

that he had suffered from dysentery, and inquiry from the hospital at which he had been treated elicited the information that the diagnosis had been bacillary dysentery, for which he was treated, but that thirteen days previous to his discharge an immotile cell (? *Amoeba histolytica*) was seen on microscopic examination of the faeces.

Pain was present in all cases. A man with a large liver abscess has had severe pain during its formation.

Tenderness over some part of the hepatic area was present in all cases at some period of the illness, and was maximal over the site of the abscess.

Enlargement of liver was present in Cases i, ii, and iii, the firm edge being easily felt; it was not present in a downward direction in Cases iv and v, and was not observed in an upward direction, pneumonic signs being present at the right base on admission.

Pyrexia was swinging, possibly with less regularity than that due to other abscesses. There was slight jaundice in two cases. Sweating was pronounced in Case ii and in Case iv, but only during the terminal collapse.

Bacteriological Findings.—The presence of *Amoeba histolytica* in the faeces is very valuable; but failure to find it is of very little value unless several examinations have been made. To obtain satisfactory results the specimens must be examined shortly after evacuation. In none of these cases was *A. histolytica* definitely found in the faeces. In one case (i) the presence of large quantities of dead amoebae, probably *A. histolytica*, was reported; in the other cases findings were negative. It will be noted that *A. histolytica* was present in the pus of the abscess in two cases.

Leucocytosis.—In Case ii the leucocyte count was only 10,800, in spite of the presence of a large abscess. I am indebted to Captains R. T. Jones and J. W. Fox, R.A.M.C., of No. 1 Military Laboratory, for these results.

Differential Diagnosis.

I. The diagnosis from primary right basal pneumonia rests on the presence of some abdominal symptoms, swinging temperature, and tenderness over some part of the hepatic area, before any pulmonary signs are noted at the right base, showing clearly that the pathological condition at the right base is secondary to some condition causing these symptoms and signs—namely, liver abscess. Cases iv and v illustrate these points. They were admitted to hospital with right basal pulmonary signs at the time that epidemic pneumonia was prevalent, and their condition was attributed to this disease; but the pneumonic condition was secondary.

Case iv had abdominal pain, nausea, and vomited in the early stage of his illness. His tongue was very coated on admission, though the stools passed were normal in appearance.

Case v had general abdominal rigidity and tenderness and a dry coated tongue. He improved upon daily enemata, which caused the evacuation of scybalous masses. In neither of these cases was enlargement of the liver downwards found, and tenderness over some part of the hepatic area was a transient sign.

Among the patients with malaria who died of epidemic pneumonia and upon whom *post-mortem* examinations were made in the same period, the pneumonia was present at the right base in several, and the physical signs present were right basal pneumonia with an enlarged liver, in some cases showing slight general tenderness. The patient was already suffering from two clinical entities and it seemed unreasonable to expect that a third should be added. The possibility of liver abscess in these cases was considered and dismissed.

II. The diagnosis from malarial hepatitis depends on the presence of splenic enlargement. I saw one case only in which the diagnosis of amoebic hepatitis, probably with abscess, was definitely made, and, although the liver was enlarged, tenderness was neither marked nor localized, and a blood film, positive for malaria, cleared away any doubt. In none of the cases was the spleen enlarged.

Number of Abscesses.

As already stated, in those cases which came to operation one abscess only was found. On the other hand, in the cases which came to *post-mortem* examination, the abscesses were multiple. Recently I have seen a case in which two abscesses were drained at operation, one in the

left epigastrium, the other in the body of the right lobe, drained by resection of the rib. In Case iv the abscess had burst into the pleural cavity. This patient had severe pain in the right shoulder. In Case v the abscess had burst into the peritoneal cavity.

In conclusion, I thank Lieut.-Colonel F. E. Roberts, D.S.O., R.A.M.C., for permission to publish these cases, and my colleagues at — Stationary Hospital for their help.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

ANOXAEMIA IN NASAL OBSTRUCTION.

To convince a patient that his troubles—which were many and “vague”—were due to intermittent blockage of his left nostril, I instituted a series of tests of which one was a walk of four miles. The first walk was carried through with the left nostril blocked; the second with the left nostril clear. The patient described his sensations thus: “The first walk my feet were as lead; in the second I felt they had wings.”

Another test was that the patient walked four miles, and at intervals, regulated by the feeling of weight in his feet, he cleared his left nostril by pressing the nose to the left side. After his return he said, “I was surprised. When I pushed my nose to the left, and thus instantly gave free passage to air through my left nose, I found my pace of walking immediately increased enormously. I felt as if I had been shot from a gun.”

I thought this statement interesting at the time—October, 1917. I think it of more interest now. In the BRITISH MEDICAL JOURNAL of July 19th, 1919, I read in Dr. Haldane's lecture:

The senses become dulled without persons being aware of it, and if the anoxaemia is suddenly relieved by administration of oxygen or other means the correspondingly sudden increase in powers of vision and hearing is an intense surprise.

Presumably nasal obstruction must cause anoxaemia. What is true of the sensory powers must be true of the motor powers. My patient's word was “surprised.”

CHAS. J. HILL AITKEN, M.D.,
Medical Officer in Charge Camps, B.T. in France.

DIAPHRAGMATIC HERNIA.

It may be interesting to record a case of diaphragmatic hernia I saw in India. I have not the exact data, but the sequence of events was as follows:

A private in the 1/10th Middlesex Regiment was admitted to Chakrata Hospital, Himalayas, suffering from acute abdominal pain with vomiting. He had been wounded in Mesopotamia in the left hypogastrium, and the exit wound was between the shoulder blades. Apparently treatment had been temporarily successful, and he was transferred to the hills, convalescent. He stated that he had eaten a large number of new walnuts, and considered this the sole cause of his trouble.

He was examined, and a diagnosis of probable diaphragmatic hernia made, as the left chest was tympanitic, and the patient was suffering severely from shock.

Arrangements were made for operation, and anti-shock measures were instituted, but he collapsed suddenly, and died almost immediately.

Post-mortem examination showed that the stomach had forced its way through a small hole in the diaphragm, and was lying in the left pleura. The organ was congested and full of gas, and had apparently become semi-strangulated.

It seems to me probable that the diaphragmatic hole was too small to interfere much with normal functions until the advent of gastric and intestinal irritation, which had produced strong peristalsis, and so helped to force part of the abdominal contents upwards. It may be the pressure was raised to a dangerous point by the continuous bending double of the patient, or again the hernia may have been the primary cause of the epigastric and hypogastric pain. Death, I think, was due to pressure on the heart causing syncope.

J. G. BENNETT, M.C.,
Marchester. Late Captain R.A.M.C.

A VESICAL CALCULUS WITH MEMBRANOUS COVERING.

DURING the early part of the present year I had as a patient a young private soldier who had had stone in the bladder for four months. There was great frequency of micturition, with pain at the point of the penis as the bladder walls gradually pressed down towards the trigone. No blood was to be seen, except some corpuscles visible on microscopic examination. There was marked cystitis. On rectal examination no hard body could be felt, and a sound also gave a negative result. At the time *x*-ray examination was not possible, and cystoscopic examination was likewise not available. Thus one had to judge for the most part by symptoms, examination, so far as it could be performed, not providing much help towards an accurate diagnosis.

Bladder lavage gave a certain amount of relief for a short time only, as also did internal medication. I performed suprapubic cystotomy, and removed a stone of a curious sort from the bladder. It was oblong, and nearly the size of a small hen's egg. It was soft and membranous on the outside, and the membranous covering could be moved freely on a hard underlying mass. The covering was rather friable. This softness explained the negative findings on examination with the sound. The bladder was very contracted, and its walls thick and inflamed.

On making a section of the calculus, which was obviously of a phosphatic nature with a small fairly hard central core, the outer membrane was found to be tri-laminar, composed apparently of mucoid material impregnated with phosphates. The specimen was shown to some other surgeons, who all said they had never seen a similarly constructed calculus.

The opening made in the bladder was closed, after removal of the calculus, and the space of Retzius drained by means of a wisp of gauze for a few days. The bladder was drained by a rubber catheter inserted through the urethra. This was removed on the eighth day. Urine was now passed normally and symptoms had disappeared. The abdominal wound, which had seemed to be closing well on removal of the gauze drain, now began to leak urine to a slight extent, and a catheter was reintroduced by the urethra for about a week. The wound healed well, and the patient was completely relieved of his symptoms, which had been very acute.

The case is of interest because of the unusual nature of the calculus, and because of the degree of difficulty in making an exact diagnosis in absence of aid from *x* rays and cystoscope.

A. E. CHISHOLM, F.R.C.S. Edin.,
Late Captain R.A.M.C.

THE CURE OF MULTIPLE WARTS ON THE FACE.

IN an interesting communication by Dr. Charles Ind, in the JOURNAL of July 5th, p. 11, mention is made of the failure of ionization with magnesium sulphate to cure small warts.

The cause of failure lies, I believe, in the omission of an important detail. Each wart must be superficially pricked with a fine needle before ionization. This can be done with great rapidity, and causes no discomfort, and with a current of 20 to 25 milliampères no complaint is made of anything beyond a slight pricking sensation. The warts show no change for from seven to nine days and then vanish. I have treated many cases, and have never seen a failure since I adopted this method.

Henley-on-Thames.

W. LONGWORTH WAINWRIGHT.

ASPIRIN IDIOSYNCRASY.

IN the JOURNAL of July 12th Dr. Karunaratne records an interesting case of aspirin idiosyncrasy. It is a fact not sufficiently well known that a patient with a low blood pressure and nasal polypi cannot safely take aspirin. Even one grain may cause symptoms similar to those described by Dr. Karunaratne. Antipyrin and oxyquinol thein cachets have a like effect, but phenacetin can, as a rule, be taken. Consequently there is great danger in giving aspirin indiscriminately in cases of asthma, especially as it is well known to give great relief in many cases. It is always

risky if the patient has or has had nasal polypi, but if there is a high blood pressure unpleasant results are not likely to follow.

London, W.

ALEXANDER FRANCIS.

Reviews.

THE FUTURE OF MEDICINE.

IT is not often that a book appears like Sir JAMES MACKENZIE'S *Future of Medicine*.¹ Every thoughtful medical man should read it, not only for its professional instruction, but in order to test his mental elasticity and power of fair judgement, to see if he can weigh without bias an unacceptable thesis, in this case a rather forcible indictment of medical methods and education as they now exist. The message is plain, independent, even iconoclastic, and certainly does not contain the smooth things that please the present-day Pangloss. The author has already stated his views in various papers, but here there is a connected argument running throughout the three, at first sight somewhat distinct, parts entitled "Critical," "Personal experiences," and "Constructive." His argument may be stated thus:

For the prevention of disease a knowledge of the early stages before structural damage has been done is essential. Further, the principle that a knowledge of symptoms is essential to any inquiry into the effects of remedies has never been properly recognized, and its neglect has rendered much investigation sterile, left our knowledge of drugs in a state of confusion, and made our pharmacopoeia mainly a storehouse of bygone beliefs. The correct assessment of symptoms, an accurate understanding of the mechanism of their production, and their bearing on the future health of the patient, are very difficult problems, and it is perhaps natural that the study of medicine has hitherto chiefly been devoted to the late effects of disease, as shown by physical signs in the wards and morbid changes in the *post-mortem* room. The failure of medicine to detect the early stages of disease is due to the fact that the patient's sensations have never been adequately investigated. In order to correct this the most experienced physicians, with all the most efficient means at their disposal, should logically see out-patients in the early stage of symptoms, when further changes can be arrested; and the younger members of the hospital staff should look after the advanced cases in the stage of physical signs in the wards.

But more than this is necessary for the efficient observation and assessment of symptoms; the patient must be under continued supervision, and this is the function of the general practitioners, who have opportunities that are rarely, if ever, open to the hospital physician as such, and should be recognized as having a definite part in the advancement of research. In reply to the possible retort that they have for all time had these opportunities without using them, it is pointed out that until comparatively recent times the teachers of medicine and those who have done so much to advance our knowledge have been to all intents general practitioners, such as Harvey, Hunter, and Jenner. The author's experience in general practice gradually forced on him the question, "Do I understand the meaning of one single sign or symptom in all its aspects—for example, the mechanism of its production or the bearing of its cause upon the patient's general health?"—and he had to admit that he did not. This led to an investigation into the significance of pain, and in the article on this subject, and in others on cardiac affections in Part II of this work, the method of investigating symptoms, acquired with much labour, is set forth as a suggestion of what may be done in the case of other symptoms. One of the objects of this book is to show that medicine can be made more simple in its practice, and at the same time more efficient. For it has become extremely complex; specialism has reached an extreme degree, and in the use of laboratory methods there is the risk that the patient may be ignored by the physician, who thus loses the opportunity of gaining much valuable information by investigating the patient's symptoms. For successful

¹ *The Future of Medicine*. By Sir James Mackenzie, M.D., F.R.S. London: Henry Frowde, and Hodder and Stoughton. 1919. (Demy 8vo, pp. 238. 8s. 6d. net.)

at home—shows that we are on the right lines of treatment. But the profession must decide whether it is fundamentally a contagious or constitutional disease. It cannot face both ways. Meanwhile Dr. Shaw's lecture has taken us a step further in emphasizing the importance of improving environment rather than killing infection.—I am, etc.,

Wells, Somerset, Aug. 3rd.

C. MUTHU.

MEDICAL APPOINTMENTS UNDER THE MINISTRY OF PENSIONS.

SIR,—Sir Douglas Haig has forcibly expressed his lack of confidence in the existing Pensions Medical Boards, his opinion being founded on reports he has received from officers and men who have been before these boards and consider that they have received neither "sympathy" nor "sentiment." Why? Because the personnel of such boards has been and is still mainly composed of medical men who have never heard a shell burst or a bomb drop, and have not the vaguest idea of the environment in which the cases they examine received their injuries. How can such medical men, whose knowledge of the late war is drawn from the illustrated papers, expect to enter into the feelings of, say, a case of shell shock, or properly to assess his disability? Hence all the trouble, and hence Sir Douglas Haig's vigorous criticism.

As regards the work done by the members of the profession who stayed at home, nobody denies it. But they never risked their skins, and never lacked a bed or a roof over their heads. It is rather amusing, therefore, to hear them speak as if they had, with great self-denial, refrained from taking part in a pleasant picnic. And it is somewhat tragic to find that they have persuaded not only themselves but a considerable body of the public that this is so.—I am, etc.,

July 26th.

IN ARDUIS FIDELIS (T.F.).

The Services.

INDIAN MEDICAL SERVICE.

NEW RATES OF PAY.

The India Office notifies as follows:

The new rates of pay, of which particulars follow, have been arrived at by adding approximately 33½ per cent. to that portion of the old rates of pay which represented military grade pay. The old rates are shown in the second column for comparison. The new rates are effective from December 1st, 1918, and the necessary adjustments will be carried out as soon as possible.

A. Military Side.

These rates were previously announced in May, but at that time the rates for the civil side were not available. They are now republished with the civil rates in order that full information for the whole service may be available.

	(1) New Rate. Rs. p.m.	(2) Old Rate for Charge of a Regiment. Rs. p.m.
Lieutenants	550	(450) ¹
Captains	700	(550)
Captains (after 5 years' total service) ...	750	(600)
Captains (after 7 years' total service) ...	800	(650)
Captains (after 10 years' total service) ...	900	(700)
Majors	1,000	(800)
Majors (after 3 years' service as such) ...	1,150	(900)
Lieut.-Colonels	1,550	(1,250)
Lieut.-Colonels (of over 25 years' service) ...	1,600	(1,300)
Lieut.-Colonels (selected for increased pay) ...	1,750	(1,400)

The new rates are consolidated and include charge pay for the command of station hospitals.

The following rates are those for certain of the higher military appointments:

	(1) New Rate. Rs. p.m.	(2) Old Rate. Rs. p.m.
D.D.M.S. (if held by a Major-General) ...	2,650	(2,200)
D.D.M.S. and A.D.M.S. (if held by a Colonel) ...	2,150	(1,800)
A.D.M.S. of Aden; Inspector of Medical Services, Army Headquarters ...	1,950	(1,600)
A.D.M.S. in the Field (when held by an officer below Colonel's rank) ...	1,700	(1,400)
Officer Commanding general hospital in the field of 500 beds ...	1,700	(1,400)
A.D.M.S., Army Headquarters ...	1,700	(1,400)

¹ In the case of a Lieutenant the rate for an officer in officiating charge only has been shown, as this is the most probable position of a Lieutenant.

B. Civil Side.

1. The rates for certain of the superior appointments are as follows:

	(1) New Rate. Rs. p.m.	(2) Old Rate. Rs. p.m.
Director-General	3,500	3,000
Deputy Director-General	2,150	1,500
Assistant Director-General	1,700	1,400
Surgeon-General, Bengal, Madras and Bombay	3,000	2,500
Inspectors-General of Civil Hospitals in non-Presidency Provinces ² ...	2,600	2,250
Sanitary Commissioner to Government of India	2,300-2,800	2,000-2,500
Sanitary Commissioner (for all provinces except Central Provinces and Assam)	1,800-2,100	1,250-1,800
Sanitary Commissioner, Central Provinces and Assam	1,550-2,050	
Inspectors-General of Prisons, Madras, Bengal, Burma, Bombay, and United Provinces	2,100-2,300	
Inspectors-General of Prisons, Punjab, and Bihar and Orissa	2,100	
Inspectors-General of Prisons, Central Provinces	1,800	

Rates drawn by present incumbents

2. The distinction between first and second class civil surgeoncies is abolished, and holders of these appointments will, in future, be paid at the new consolidated rates, given under A above, according to their military rank. This change results in increases varying according to rank from Rs. 200-400 per mensem.

3. Holders of professorial and bacteriological appointments will, like civil surgeons, be paid at the new consolidated rates, given under A above, plus a special allowance of Rs. 250 per mensem. The resultant increase over the old rates varies from Rs. 150 per mensem in the case of junior captains to Rs. 400 per mensem in the case of senior lieutenant-colonels.

4. Holders of other special classes of appointments will receive the consolidated pay of rank, as under A above, plus special allowances of differing amounts—for example, alienists and plague officers Rs. 200 per mensem, superintendents of first-class gaols Rs. 150 per mensem, personal assistants to surgeons-general Rs. 100 per mensem, superintendents of second-class gaols Rs. 50 per mensem.

The examples above are not exhaustive, but are given as illustrations of the manner in which the principle previously announced has been carried into effect.

PALESTINE DISPATCH.

FIELD-MARSHAL SIR EDMUND ALLENBY, G.C.B., G.C.M.G., Commander-in-Chief, Egyptian Expeditionary Force, in the course of a dispatch dated June 28th, 1919, describing events in Syria and Palestine subsequent to the conclusion of the armistice with Turkey on October 31st, 1918, says:

The climate was trying and sometimes extremely unhealthy. That the health and morale of the men was maintained was due to their own inimitable spirit and willingness; to the constant care and foresight of the medical authorities; and to the organizations, official and private, which provided in spite of all difficulties for the comfort and recreation of the troops.

In recording his appreciation of services rendered, the Commander-in-Chief refers to the medical services as follows:

The medical services have dealt successfully with the difficulties of evacuation over long distances in a country of undeveloped communications, and have combated with excellent results the chief scourge of Syria and Palestine—malaria. I desire to mention the good work of Major-General A. E. O. Keble and Major-General Sir R. H. Luce as Directors of Medical Services at various periods.

The King of Hellenes has appointed Surgeon Commander Thomas W. Myles, R.N., to be an Officer of the Order of George I, in recognition of distinguished services rendered during the war.

² Corresponding to the appointments of surgeon-general in the three Presidency provinces.
³ Assuming that a civil surgeoncy is not held by an officer of lower rank than a captain.

Universities and Colleges.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

FIRST EXAMINATION FOR THE FELLOWSHIP.

A CORRESPONDENT, late R.A.M.C., who finds himself ineligible for the first examination for the diploma of Fellow on the special conditions issued by the College at the end of January, writes to express the opinion that if facilities are to be given (and those in respect of ancillary studies difficult for a service man to return to) all who joined voluntarily should be given them. With regard to the subjects in which relief is given (morphology, embryology, histological or chemical methods, and physiological laboratory apparatus) he writes: A certain standard of knowledge in certain subjects has hitherto been demanded in the Primary Fellowship. If, however, the College could be satisfied that this standard had been attained by practical experience, they might reasonably allow a candidate to skip portions of the actual examination. For instance, one would consider it reasonable to allow a professor of anatomy to be passed

through the anatomy part of the examination without actually facing the examiners. But to apply this principle for these ancillary subjects because of military service is quite illogical. How can any one have attained by being on military service the standard of knowledge sufficient to warrant him being excused examination? Much more likely that his nomadic life will have diminished the knowledge he once had. If it were a question of the Final Fellowship, it would be a different matter. Many men must have had opportunities for getting practical knowledge of the subjects which would warrant the assumption that they were up to standard. Even then, to give the facility to some and not to others would not be fair.

Obituary.

DR. FRANCIS HENRY WEEKES, formerly of York, died at Malvern on July 31st at the age of 65. He received his medical education at St. Thomas's Hospital, and took the diplomas of M.R.C.S. and L.S.A. in 1877; he was house-surgeon to that hospital, and afterwards to the York County Hospital, a post he retained for some years, until he settled in general practice in York as the successor of the late Dr. Bird. He became surgeon to York Dispensary, and continued to be interested in surgery, taking the F.R.C.S.Eng. in 1885. For twenty-five years he had an extensive general practice in York and the neighbourhood, earning for himself a high place in the regard and esteem of all who knew him, not only for his professional ability, but for his gentle kindness backed by generous actions. He took the degree of M.D.Durh. in 1905, and his keen interest in the profession continued to the end. He had many other interests. All scientific subjects attracted him, but he took a special interest in archaeology. Of late years he travelled widely and with an observant eye. Many of his professional brethren and very many others will much regret to learn that he has succumbed to a long illness well and patiently borne.

LIEUT.-COLONEL WILLIAM HILL CLIMO, R.A.M.C.(ret.), died at Yateley, Hants, on July 22nd, aged 80. He was born at Blacksod, co. Mayo, on November 4th, 1838, and took the degree of M.D. Queen's University, Ireland, and the diploma of M.R.C.S.Eng. in 1860. He entered the army as assistant surgeon on April 1st, 1861, became surgeon on March 1st, 1873, surgeon-major on April 1st, 1876, and brigade-surgeon on March 19th, 1890, retiring on November 4th, 1895. In the regimental days he served in the Rifle Brigade from 1862 to 1868, and subsequently on the staff. He took an active part in the controversies which preceded the reforms in the Army Medical Service. While in India he published (1892) a series of papers pointing out the danger to the public health of Northern India arising out of the insanitary condition of Kashmir, and made various recommendations which he considered well within the resources of the Kashmir State.

CAPTAIN J. MACLEOD, R.A.M.C., was reported as accidentally killed, in a casualty list published on August 4th.

ERNST HEINRICH HAECKEL, the German biologist who died at Jena on August 8th at the age of 85, was born at Potsdam, studied at Würzburg under Kölliker and at Berlin under Johannes Müller and Virchow. There he took the degree of doctor of medicine in 1857, and afterwards spent some years in practice, but his true vocation was biology. He became extraordinary professor of comparative anatomy and director of the Zoological Institute at Jena in 1862. In 1865 a chair of zoology was founded for him and he remained at Jena for the rest of his life, refusing many offers of promotion. He travelled extensively for the prosecution of his researches in comparative anatomy. When Darwin's *Origin of Species* appeared in 1859 Haeckel at once accepted the new doctrine and pushed the theory much further than his more cautious master. Haeckel's literary activity was remarkable and continued unabated to the end of his life. He was intolerant and aggressive; his attitude towards religion was one of almost fanatical hostility and his teaching reached the extreme of materialism. Haeckel was one of the signatories of the manifesto issued by the German professors in October, 1914. His rabid hatred of this country, in which he had been welcomed as an honoured guest, showed the German temper at its worst.

Medical News.

DR. A. FINEGAN, Medical Superintendent of the Mental Hospital, Douglas, Isle of Man, who resigned the post on July 31st, has received a presentation from the staff. It consisted of a rose bowl; the presentation was made on behalf of the staff by Dr. Y. Kadam, A.M.O.

DR. ANTONIO JOSÉ DE ALMEIDA, the new President of the Portuguese Republic, began his political career while still a student of medicine at Coimbra, where he suffered imprisonment for three months; afterwards for some ten years he practised in the island of Sao Thomé, a Portuguese colony in the Gulf of Guinea. Since the revolution Dr. Almeida has been almost continuously in office as Minister.

MR. R. DAVIES-COLLEY, C.M.G., M.Ch., F.R.C.S., having completed his military duties, has returned to practice in London, and has resumed his work at Guy's Hospital.

IT is proposed to establish in Italy a society for the study of questions relative to the alimentation of man and animals. A part of its work is to be the co-ordination of the results of investigators in all countries, and it proposes to publish a review giving a summary of researches. Communications should be addressed to Professor Napoleone Passerini, Istituto Agrario di Sclavi, Florence, or to Professor Ronoloni, Laboratorio di Patologia Generale, Via Alfani, 33, Florence.

THE French hospital founded at Athens mainly through the efforts of Dr. Portmann, a medical officer of the French navy, was formally opened by M. de Billy, the French Minister, in the presence of M. Athanassaki, Under Secretary of the state health board, Professor Bennis, dean of the faculty of medicine, and a number of representative Greek and French citizens. The hospital contains 53 beds, and there is a bacteriological department under the direction of Dr. Potiriades.

THE National Association for the Prevention of Tuberculosis will hold its seventh annual congress at the Central Hall, Westminster, in October. It will be opened on October 16th by Dr. Christopher Addison. The conference will be concerned with the discussion of the completion of tuberculosis schemes in relation to the Ministry of Health, and local authorities and Insurance Committees. On the first day the relation of the schemes to pensions boards and committees, and general practitioners, will be discussed, and addresses will be delivered by, among others, Sir R. W. Philip, professor of tuberculosis in the University of Edinburgh, Dr. Hermann Biggs of New York, Dr. Nathan Raw, M.P., Dr. Cunyngham Brown (of the Ministry of Pensions), and Dr. F. N. K. Menzies (of the London Public Health Department). On October 17th and 18th the relation of the schemes to Red Cross and other voluntary activities, and the training of doctors and nurses will be discussed by, among others, Sir Arthur Stanley, G.B.E., Sir William Osler, and Sir German Sims Woodhead.

THE task of establishing an International Council of Scientific Research has been carried a step further by the meeting held last month in Brussels at the invitation of the King of the Belgians and Burgomaster Max. The scheme had its origin in a meeting called by the Royal Society in London last October. The second conference was held in Paris in November, when an international executive committee was appointed. Great progress has been made in establishing international associations for astronomy and geophysics, and steps have been taken to establish a similar association for chemistry; this proved a more difficult task owing to the numerous industrial applications. The meeting in Brussels prepared schemes for associations of a number of other sciences, including pure and applied biology. These schemes will all require national recognition, which it is hoped may be obtained before the first day of next year. The general assemblies of the council will be held in Brussels, but the business office will remain in London.

IN a report presented to the annual meeting of the American Medical Association it was stated that the number of medical practitioners in the United States was larger in proportion to population than in any other civilized country. According to the sixth edition of the *American Medical Directory*, completed in 1918, there were then 147,812 doctors in the States. The total population, according to an estimate furnished by the Census Bureau in 1918, was 105,253,300. This gives one practitioner for every 712 people. Statistics gathered just before the war showed that the proportion in European countries ranged from 1 in 1,500 to 1 in 2,500. The total

enrolment of medical students for the session 1918-19 is approximately 120,090, being 1,540 less than the number for 1917-18.

In consequence of the occurrence of a small number of outbreaks of small-pox during recent months, the Ministry of Health has issued a memorandum for the use of medical officers of health with regard to the supply and use of vaccine lymph for the vaccination or revaccination of persons who may have been exposed to small-pox infection. It is considered necessary to emphasize the importance of obtaining the prompt vaccination of such persons, because cases have recently come to notice in which known contacts have not been offered vaccination promptly and subsequently have developed small-pox. It is the duty of the medical officer of health immediately to acquaint the public vaccinator and vaccination officer when cases of small-pox come to his notice, and of the public vaccinator to vaccinate or revaccinate at the public expense persons in his district who apply to him for the purpose and have not been vaccinated or revaccinated within a period of ten years. The Government Lymph Establishment will supply medical officers of health with lymph, which it advises should be used within a week. Only medical officers of ports in frequent communication with the Continent are advised to keep themselves supplied with stocks of lymph for emergency use. The memorandum contains the following further statement: "Recent experience shows that it is important to bear in mind that inspectors or others concerned with the removal of small-pox cases or the disinfection of their clothing, and members of hospital staffs who at any time are likely to come into contact with a small-pox case, should at all times be well protected by revaccination, and should not take the risk of waiting to be vaccinated until exposure to infection has occurred."

Letters, Notes, and Answers.

ORIGINAL ARTICLES and LETTERS forwarded for publication are understood to be offered to the BRITISH MEDICAL JOURNAL *alms* unless the contrary be stated.

CORRESPONDENTS who wish notice to be taken of their communications should authenticate them with their names—of course not necessarily for publication.

AUTHORS desiring reprints of their articles published in the BRITISH MEDICAL JOURNAL are requested to communicate with the Office, 429, Strand, W.C.2, on receipt of proof.

IN order to avoid delay, it is particularly requested that ALL letters on the editorial business of the JOURNAL be addressed to the Editor at the Office of the JOURNAL.

The postal address of the BRITISH MEDICAL ASSOCIATION and BRITISH MEDICAL JOURNAL is 429, Strand, London, W.C.2. The telegraphic addresses are:

1. EDITOR of the BRITISH MEDICAL JOURNAL, *Aitology*, Westrand, London; telephone, 2631, Gerrard.
2. FINANCIAL SECRETARY AND BUSINESS MANAGER (Advertisements, etc.), *Articulate*, Westrand, London; telephone, 2630, Gerrard.
3. MEDICAL SECRETARY, *Medisecra*, Westrand, London; telephone, 2634, Gerrard. The address of the Irish Office of the British Medical Association is 16, South Frederick Street, Dublin.

QUERIES AND ANSWERS.

"P." asks for advice in the treatment of a man in whom, owing to neglected gleet, the inguinal glands have been destroyed, leaving a large suppurating cavity. The following methods of treatment have been tried: (1) Swabbing out with carbolic solution (1 in 40) night and morning, and packing with sal alembroth gauze; (2) swabbing with carbolic solution followed by painting with a solution of silver nitrate gr. xxx ad 3j; (3) swabbing three times daily with a solution of mercuric potassium iodide (1 in 1,000) and packing.

INCOME TAX.

J. E. L.—Can the cash basis method of return be insisted on if the surveyor objects?

.* The cash basis system is in almost universal use, unless there are circumstances rendering the "cash" profit an untrue index of the true profit based on the value of the year's bookings. If there are no such circumstances in our correspondent's case he might ask the surveyor why he declines to accept the usual basis of return for medical practices, and write again if he has further difficulty.

E. S. H. W. inquires as to the purport of a request received from the surveyor with regard to the sale of a motor car, for information as to the cost and description of the new car.

.* The surveyor has no statutory right to demand the information, but is presumably merely endeavouring to obtain it for the purpose of making a correct assessment.

There is no right to deduct as such a loss on sale of a professional car; the claim lies to deduct the expenditure incurred in replacing a car. The surveyor apparently seeks to know, first, that there was a replacement, and second, to what extent the purchase of the "replacement" car was merely a reinstatement; or, on the other hand—if the cost of the new car be greater than that of the original car—to what extent it represents a further outlay of capital on the equipment of the practice.

LETTERS, NOTES, ETC.

A COMPLICATED CASE OF HYDRAMNIOS.

E. F. writes: I was called to see a patient in labour. Having seen her previously at different periods, I knew there was a history of renal disease with cardiac complications. She gave a history pointing to six months pregnancy, but the abdomen was markedly distended and fluctuation was present. I felt what appeared to be a soft fetal head, and in a little time a macerated fetus of two months was born. The umbilical cord was prolapsed and pulseless. Having delivered this, I next ruptured the membranes and typical amniotic fluid came away, the quantity being about 12 pints. There was no shock or any unusual symptoms. After some delay a large placenta came away; to its distal aspect another umbilical cord was attached, and later on a six months fetus, healthy and normal, was born as a breech. The interesting features are the twins—one two months old, the other six months old. I can only account for this by the younger fetus being dead, whilst the other developed as the younger was macerated. The case may be summed up as follows: (1) Prolapsed cord; (2) macerated fetus of two months; (3) double placenta; (4) healthy fetus of six months born by breech. The patient later succumbed to fits of eclampsia.

ACCESSORY FOOD FACTORS.

A CORRESPONDENT calls attention to the fact that, in our notice of the memorandum on the importance of accessory factors in food, no mention was made of onions as possessing antiscorbutic qualities. In response to an inquiry, Dr. Harriette Chick informs us that onions were omitted from the table in the memorandum by an oversight. An exhaustive investigation of onions has not been made, but cooked onions were studied, and it was found that they are at least as good as cooked potatoes, and may be much better. In reply to another correspondent, we may point out that the memorandum, as was stated in the JOURNAL of July 19th, p. 84, noted that green leaves are a cheap source of the fat-soluble vitamins, the absence of which is believed to produce rickets. It is recommended that juices expressed from cabbages or other green-leaf vegetables—raw, or after steaming but not boiling for a few minutes—should be given, as also a teaspoonful a day of purées prepared from cooked spinach or lettuce.

VACANCIES.

NOTIFICATIONS of offices vacant in universities, medical colleges, and of vacant resident and other appointments at hospitals, will be found at pages 36, 40, 41, 42, 43, and 44 of our advertisement columns, and advertisements as to partnerships, assistantships, and locum tenencies at pages 37, 38, and 39.

WORKMEN'S COMPENSATION ACT, 1906.

THE following vacancies are announced: (1) Second Medical Referee for the Sherifdom of the Lothians and Peebles, to be attached more particularly to the Midlothian County Court; (2) Specialist Medical Referee for cases of Industrial Disease in County Court Circuits Nos. 24, 28, 30, 31, and 54; (3) Medical Referee for County Court Circuit No. 11, to be attached more particularly to the Bradford, Keighley, Otley, and Skipton County Courts. Applications for (1) to the Private Secretary, Scottish Office, Whitehall, S.W.1, and for (2) and (3) to the Private Secretary, Home Office, by September 4th.

THE following appointments for certifying factory surgeons are vacant: Abertillery (Monmouth), Bishop's Castle (Shropshire), Borrisoleigh (Tipperary), Darlington (Durham), Staveley (Westmorland), Tallow (Waterford).

SCALE OF CHARGES FOR ADVERTISEMENTS IN THE BRITISH MEDICAL JOURNAL.

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Seven lines and under	0 6 0
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All remittances by Post Office Orders must be made payable to the British Medical Association at the General Post Office, London. No responsibility will be accepted for any such remittance not so safeguarded.

Advertisements should be delivered, addressed to the Manager, 429, Strand, London, not later than the first post on Wednesday morning preceding publication, and, if not paid for at the time, should be accompanied by a reference.

NOTE.—It is against the rules of the Post Office to receive postal remittance letters addressed either in initials or numbers.