circulation to lungs?

Wainfleet, Lincs. G. A. WOLFENDALE.

MESSRS. LEITZ, 9, Oxford Street, London, W., have issued a new edition of their catalogue of prismatic binoculars.

THE *London Gazette* of August 15th announces that the King has been pleased to appoint Dr. William H. Langley, C.M.G. (Principal Medical Officer, Gold Coast), to be Principal Medical Officer, Southern Nigeria; and Dr. Francis G. Hopkins (Deputy Principal Medical Officer, Southern Nigeria) Principal Medical Officer of the Gold Coast Colony.

Reviews.

A HANDBOOK FOR MILITARY MEDICAL OFFICERS.

IN the introduction to his *Medical Service in Campaign*,[1] Major STRAUB combats the mistaken notion, commonly held by the lay public, to the effect that provided a man is a good doctor he requires no further training to enable him to fulfil the duties required of an army medical officer. A good practical knowledge of doctoring and sanitation is, of course, essential, as disease has in most campaigns caused considerably greater losses than the enemy's bullets, but, in addition, an army medical officer must have a working knowledge of such military matters as writing orders, map reading, the effect of different weapons, the number of casualties to be expected after an engagement, and the evacuation of wounded. These subjects are discussed in Chapter ii, under the title of "Collateral Military Subjects." By means of examples, diagrams, and a brief description, Straub has succeeded in presenting medical officers with a clear summary of all they need know about these matters. The examples of orders given are not quite in the form laid down in our field service regulations. Under "Casualties," Straub shows that the improvement in weapons down to the time of the Russo-Japanese war had not materially affected the number of casualties or the proportion of killed to wounded in battle. It is quite possible, however, in view of the type of bullet recently introduced in many European armies, that the next campaign may show somewhat different results. When discussing the various categories of wounded, Straub remarks:

It is gradually becoming more and more appreciated that the care and treatment of the less severe cases is of greater importance to the army in the field than that of the serious ones, as a large percentage of the former may be expected to recover soon, and resume duty at the front.

This sentence supplies a necessary caution, as the surgeon's instincts naturally are to expend much time and effort on a severely wounded man rather than on a number of less severely injured ones. The section on transportation contains much useful information—for example, Straub shows that to dress a man, carry him a thousand yards, and return with the empty stretcher, will, on the average, occupy one hour. The formulae for calculating the time or vehicles required to remove a given number of wounded are given, but for some unexplained reason an x is introduced which does not seem to have any bearing on the equation. As it stands, the formula may easily be forgotten. Whether used to find the time or the number of vehicles required three of the factors are constant, and if the formulae were stated thus:

$$T = \frac{1}{m}\left(\frac{w \times t}{n}\right) \text{ and } m = \frac{1}{T}\left(\frac{w \times t}{n}\right)$$

where T is the time and m the units of transport required they would be more easily retained in the somewhat overtaxed brain of the medical officer on active service. The chapter on organization deals with that of the United States army, but that on administration contains much that is useful and applicable to all armies. The chapter on battle dispositions gives a good review of the various kinds of action which may be fought, and the disposition of the medical units to conform with the military situation. The remainder of the book discusses in detail the functions of each post in the medical echelon from the front to the base. Although intended primarily for officers of the United States army, the general principles enunciated are applicable to all armies. Straub has taken great pains to explain clearly just what medical officers ought to know of military matters in the field, and has condensed most of the somewhat voluminous foreign military medical literature into a handy and readable form.

[1] *Medical Service in Campaign: A Handbook for Medical Officers in the Field.* By Major P. F. Straub, Medical Corps (General Staff), United States Army. Prepared under the direction of the Surgeon-General, United States Army, and published by authority of the War Department. London: Rebman, Limited. 1911. (Demy 8vo, pp. 164, 2 plates, 9 figures. 6s. net.)

May we add that the feeling created by invidious resolutions such as have been passed by the Representative Meeting cannot fail to have some influence on the unity of the profession and in aiding a policy whose obvious effect will be to separate the profession into two camps—that of the medical official and that of the medical practitioner—a result which will have a deplorable effect on the whole profession.—We are, etc.,

Rashell Davison,
Chairman.
David A. Belilios,
Honorary Secretary.
Association of Medical Officers of Health.

New Malden, Aug. 21st.

The Services.

R.A.M.C. TERRITORIALS.

2nd London Division in Camp, 1911.

The annual training this year was fixed from August 6th to 20th, and took place in Kent, two-thirds being at Shorncliffe and the remainder at Fort Burgoyne, near Dover. The three Field Ambulances went through a progressive course of training, each under its own C.O., and on several occasions practised in the field with the brigade to which it would naturally be attached. A novel feature was introduced on one of these occasions, an opportunity being given to the local Voluntary Aid Detachments by the A.M.O. to fill the parts assigned to them in war on the lines of communication. The arrangements were made by Lieutenant-Colonel Thornton-Gilbert, V.D., the local Director for the Folkestone Division of Kent, and he succeeded in getting together from the neighbouring towns and villages 21 officers, 2 doctors, 22 men, and 95 women, some from detachments raised by the Red Cross Society and some by the St. John Ambulance Association. The Field Ambulance sent on to them about 80 cases that had been marked with tallies and picked up on the field, and their organization was so complete that they were able to deal with them easily, and could have managed a good many more. Two rest stations were established at suitable places, and an elementary school was fitted up as a temporary clearing hospital. The rest stations had each a bell tent, but as the weather turned out so fine they were really not required. The men had brought fifteen stretchers, and three civilian wagons were prepared to carry those who were unable to walk. The "wounded" were all passed through one or both rest stations, and finally taken to the clearing hospital, where they were registered and treated under the direction of the local county director and provided with some refreshment. They were visited by the G.O.C. of the division, who expressed his satisfaction with the way the general arrangements had been made, and by the A.M.O. (Colonel Andrew Clark, V.D., K.H.S.), who examined many of the cases and complimented the nurses on the way they had dealt with them. The experiment shows that, should the necessity arise, the Territorial Force could rely on efficient assistance from Voluntary Aid Detachments—at any rate, in this part of the country, and probably it would be the same in many others. It is the first time we have heard of the Voluntary Aid Detachments working with the Territorial Force on as large a scale and in connexion with actual manœuvres.

Universities and Colleges.

UNIVERSITY OF LONDON.

The following candidates have been approved at the examination indicated:

Second M.B. (*Part II.*).—E. S. Abraham, W. D. Arthur, J. E. Ashby, L. B. Baird, Irene Bastow, R. M. Beath, F. P. Bennett, †‡G. A. Bird, Alice D. Brooks, F. C. S. Broome, Marion M. B. Burt, W. Burt, N. St. J. G. D. Buxton, A. S. Cohen, F. H. L. Cunningham, J. H. Dancy, J. de Silva, *A. R. C. Doorly, P. O. Ellison, G. A. Gassmann, H. L. H. Greer, C. R. Harrison, *‡H. J. Hoyte, *†A. L. Jones, E. P. Langley, A. S. Liebson, O. C. Link, G. T. Loughborough, N. P. L. Lumb, R. G. Lyster, A. G. Maitland-Jones, Refna Mallet, *J. E. Pearce, C. E. Petley, R. E. Roberts, W. E. R. Saunders, R. H. Simpson, H. Smith, ‡F. G. A. Smyth, H. J. D. Smythe, ‡W. E. Tanner, C. H. Thomas, Naomi Tribe, J. S. Wallace, J. G. Wardrop, T. B. Welch, Eva M. White, H. P. Whitworth, W. B. Wilson, A. G. Winter, H. G. Winter, W. P. Whippell, M. S. Woolf, *†J. M. Wyatt.

* Distinction in Anatomy. † Distinction in Physiology.
‡ Distinction in Pharmacology.

UNIVERSITY OF BRISTOL.

Extra-mural Medical Lectures.

The second course of extra-mural lectures on Pathology and Bacteriology: Practical Applications of Recent Researches, will be given by the Professor of Pathology at Taunton on succeeding Fridays, commencing on Friday, September 8th. The third course will be held at Dorchester during October.

APOTHECARIES' HALL OF IRELAND.

On August 16th, in the Gresham Hotel, Dublin, honorary diplomas of the Apothecaries' Hall of Ireland were conferred on the following members of the medical profession in recognition of their scientific attainments and contributions to medical science: Sir James Crichton-Browne, M.D.; the Right Hon. Michael Francis Cox, M.D.; and Dr. Robert Sydney Marsden, M.D. Dr. McWalter, Deputy Governor, presented each of the distinguished doctors, and the Governor, Dr. Magennis, handed them the diplomas. The company was afterwards entertained to luncheon.

Obituary.

FRANK PIERCE FOSTER, M.D.,

EDITOR OF THE "NEW YORK MEDICAL JOURNAL."

We regret to have to record the death, on August 15th, of Dr. Frank P. Foster, for thirty-one years editor of the *New York Medical Journal*. Dr. Foster, who was born in Concord, N.H., on November 26th, 1841, was of old New England stock; he received his education at the public school of his native town, and at the age of 15 became a pupil of Dr. Lyman Gage. He entered the medical school at Harvard University in 1857, and became M.D. of the College of Physicians and Surgeons of New York in 1862. After serving for two years as interne at the New York Hospital he made a voyage as surgeon to a Pacific mail steamer from New York, through the Straits of Magellan, to San Francisco. During this voyage he studied German with so much success that he laid the foundations of an intimate knowledge of that language, and in 1900 was associated with Dr. E. Althaus in preparing a revised edition of *Adler's German and English Dictionary*, which appeared in 1902. From 1864 until the end of the war, he was a contract surgeon in the United States Army. In 1865 he began general practice in New York, but subsequently specialized first in dermatology and afterwards in obstetrics and gynaecology. In 1871 he introduced the preparation of calf vaccine at the New York Dispensary. In 1873 he spent half a year in London, and on his return was offered, but declined, the chair of Obstetrics at Yale University, but accepted the position of Librarian to the New York Hospital. In January, 1880, he became editor of the *New York Medical Journal*, which had been founded in 1865 by Surgeon-General W. A. Hammond, United States Army. At that time the periodical was published monthly, but in 1883 the issue of a weekly edition was commenced and has been continued since; in 1902 it absorbed the *Philadelphia Medical Journal*, and in 1906 the *Medical News*.

Dr. Foster's knowledge of languages, both ancient and modern, was well recognized, and he was the editor of the *Encyclopaedic Medical Dictionary*, in four volumes, which was translated into seven languages. He was chairman of the commission on medical nomenclature appointed by the American Medical Association, and was the author of the reports presented in 1909, 1910, and 1911—a fact which proves his devotion to work, for already he was stricken with the fatal disease, cancer of the throat, which caused his death.

Dr. Foster's active and useful life reflected honour on the profession in New York and on medical journalism. Charitable in his judgement of others, willing to help his friends, careful not unnecessarily to offend, gladly giving from his great store of knowledge, a master of the pen, he will be gratefully remembered by every one who had the good fortune to become associated with him.

Deputy-Surgeon-General John Jones, M.D., late of the Indian Medical Service, died on August 8th, at Cromwell Road, London, at the age of 81. He entered the Bengal Medical Department as an Assistant Surgeon, February 20th, 1856; becoming Brigade Surgeon, April 1st, 1882; and retiring from the service in 1885. He took part in the Indian Medical Campaign in 1857-8 with the Delhi Field Force after the the capture of Delhi, and was present in the actions of Narnoni and Karkarala, at the capture of Bareilly, in operations in Oude, and at the engagement at Mehndee. He had received the Indian Mutiny medal. Dr. Jones qualified as a Member of the Royal College of Surgeons, England, in 1853, and obtained his M.D. degree at St. Andrews University in 1856, and the Membership of the Royal College of Physicians, London, in 1860.

Medical Service that every effort should be made to obtain the sympathy and assistance of the Local Government Board, and that only as a last resort should the policy of a "Warning Notice" be adopted. The honorary secretary was instructed to write to the St. Pancras Division, urging that there should be a further inquiry into the matter, and that, if possible, the "Warning Notice" should be withdrawn at the earliest opportunity.

National Insurance Bill.

The council then considered the probable effect of the National Insurance Bill on the Poor Law Medical Service if it became law. The letter of Mr. Sidney Webb, published in the issue of the *Poor Law Medical Officer* of June last, in which the writer contended that out-door Poor Law offices "will dwindle at every change, and at no point will it be possible to claim compensation," was considered. Attention was also given to the question addressed by Sir Harry Samuels (Poor Law Officials, Compensation) to the Chancellor of the Exchequer and the reply thereto, "that such reductions as took place would not outstrip the regular wastage through death and superannuation among the officers employed."

In the opinion of the council there was danger that many of the present outdoor medical officers would suffer seriously in their official emoluments; and that reduction of their present salaries might profoundly affect their future superannuations. As the superannuation allowance had to be calculated on the emoluments of the last five years of office, such reduction might greatly affect the pension they would be entitled to. It was finally resolved that an effort should be made to induce the Chancellor of the Exchequer to receive a deputation from them on these points, and to ask for amendments on the following lines:

1. That where it could be proved that the effect of the measure had been to seriously reduce the salary of a Poor Law medical officer, if the latter had served for a period of twenty years and upwards, he should be entitled to claim his superannuation forthwith according to the scale laid down for his length of service.
2. That all Poor Law medical officers after the passing of the measure shall have an option of claiming their superannuation on the average emoluments received during the last five years before the measure became law.

SCHOOL CHILDREN: SICK CERTIFICATE.

IN reply to several correspondents it may be said that the Local Government Board has stated that although a local authority has power to pay for a medical certificate relating to a child absent from school through illness the onus of supplying evidence of a reasonable excuse for the non-attendance of a child at school devolves on the parent of the child.

The Board has likewise stated that where, through poverty or other cause, the parent of a child cannot pay for a medical certificate relating to a child absent from school through illness, the reasonable cost of obtaining the certificate by the local education authority would be a legal charge on the rates. The Kent Education Authority pays a fee of 1s.

THE EARLY NOTIFICATION OF BIRTHS ACT.

W.A.M.—There is no provision for the payment of any fees for notifying under the Early Notification of Births Act. A few months ago, with a view to the adoption of the Act in Manchester, and to remove one of the objections of the profession, the Manchester Corporation applied to the Local Government Board for permission to pay a fee to medical men for each notification. It is understood that such permission was absolutely refused, and the question of adopting the Act in Manchester is at present in abeyance. In several rural areas in Lancashire where the Act is in force, prepaid postcards are distributed to medical men, which simply require names and addresses to be filled in, but in no case is any fee paid. The Act specifically provides that the notification "shall be given by posting a prepaid letter or postcard addressed to the M.O.H.," or by delivering a written notice, and it is further provided that "the local authority shall supply without charge addressed and stamped postcards containing the form of notice to any medical practitioner or midwife residing or practising in their area who applies for the same." It may be added that in more than one area where the stamped and addressed postcards are distributed, the medical practitioners simply take no notice of them, and refuse to notify in spite of the penalty that is attached to failure to notify.

ISOLATION OF INFECTIOUS DISEASE AT HEALTH RESORTS.

H.—(1) A sanitary authority is under no statutory obligation to provide isolation hospital accommodation for the inhabitants of its district. Even when such accomodation has been provided, or when arrangements have been made with a neighbouring authority to isolate cases, the authority is not bound to arrange for the isolation of every infectious case occurring within the area of its administration. (2) In the event of the sanitary authority refusing to arrange for the isolation of an infected child, and if as a consequence a second child became infected, the parents would have no remedy against the authority. (3) Unless consultation with another practitioner was ordered for the purpose of confirming a diagnosis by the sanitary authority, the latter would not be responsible for any fee. Strictly speaking, the statement attributed to the medical officer of health to the effect that a medical practitioner having notified a case his responsibility ceases is correct if the responsibility is confined to measures for the prevention of the spread of the disease, though happily most practitioners take a great deal of trouble as regards preventive measures, and it is very desirable that they should continue to do so. (4) It is almost incredible that any health resort at the present day, with any desire to attract and retain visitors, should not be able to remove infectious cases promptly, and the medical practitioners of the town referred to by our correspondent might well represent to the sanitary authority the urgency of providing the necessary isolation accommodation.

Medical News.

COURSES of lectures and demonstrations for sanitary officers, for meat inspectors, and for school teachers and others entering for the examination in hygiene will be given at the Royal Sanitary Institute, commencing on September 18th. Further particulars can be obtained on application to the secretary, 90, Buckingham Palace Road, S.W.

THE Managing Committee of the Sleeping Sickness Bureau has decided to publish a quarterly bulletin dealing with the *Leishmania* group of diseases. Dr. C. M. Wenyon, protozoologist to the London School of Tropical Medicine, who has been chosen to undertake this part of the work, is at present investigating "oriental sore" in Asia Minor, and has already published an interesting report on this condition. The similarity, morphologically, of the parasite of "oriental sore" to that which causes kala-azar is well known. There are many other important points requiring investigation as regards the *Leishmania* group of diseases, and the committee is fortunate in having been able to procure the services of a man of Dr. Wenyon's attainments. Dr. Bagshawe, the director of the Sleeping Sickness Bureau, in the last *Sleeping Sickness Bulletin* (July, 1911), states that a list of references is now in preparation, and will form the first number of the new bulletin. Those who wish to receive this should send their names to him.

BY way of comment on some cases of nutmeg poisoning recently published in the BRITISH MEDICAL JOURNAL, Messrs. F. B. Power, Ph.D., and A. H. Salway, Ph.D., have forwarded a reprint of an article published in the *American Journal of Pharmacy* some two years ago. It records an investigation undertaken by them in the Wellcome Research Laboratories to determine to what constituent the narcotic effects of nutmeg are due. They found no alkaloid nor soluble toxic protein, and, after complete study of the essential oil, the expressed oil, and the "press cake," concluded that the physiologically active body was a constituent of the essential oil—namely, myristicin ($C_{11}H_{12}O_3$). Their results also confirmed Jürss's observation that myristicin, besides acting on the central nervous system, may induce acute fatty degeneration of the liver in animals that do not succumb to its action very quickly. They also found that a dose of nutmeg containing a smaller quantity of myristicin than would produce any appreciable effect when given orally would nevertheless suffice to cause death in a few days' time. This apparent discrepancy, they show, is probably explicable by the fact that when isolated from its natural admixture myristicin is absorbed with difficulty.

DR. GIRDHARI LALL BATRA of Lahore, Punjab, has commenced a series of medical inspections of Indian school boys and students which promises, when sufficient data have been collected, to furnish interesting facts. He has drawn up forms in which information regarding the student's family and personal history and the hygienic condition of his home, and observations respecting physique and health are systematically recorded. Dr. Batra has examined 258 students in three educational institutions, and has published in a local paper some results of his investigations. The ages varied from 15 to 22 and weights from 64 lb. to 156 lb. The majority were pale and anaemic, many had weak hearts and lungs, a considerable proportion bad teeth, and a large number defective vision; 29 per cent. of them were married, and to this circumstance Dr. Batra attributes the weak physique and delicate health which were so painfully in evidence. "Think," he remarks, "of an Indian student who has quarrels with his mother, is worried by his wife, and has the care of children at 17!" These inquiries were made under the auspices of the Society for Promoting Scientific Knowledge, and ought, if prosecuted with care, to be of service to educational authorities as well as of anthropological value.