VOMITING IN GRAVES'S DISEASE AND ITS TREATMENT.

BY J. A. NIXON, M.B., F.R.C.P.,
PHYSICIAN TO THE BRISTOL ROYAL INFIRMARY.

THE symptom of obstinate vomiting in Graves's disease is fortunately not of very common occurrence. Sometimes, however, it becomes a complication of grave import. Recently three cases have come under my notice in which the patients' lives appeared to be threatened by the persistence and frequency of the vomiting. In each case the patient had contributed to her own undoing by over-exertion at a time when the general symptoms of exophthalmos, goître, tremor, and tachycardia were very severe; each of the patients was up and about, doing active housework, at a time when rest in bed had long since been imperatively indicated; each of them volunteered the statement that the slightest movement in walking, going upstairs, and lifting weights, produced the vomiting.

The vomiting had become an alarming complication, dieting and drugs seemed useless.

In my first two cases absolute confinement to bed with the use of the bed-pan, and strict supervision to ensure that the patient did not move hand or foot to supply her own wants, was combined with the administration of a substantial diet by mouth; milk, bread-and-butter, eggs, fish, chicken, broth, were freely given. At first the patients vomited at rare intervals, but within two days tolerance was established and the food retained. The patients soon discovered for themselves that the vomiting was produced by exertion or movement, rather than by a true inability to digest solid food; and having found this out they took their food with increasing confidence, and improved rapidly.

The third case was admitted to the Bristol Royal Infirmary with similar symptoms. The orthodox method of rectal feeding was adopted, and small quantities of milk given by the mouth; the patient continued to vomit, and her general condition became worse. A marked acidosis developed. Finally, on the fifth day after admission, the plan of dieting was changed, and the patient was given moderate meals of solid food; she vomited on three occasions more, and was after each promptly fed again. After two days of this treatment tolerance was established, the acidosis disappeared, the patient improved in every respect, and her danger from this symptom was at an end.

It seems worth while to direct attention to this mode of dealing with obstinate vomiting in Graves's disease; the more so since the advice usually given and the plan commonly adopted is to withhold food by mouth and resort to rectal feeding, a plan which I believe to be as useless in Graves's disease as it is in the vomiting of whooping-cough.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

TWO TESTICLES ON ONE SIDE.

IN the JOURNAL of September 2nd, pp. 513–14, is a short article on this condition, based on a probable case reported by Dr. Caroline V. Lowe, in which it is stated that, according to Ahlfeld, only one instance is reported in a properly dissected dead body. Ahlfeld's report was made in 1880. As the condition is so extremely rare and so extraordinary, the following brief account of a case recorded by me in the *Journal of Anatomy and Physiology*, January, 1898, p. 216, will doubtless interest both the writer of the article and many of your readers, and throw some light on the case in question.

A boy aged 3 was operated upon by me in the Queen's Hospital, Birmingham, on August 21st, 1896, for a large congenital inguinal hernia on the left side. On exposure of the external ring two cords were seen emerging and passing down to the two testes, enclosed in one tunica vaginalis. The child died of shock some thirty-six hours later, and at the autopsy a careful dissection of the parts was made by my then house-surgeon, Dr. R. A. Bennett.

There was only one vesicula seminalis, situated on the left side, and considerably larger than normal, and in connexion with it was a very large vas, as thick as an ordinary drawing pencil, which took the normal course as far as half an inch from the internal ring, where it divided into two of equal size, which passed down the inguinal canal into the scrotum to the two testes. The right spermatic artery crossed over the middle line about 3 in. below the umbilicus, and meeting its fellow of the opposite side just inside the internal ring, joined with it to form a single trunk, which divided again before reaching the external ring, the two vessels being distributed to the testes in the ordinary manner.

With this case in view, that of Dr. Lowe—a left-side hernia also—may well be another instance of this curious and remarkable developmental anomaly.

F. MARSH, F.R.C.S.,
Consulting Surgeon, Queen's Hospital, Birmingham, etc.

A CASE OF TUBERCULOUS DISEASE OF THE EYEBALL?

E. N., 21, dressmaker, first came to consult me about five years ago concerning the right eye. She had a large phlyctenule on the outer half of the right cornea, and a moderate-sized pustule on the conjunctiva, about one-sixth of an inch from the corneal margin. There was a good deal of pain, redness, and photophobia. She was pale and thin, and her general condition poor. She had been under another medical man, but had not improved. By the use of atropine and tonics she improved for a time; then I lost sight of her. She came to see me again two years ago; her condition was as bad as ever, and no treatment seemed to benefit her permanently. This unsatisfactory result was no doubt due to her having to keep on with her occupation as a dressmaker, and thus not getting sufficient rest and fresh air. Last year, at the end of July, she again came to see me, and I found matters much worse. The eye was intensely inflamed, and the anterior chamber full of pus. She was suffering great pain, and was looking very ill. After careful consideration I advised her to have the eye removed. To this she agreed, and was admitted into Stockton Hospital on August 4th. After removal of the eye, an examination of it revealed the following conditions: The anterior chamber full of pus. The sclerotic from the outer side of the cornea to beyond the insertion of the external rectus was greatly thickened, and there was an abscess cavity between its layers. A caseous nodule on the sclerotic just outside the cornea led down to the abscess cavity. The vitreous was fluid, and full of cholesterine crystals, which settled down as a golden-brown residue. For some time after the removal of the eye she continued to look very ill, and suffered so much from severe headaches that I began to suspect she might have some meningeal trouble; but after a long change at the seaside she improved greatly in health and gained in weight. I might add that she had no strumous glands, nor was there any phthisical history in the family.

G. VICTOR MILLER, M.D.,
Ophthalmic Surgeon, Stockton and Middlesbrough Hospital.

ACUTE INVERSION OF THE UTERUS.

ON August 9th I received a call to a Kaffir woman. It was stated that immediately after the birth of a child, her womb, with the afterbirth attached, had appeared outside the body. Owing to the long distance from town, I did not arrive on the scene until eleven hours after the accident. I found a young woman lying on the floor of a hut. Her pulse was 75, and she related her history quite clearly. This was her second child, born easily during the night while she was lying on her back. Soon after the afterbirth appeared, and when they went to remove it they were surprised to find it still attached to the body. The attendants denied having pulled upon the cord or in any way assisted delivery of the afterbirth. This I can believe, as native midwives here exhibit a masterly inactivity, and I have never known one to meddle.

The uterus, with the placenta attached, was turned almost completely inside out, and was lying outside the body, supported by some dirty sacking. About 30 inches of cord was still attached to the placenta, so that shortness of the cord had not caused the inversion, unless perhaps it had been wrapped round the child's neck. On

this point, however, I received no evidence. Anticipating haemorrhage from the placental site, I proceeded to clean the surface of the uterus before detaching the placenta. Bits of straw and other débris were removed, and the whole surface swabbed with 20 per cent. iodine solution. The placenta was then removed, easily and without haemorrhage. The whole surface of the uterus presented a livid and blotchy appearance, and was oedematous as if it were strangulated. Reduction was easy, but so friable did the organ appear to be that rupture seemed imminent, and it was with great relief that I saw the fluid returning freely during the subsequent douching. No anaesthetic was used, and the manipulations caused little pain. The puerperium was normal. Inversion of the uterus is said to occur only once in 200,000 births, and about 70 per cent. of cases die from shock, haemorrhage, or sepsis. In this case none of these things occurred, and the serious nature of the condition has certainly not been brought home to me by my solitary experience thereof.

Bedford, Cape Colony. H. F. B. Walker.

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

CHURCH MISSIONARY SOCIETY'S HOSPITAL, NINGPO, CHINA.

UNUSUAL SYMPTOMS IN BERI-BERI.

(By Arthur F. Cole, L.R.C.P., M.R.C.S.)

As the subject of beri-beri is always of interest to a section of your readers, an unusual symptom which occurred in a recent fatal case in my practice should be reported; one reason leading me to do so is that neither in Manson's *Tropical Diseases*, nor in Allbutt's *System of Medicine*, nor in the recently published *Diseases of China*, by Jeffreys and Maxwell, is there mention of glycosuria in association with beri-beri.

I was asked to see a Chinese boy of 16, who was reported to be "swelling visibly." On arrival at the school, I found him in a crowded dormitory, not built for its purpose. He was generally oedematous, had a feeling of oppression in the chest, and threw himself from side to side. The knee-jerks were present. He was said to have been playing tennis a week before, and without doubt had been able to sit for his terminal examinations twenty-four hours before I saw him. Beyond a certain feeling of debility for some weeks, he chiefly complained of feeling "stuffed up" in chest and abdomen for the last six days. As he was unable to sit up in a Chinese sedan chair, he was brought to the hospital on a stretcher as a possible case of beri-beri.

On admission his temperature was 100° F., respiration-rate 40, pulse 118. The knee-jerks were both present, though he could not stand. Calf tenderness was present on the left side; he was generally oedematous, very dyspnoeic, markedly perspiring, and throwing himself from one side of the bed to the other in great distress, especially complaining of tightness across the chest. Except for some dullness at the bases behind, the lungs seemed normal. The heart had a galloping rhythm, and there was a doubtful murmur in the pulmonary area; the deep cardiac dullness was in the vertical nipple line. The liver and spleen seemed normal on palpation and percussion. The urine was examined on two occasions: it was acid, specific gravity 1040; it contained no albumen, but a quantity of sugar. He was given a saline aperient, and pulv. opii ½ gr. Tinct. digitalis ♏ 10 was ordered every two hours the next morning. Amyl nitrite capsules were at hand in case of necessity. Less than twenty-four hours after admission he had two attacks of acute cardiac distress with dyspnoea and dusky lips, and though inhalation of amyl nitrite greatly relieved him in the first, the second, half an hour later, proved fatal. Diagnosis made of acute beri-beri with glycosuria.

It was practically certain that death was due to beri-beri toxins acting upon the heart muscle (possibly through nerves), for the next day 3 more cases were admitted, in varying degrees of severity, one from the bed adjacent. In each of these cases the urine was found to be normal, though the specific gravity of one was 1040.

His past history included a stay of over a month in hospital some eight months previously, with one of the undiagnosed fevers of the tropics, lasting thirty-five days, terminating by lysis, and unaffected by treatment. At this time his urine contained albumen in quantity, disappearing with convalescence, but no sugar. In this part of China this clinical type of disease is called "seven-day fever," because in nearly all cases some multiple of seven days again sees the temperature on the normal line; as a matter of fact, one is not anxious as to the prognosis of such cases. His temperature then varied from 103° to 105° F. more or less continuously. The blood agglutination reaction was negative on the twelfth day of fever both to *B. typhosus* (1 in 20) and *M. melitensis* (1 in 100). His blood was never found to contain malarial parasites, and on three occasions when counts were made—

The red cells were 3,750,000, 3,784,000, and 3,515,000.
The white cells were 4,000, 4,000, and 4,667.
The haemoglobin percentage 75, 75, and 60.

These notes on the subject of beri-beri, possibly pointing to specific action of the toxins on the medulla, possibly to an infective pancreatitis, are sent in the hope that every additional fact may help towards its elucidation.

British Medical Association.

CLINICAL AND SCIENTIFIC PROCEEDINGS.

BIRMINGHAM BRANCH:

PATHOLOGICAL AND CLINICAL SECTION.

Friday, October 27th, 1911.

Dr. Kauffmann, President, in the Chair.

Tuberculous Disease of the Caecum.

Mr. George Heaton showed a man aged 52 whose caecum and lower end of ileum he had removed for tuberculous ulceration, and also showed the portion of intestine removed, with microscopic sections. The patient had complained of obscure abdominal pains for several months, with increasing difficulty in getting an action of the bowels. An ill-defined tumour could be felt in the right iliac region. Abdominal section was performed, and the caecum was found distended into a hard irregular tumour with numbers of miliary tubercles on its peritoneal aspect. The rest of the intestines and the peritoneum were healthy. The caecum with 3 in. of the ileum and a portion of the ascending colon were resected and the ileum joined to the ascending colon. The man was now in good health, except for a small faecal fistula. The specimens showed extensive thickening of the caecum, with irregular ulceration of its mucous membrane. The ileo-caecal valve would only just admit a glass rod. The microscopic section showed a few definite tubercles in the deeper parts of the intestinal wall.

Transposition of Viscera.

Dr. Rose Jordan showed a boy just over 13 years of age, who came under her notice in the course of the routine medical inspection of children about to leave school. The schoolmaster, in presenting him for examination, mentioned that he had several times fainted in school and that he was said to have a displaced heart. Both on this occasion and on a subsequent occasion when examined he gave ocular demonstration of his liability to faint. Nothing unusual was noticed about him until he was 3 months old, when he swooned away one evening and had to fight for his breath. He was seen by two doctors who did not expect him to live through the night, and who told the mother it was best for him to die as he could never be strong. He, however, recovered from this attack. From that time until the age of 7 he frequently fainted and sometimes fell into trances during which he was occasionally unconscious for twenty-four hours. He was always very nervous and often almost jumped out of bed during sleep. Before the age of 7 he contracted measles, chicken-pox, and whooping-cough, the latter very badly. Since the age of 7, though still nervous and prone to faint, his general condition had steadily improved. As regards the circulatory system, the pulse was 72, slightly irregular. The heart's apex beat was visible in the fifth space on the right side, ½ in. internal to the mid-clavicular line. The

maintained? I found tubercle bacilli in 5 per cent. of cases examined by me on the Gold Coast, Ofin River, and Ashanti; as I have examined about 2,000 cases, tuberculosis therefore exists among the negroes and alcoholism is rife.

Malignant tumours, tuberculous growths, and syphilitic gummata are very common in West Africa, Central Africa, and East Africa. Rheumatism is not so uncommon among the natives as Dr. Silverman states, and scores of relapses of rheumatism can be seen among the natives in the rainy season. Dysentery is very severe in certain parts of Southern Nigeria, Gold Coast, Portuguese East Africa, and Central Africa. From my twelve years of medical research work on malaria and its sequelae and general native diseases, I strongly recommend examination of the blood for malaria and blackwater fever; in fact, I recommend the microscope as the one and only instrument of value to reach a correct diagnosis in the tropics. Those that only rely on clinical phenomena will be almost always wrong. Allow me also to point out that blackwater fever is a disease *sui generis*, and stands by itself. Out of 187 cases I always found a special micro-organism in the blood, which I shall term for convenience sake *Treponema spirillum verticalis*, measuring 3 to 5 μ, and not easily stained. The staining I use is carbol-fuchsine, and I have also been able, after injection of the culture, to produce haemoglobinuria in animals in from three to ten days. I am now in England and at the disposal of the medical profession to prove my statement.—I am, etc.,

C. Anthony,
Late Chief Bacteriologist, Medical Research Laboratory, Royal University, Naples.

London, W., Oct. 19th.

DEMONSTRATION OF SPIROCHAETA PALLIDA.

Sir,—I have read with great interest the convincing article on "The Comparative Value of Certain Microscopical Methods of Demonstrating *Spirochaeta pallida*," by Dr. M. Phillips and Dr. E. E. Glynn, that appears in the issue of the British Medical Journal of November 11th.

I am entirely in accord with them in their conclusion that dark-ground illumination is by far the best method of demonstrating the organism in question in superficial, primary, and secondary lesions. The authors, after quoting Hofmann and Eiter, state (paragraph 2, page 1283) that they "have been unable to find any other reference to the spirochaete of balanatis in any English, American, German, or French literature," except in the report of a demonstration that I gave before the Royal Society of Medicine in 1909.

May I point out that P. Gaston[1] and J. Comandon[2] both mention and give illustrations of this spirochaete in their respective works on dark ground illumination; and that they were kind enough to permit me to make use of several of their illustrations for an article that I wrote on the subject of the diagnostic value of this method of microscopic investigation.[3]—I am, etc.,

Hugh Wansey Bayly,
Pathologist to the London Lock Hospitals, etc.

London, W., Nov. 11th.

STERILIZATION OF THE SKIN BY IODINE.

Sir,—I note in the British Medical Journal of November 11th a letter from Dr. L. Stretton, in which he states he was the first surgeon to use tincture of iodine in the sterilization of the skin in surgical operations; and I should like to point out that I wrote a short note in the British Medical Journal shortly before his paper appeared, referring to the use of this drug in Vienna in the hands of Professor von Eiselsberg in his clinic at the Allgemeine Krankenhaus, giving details of his results and stating the strength he used; also I would refer you to Dr. Stretton's paper of the date quoted in which he mentions my paper. It is therefore obvious that he was not the first surgeon to use this method, as I had been using it for two years, and I think I am right in stating that it was entirely as a result of my paper that the method was adopted at the Middlesex Hospital under Sir A. Pearce Gould and other surgeons on the staff. Grossich's paper was the first published in this country, and his solution was 10 per cent. This is the strength used in Vienna, and, if my memory serves me, Dr. Stretton stated that he thought this solution too strong. I have always used this strength and have never found it produce any skin irritation, and skin abscess and stitch infection has been entirely absent. Apologizing for the length of my letter—I am, etc.,

H. Goodwyn, F.R.C.S.Edin.

Bovey Tracey, Devon, Nov. 12th.

[1] *L'Ultra Microscope*. Paris: Baillière. 1909.
[2] *De l'usage en clinique de L'Ultra Microscope*. Paris: Steinheil. 1909.
[3] The Use of the Ultra Microscope for the Early Diagnosis of Syphilis.—*Practitioner*, February, 1910.

Medical News.

Dr. J. C. Boulle, of St. Valérian, has recently died at the age of 102.

Sir Thomas Boor Crosby, M.D., Lord Mayor of London, will distribute the prizes and address the boys at Epsom College on Founder's Day, July 27th, 1912.

We learn from the *Guy's Hospital Gazette* that a discussion on bonesetting is to take place under the auspices of the Physical Society on December 13th. The debate will be opened by Mr. Arbuthnot Lane, and Dr. Shaw, Mr. Steward, Dr. Beddard, and Mr. Rowlands are expected to take part in the discussion.

The annual dinner in connexion with the Royal Free Hospital and School of Medicine for Women is to be held on Wednesday, December 13th, at the Trocadero Restaurant. The chair will be taken by Mr. Stanley Boyd. Application for dinner tickets (price 7s. 6d.) will be received by the honorary secretaries, Dr. A. G. Phear, 47, Weymouth Street, and Mr. T. P. Legg, 139, Harley Street, up to Friday, December 1st.

The British Institute of Social Service and the National League for Physical Education and Improvement will hold a joint conference on "Some Preventive Measures against Consumption" in the library of the institute, 4, Tavistock Square, on Wednesday next, when the chair will be taken by Dr. Arthur Newsholme at 5 p.m. Free tickets of admission may be obtained on application to the secretary at that address.

In view of their departure for India, the Duke of Teck and Viscount Iveagh, two of the three governors of King Edward's Hospital Fund for London, have, with the approval of His Majesty the King, Patron of the Fund, and the concurrence of the Speaker of the House of Commons, appointed the Earl of Donoughmore, Chairman of Committees of the House of Lords, and the Right Hon. Sir T. Vesey Strong, Bart., K.C.V.O., to act with the Speaker as a Committee to exercise the powers of the governors until their return.

In the list of mayors elected on November 9th are the following members of the medical profession: Dr. S. R. Alexander (re-elected), Faversham; Dr. J. P. Atkinson (re-elected), Saffron Walden; Dr. Fern, Congleton; Dr. W. S. Gibb (re-elected), Hartlepool; Dr.. W Griffith, Pwllheli; Dr. J. R. Harper, Barnstaple; Dr. H. S. McCalmont Hill, Bournemouth; Dr. G. W. Joseph (re-elected), Warrington; Alderman Surgeon-Major E. L. McSheehy, Wimbledon; Dr. H. Mason (re-elected), Leamington; Alderman Dr. Oldershaw, Wallasey; Dr. J. McGinn, Newport (Mon.); Dr. J. Burnett Smith, Hertford, Dr. C. J. Vlieland, Exeter; Alderman Dr. Young, Bolton.

According to Planchu and Robert Rendu ("Etude du beurre dans le lait de la femme par la centrifugation," *Arch. de méd. des enfants*, August, p. 582), the best method for estimating or controlling the proportion of butter in woman's milk is centrifugalization. These observers analysed the milk of forty-six wet nurses, and made out distinct "curves" in the amount of butter. The more milk yielded the less butter will that milk contain. The milk secreted in the morning holds the largest proportion of butter, that which issues first at each act of suckling yields less than the last drops. If the mammae are asymmetrical, the milk from the smaller gland contains the larger proportion of butter. The average amount of butter, according to Planchu and Rendu's analysis of 3,450 samples, is 34 grams to the litre of milk, the maximum 164 grams and the minimum 5.6 grams. The influence of multiparity, age, and length of the period of lactation is variable, and in all cases not very marked. A further conclusion is that diet, galactagogues, and menstruation seem to have no effect on the proportion of butter in woman's milk.

Universities and Colleges.

UNIVERSITY OF OXFORD.

SCHOLARSHIPS in Natural Science are offered for competition at the following colleges on the undermentioned dates: December 5th: Balliol, Christ Church, Trinity, and Queen's Colleges. January 16th, 1912: Jesus College. March 25th, 1912: University, Lincoln, Magdalen, and St. John's Colleges. March 12th, 1912: Keble College. March 19th, 1912: Merton, Exeter, New College, and Corpus Christi Colleges. July 12th, 1912: Brasenose College.

UNIVERSITY OF CAMBRIDGE.

Dr. WILLIAM ARTHUR BRAILEY, Consulting Opthalmic Surgeon to Guy's Hospital, formerly scholar and Fellow of Downing, has been elected to an honorary fellowship in that college.

The following degrees have been conferred:

M.D.—J. M. Woolley.
M.B.—H. E. Humphrys.

UNIVERSITY OF LONDON.

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

Appointments.

THE Council has appointed Dr. Walter d'Este Emery to be Lecturer in General Pathology, and Dr. W. H. B. Stoddart to be Lecturer in Mental Pathology.

Exhibitions and Scholarships.

The St. Dunstan's Trustees have awarded an exhibition, tenable at the Medical School, to Miss N. Gibson, and a special grant to Miss Joyce B. Reed. The School Scholarship has been awarded also to the same student. The Mabel Webb Research Scholarship has been awarded to Miss C. Leetham, who will carry out research in physiology in the Physiological Department.

UNIVERSITY COLLEGE, CARDIFF.

PROFESSOR EMRYS ROBERTS has been appointed Instructor in Vaccination to the Medical School.

The Royal Commissioners for the Exhibition of 1851 have invited the College to recommend a candidate for a science research scholarship of the annual value of £150.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

AN ordinary council was held on November 9th, Mr. C. Mansell Moullin, Vice-President, in the chair.

Diplomas of Membership.

Diplomas were granted to eighty candidates found qualified at the recent examination.

Diploma in Tropical Medicine.

This diploma was granted, jointly with the Royal College of Physicians, to one candidate found qualified.

The American Medical Association.

The Chairman reported that Mr. Hallett had been invited by the Council on Medical Education of the above association to address a conference to be held at Chicago on February 26th, 1912, on the subject of the methods of conducting examinations for licences to practise medicine adopted by the Conjoint Examining Board in England; and that, after consultation with the Chairman of the Committee of Management, he (the Chairman) had agreed with the President of the Royal College of Physicians to give Mr. Hallett leave to accept the invitation.

Bradshaw Lecture.

This lecture will be delivered by Mr. R. Clement Lucas on Wednesday, December 6th, at 5 p.m., on Some Points of Heredity.

Resignation of Sir Henry Butlin.

After the ordinary meeting a special meeting of the Council was held to receive the resignation of the President, Sir Henry T. Butlin, which was occasioned by ill health. The resignation was accepted with regret, and the following motion was adopted:

> In accepting the resignation of the President of the College, as they very regretfully and reluctantly have just done, the Council desire to convey to Sir Henry Butlin the expression of their deep sympathy with him in that he has been compelled on account of illness to curtail the period during which he otherwise would have held the position of President of the Royal College of Surgeons of England.
>
> The Council fully recognize and appreciate the intrepid and unflinching manner in which Sir Henry Butlin, in spite of imperfect health and impaired strength has, throughout, performed the varied and important duties of President, and they share with him the disappointment, which they are sure he himself keenly feels, that he is not physically able to continue in office any longer.
>
> The Council, moreover, desire to express their admiration for the ability, dignity, and courtesy with which Sir Henry Butlin has represented the College, and to assure him that the high standard of his example will always be remembered and cherished by his colleagues.

Election of President.

Mr. Rickman John Godlee, M.S., F.R.C.S., was elected President for the remainder of the current collegiate year.

CONJOINT BOARD IN ENGLAND.

AT a meeting of Comitia of the Royal College of Physicians on October 26th, and of the Council of the Royal College of Surgeons on November 9th, diplomas of L.R.C.P. and M.R.C.S. were respectively conferred upon the undermentioned candidates:

J. W. Adams, T. E. Ashley, C. N. Atlee, C. H. Attenborough, C. C. Austen, *J. B. Baird, J. B. Ball, J. H. Barclay, H. W. Barnes, R. C. Begg, T. M. Bellew, B. Blackwood, G. A. Blake, R. F. Bolt, H. Bullock, M. Burnett, L. C. W. Cane, H. E. Cockcroft, H. A. Cooper, J. L. Davies, H. Daw, L. M. Dawson, E. R. Evans, G. D. D. Fergusson, F. T. Fisher, P. S. Foster, F. Garratt, L. Gibbons, A. S. Gillett, E. F. W. Grellier, J. B. Hance, *R. C. Harkness, W. P. Harrison, J. R. Heath, A. E. Herman, J. W. W. Hogan, G. A. Hooton, A. E. A. Ismail, A. C. Jap, *V. S. Kaufman, R. Kennon, G. E. W. Lacey, W. M. Langdon, †E. M. Livesey, D. C. Lloyd, G. C. Lowe, N. Mahrus, C. E. H. Milner, P. J. Monaghan, R. S. Morshed, S. Mozumder, M. M. Mundon, W. M. Oakden, B. R. Parmiter, H. Pierce, R. E. Porter, T. C. Reeves, *H. G. Rice, J. F. Richardson, H. B. G. Russell. W. A. Russell, L. L. Satow, H. W. Scott, H. W. Scott-Wilson, A. Shafeek, G. W. Shore, T. H. G. Shore, A. B. P. Smith, A. R. Snowdon, H. Stobie, W. A. Stokes, D. M. Stone, E. J. Storer, J. L. M. Symns, C. J. G. Taylor, J. Taylor, J. W. Tonks, P. D. Warburton, J. W. Whiteman, J. H. Wilkinson, T. D. Williams, J. E. S. Wilson, C. C. Worster-Drought, F. C. Wright.

† L.R.C.P. diploma not yet conferred.
* M.R.C.S. diploma granted on October 12th.

Public Health AND POOR LAW MEDICAL SERVICES.

METROPOLITAN CASUAL PAUPERS ORDER, 1911.

THE Local Government Board has issued an Order with the above title which is to come into operation on March 31st, 1912. Under this Order a district conterminous with the Metropolitan Asylum District has been formed and placed under the management of the Managers of the Metropolitan Asylum District. This will place the administration of the casual wards of London under one body, as was contemplated by the Act of 1871. It is believed that the consolidation of the casual wards under one authority will give an opportunity for classification not hitherto practicable. It is intended to enlist the co-operation of the many voluntary agencies concerned with the houseless poor.

ADMISSION OF INFECTIOUS CASES TO WORKHOUSES.

ENTERIC.—As regards the admisssion to a workhouse of destitute persons suffering from dangerous infectious diseases, the Local Government Board has stated that it is a matter for the discretion of the board of guardians, but observed that it is very undesirable that persons suffering from such diseases should be admitted to the workhouse, the infectious wards provided in workhouses being generally intended only for the temporary isolation of cases arising amongst the inmates. The Board at the same time expressed the opinion that the hospital accommodation required in any locality for the treatment of dangerous infectious disease should be provided by the sanitary authority, who should arrange with the guardians to receive their pauper infectious cases upon terms of payment to be mutually agreed upon.

The Services.

R.A.M.C. LOWLAND DIVISION (T.)

AT the regular meeting of the Glasgow Territorial Force Association, held on November 7th, it was reported that Lieutenant-Colonel Somerville, R.A.M.C.(T.), whose term of command in the First Lowland Field Ambulance had expired, had tendered his resignation as a military member of the Association. It was agreed to recommend that Lieutenant-Colonel A. Dryden Moffat, commanding the Second Lowland Field Ambulance, who was next in seniority, be appointed to fill the vacancy.

Captain R. B. Hole, R.A.M.C., from Cosham, has joined the Scottish Command for duty as adjutant of the R.A.M.C. School of Instruction, Lowland Division, Territorial Force.