ribs the liver dullness seems to extend upwards into the axilla and the resistance to the fingers is increased. No definite change in the breath sounds beyond some lessening over the dull area. *X*-ray evidence showed a large cyst, about 4 to 5 inches in diameter, present in the axillary line, just above the diaphragm on the right side. A beautifully clear outline was shown and there was no possible doubt as to the nature of the disease. No blood cell changes. There was a shadow at the root of the lung of small size. The radiologist reported that this was due to inflammatory thickening around a bronchus. Operation revealed a degenerated cyst full of odourless pus and cyst débris. The patient has since developed phthisis.

2. F. F., aged 38, sailor, admitted May, 1914, with pleural effusion. He had a history of left-sided pneumonia and pleurisy for the last eighteen months. Complained of cough and increasing weakness. After aspiration there remained some dullness below third rib in front. The pleural fluid contained polynuclear cells. He was discharged at the end of three weeks relieved. Readmitted May, 1915. He had lost flesh, and had an irritating cough, relieved by lying on the left side. Movement on left side restricted. The heart was displaced to the right, 3 in. from mid-sternal line. There was fluid in the left pleura. There was evidence of consolidation of the lung in front, from the clavicle to the nipple line. Crepitations could be heard at the base of the left lung, The right lung was clear. The radiologist reported that the right lung was healthy throughout. The heart was displaced to right; the left lung was dense all over, lessening a little at apex and base and most dense in lower lobe. Later he reported a rounded deeper shadow, the maximum depth being in the position of the left nipple. June 2nd, lung still clear. Later in June it was found that the fluid in the pleura was purulent. A rib was resected and the pleura opened and a large quantity of hydatid material was discovered, When first admitted his temperature fluctuated between 101.8° and normal; later it remained normal till just before the operation, but was never so high as on admission. From time to time the sputum was blood-stained during a period of eighteen months or more. He had a positive Wassermann reaction, and the general opinion of the staff was that the lung was syphilitic. No eosinophilia was found in repeated examinations, and in spite of a normal temperature the physical signs did not improve. At the time he first came under my care I made a diagnosis of cyst, but I was unable to induce a surgeon to make a thorough exploration of his chest. It was only the subsequent occurrence of an empyema that led to an operation.

3. J. L., labourer, aged 42, admitted October 22nd, 1918, complaining of pain in lower right anterior chest, worse on taking a deep breath; he sought advice on this account. Temperature normal, lungs slightly emphysematous, heart normal as to position and sounds; general health always good—he was at work up to the day of admission. Cough very little. On examination no pleuritic rub was found. There was a circumscribed area of dullness in the lower right chest, with a slightly more resonant area between the lung and liver dullness in the anterior axillary line margin and extending upwards about four inches. The transition from dullness to resonance was sharp. Breath sounds over dull area weak, no adventitious sounds heard, and no bronchial breathing. *X* rays showed a clearly defined cyst occupying a large part of the lung, the radiologist estimating this as half the lung. No eosinophilia. Refused operation, as he did not consider it necessary; he is not inconvenienced at all.

Conclusions.

It will be apparent that hydatid cyst may simulate many lung diseases, and to discuss differential diagnosis in detail would be to discuss the character of almost every known disease of the thorax. Moreover, it is clear that a cyst so rarely gives rise to pressure symptoms that the diagnosis must depend on the history and *x*-ray evidence.

VOLVULUS OF THE SMALL INTESTINE FOLLOWING ILEO-COLOSTOMY.

BY

NORMAN DUGGAN, M.B., CH.B.VICT., F.R.C.S.ENG.,

WORCESTER.

THE following case seems worthy of record, owing to the comparative rarity of the condition, and the successful result of operation.

Mrs. G., aged 62, had for three years suffered from progressive loss of weight, increasing constipation, and frequent attacks of severe indigestion and abdominal pain. When first seen, in the autumn of 1919, she was leading a semi-invalid life, and looked very thin and ill. There were no definite signs of abdominal disease, but operation was advised in view of the possibility of cancer.

First Operation: Ileo-colostomy.

Laparotomy on December 7th, 1919, revealed no growth, but there was marked visceroptosis, and the colon was thin and atrophic. Ileo-colostomy was performed by lateral anastomosis of the closed and divided lower end of the ileum to the pelvic colon. The patient made a good recovery from the operation; the bowels acted freely, pain and indigestion were relieved, and in the spring of this year she was walking up to eight miles a day. A post-operative hernia was controlled efficiently by a Salt's corset-belt.

Second Operation (for Volvulus).

She remained in improved health till June 26th, 1920; on this day she was seized with sudden acute abdominal pain, which gradually became worse. When seen next day, the abdomen was slightly distended and tender, but not rigid; the tongue dry and furred, and the pulse feeble and irregular. She had passed some flatus, but no faeces. She was evidently suffering from obstruction, but her general condition was so bad that palliative measures were tried first. No result followed a large turpentine enema, and on the third day from the onset vomiting set in. Operation was then undertaken as a last resort, though her condition was desperate. Under open ether anaesthesia (given by my partner Dr. W. E. Moore Ede), preceded by morphine and atropine, two pints of saline were given intravenously, and the abdomen opened by a median incision below the umbilicus. A twisted mass of intestine, black and gangrenous, the size of a fetal head, was found in the pelvis. The peritoneal cavity contained a quantity of turbid fluid with a strong faecal odour.

The mass proved to be a volvulus of the lower end of the ileum caused by a short cord-like adhesion between two folds of mesentery. As the gut involved was already gangrenous, the intestine above and below was divided between clamps, and a wedge of mesentery resected, the whole specimen being thus removed without attempting to untwist the volvulus. Even so the gangrenous portion burst in the necessary handling and distributed its contents in the wound. The length of gut removed was two feet, and the volvulus had two complete revolutions on its axis. The cut ends of intestine were united by an end-to-end anastomosis, two layers of catgut sutures being used; the peritoneum was cleansed by dry swabbing, and the wound closed by through-and-through silkworm sutures.

Recovery.

The patient made an excellent recovery, shock being combated by the intravenous saline given before the operation, and by frequent rectal saline injections during the twenty-four hours after. In the second week some troublesome diarrhoea, with undigested food in the faeces, was arrested by the use of a mixture containing hydrochloric acid and malt extract. The wound suppurated slightly, but not so much as might have been expected after the gross soiling of the wound at the operation. There was never any sign of peritoneal infection.

The patient was up in a month, and able to walk two miles in six weeks from the date of operation. Since then her progress has been steady; she looks and feels well, is gaining weight, and the bowels act regularly without pain.

Strangulation of a coil of intestine, which, following an ileo-colostomy, has slipped through the gap between the mesentery of the ileum and that of the pelvic colon, is a well recognized accident; and all authorities therefore recommend that the gap be closed by a suture to prevent the occurrence of this form of internal hernia. This had been done at the first operation in the case now recorded, but when the acute obstruction occurred, it was thought that the suture had possibly given way.

Operation, however, showed that the gap remained closed, and that the condition was due to a volvulus. The adhesion giving rise to the volvulus was no doubt a sequel of the first operation—ileo-colostomy.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

TRANSPOSITION OF VISCERA IN TWO MEMBERS OF ONE FAMILY.

TRANSPOSITION of viscera is a condition not often met with, and two cases of transposed viscera occurring in members of one family must be so rare that I think the following notes are worthy of publication.

When I was carrying out a medical inspection at a school in Somerset in November, 1919, a girl, aged 12, was presented for routine examination. Upon inspection of her chest, the cardiac impulse was visible just inside the right nipple line; percussion and auscultation showed that the heart was transposed. The abdomen was then examined, and it was found that the stomach, liver, and spleen were transposed also. The mother of the girl, who was present at the examination, then informed me that the girl's brother, aged 10, "had his heart on the wrong side." I examined this boy the next day, and found that in his case, too, the heart, stomach, liver, and spleen were transposed. Both children appeared to be quite healthy.

I also examined the father, mother, and a remaining child, a girl of 15, but in their cases there was no transposition of viscera.

The diagnosis in each case was confirmed by *x*-ray photographs taken by Dr. Norman Haig of Yeovil. I wish to express my thanks also to Dr. Savage, County Medical Officer of Health and Chief School Medical Officer, for permission to publish these cases.

S. L. BRIMBLECOMBE,
School Medical Inspector, Somerset County Council.

PREGNANCY AFTER LIGATURE OF FALLOPIAN TUBES.

IN the JOURNAL of August 14th, 1920, p. 244, Mr. A. Crook of Norwich writes of a case of pregnancy occurring after ligature of Fallopian tubes. There are quite a number of cases on record in which this occurred. I think these records may be found in most of the year-books of gynaecology and obstetrics.

Some years ago I operated on a woman for prolapsus uteri, performing amputation of the cervix, anterior colporrhaphy, extensive colpoperineorrhaphy, and suspension of the uterus, and ligatured both Fallopian tubes with silk. Eighteen months afterwards she appeared in my consultation room four months pregnant. I had told her she need not be afraid of becoming pregnant again. She took no precautions, whereas for nine years previously she had taken precautions with success. Ultimately a child weighing 14 lb. was born; the mother was torn to the uttermost and prolapse occurred worse than ever. I had to operate again; there was no sign of the silk, no evidence of stricture of the tubes, which both looked quite normal.

The reparative power of a mutilated tube is extraordinary, and now, when sterilization is demanded, I adopt only one method—namely, complete removal of the tubes and the greater portion of the uterine ostium. By doing so one is, in the first place, certain of sterilization, and, secondly, that there are at least no receptacles for infection.

A. NORMAN MCARTHUR, M.B., B.S.,
M.R.C.S., L.R.C.P., Senior Indoor Gynaecological Surgeon to St. Vincent's Hospital, Melbourne.

THE SUPERIORITY OF SODIUM ANTIMONY TARTRATE TO EMETINE IN BILHARZIA.

DR. S. J. D. ESSER'S letter in the JOURNAL for October 23rd, asking about the use of emetine in bilharziasis, induces me to record the following case. In it all recognized forms of treatment, including emetine, had been tried, and a cure (complete as far as one is able to say) was eventually effected by the intravenous injections of sodium antimony tartrate.

The patient was infected some fifteen years ago in South Africa, and the disease gave rise to the usual symptoms—haematuria, frequency of micturition, pains in the back and attacks of renal colic. Urotropine and other urinary antiseptics gave no permanent benefit, nor did vesical irrigations. Two courses of subcutaneous or intramuscular injections of emetine hydrochloride were given for amoebic dysentery which supervened, the one course in July, 1915, lasting a fortnight, and the other in March, 1916, lasting three weeks. On each occasion gr. ½ was given night and morning every day, making a total of gr. 14 in the first course and gr. 20 in the second course. The patient was kept in bed during the injections, and the symptoms improved for a short time, but no cure resulted. After a time the symptoms of bilharzia were as marked as ever.

Just previous to the commencement of the course of intravenous injections of sodium antimony tartrate the symptoms, chiefly pain, frequency, and the passing of large numbers of clots, were as severe as they had been since the infection was first noticed. The urine contained large quantities of albumin and blood, and numerous ova, which hatched out easily under appropriate conditions. Injections were given three times a week, beginning with gr. ½; the dose was increased by gr. ½ at each subsequent injection up to a maximum of gr. 2½, which was continued until the patient had had in all gr. 25. The ova hatched out until gr. 10 had been injected, but about this period some appeared "black and shrivelled" and would not hatch out. The number of ova which behaved thus increased as the injections proceeded, until all those coming away were sterile; at the same time the ova became very scanty and increasingly difficult to find. The blood and albumin decreased rapidly after each subsequent injection. Pain and frequency gradually disappeared, while the general health improved considerably. The urine now contains neither blood nor albumin, and the very few ova seen are all and always definitely sterile, granular, blackened, and shrivelled. The last injection was given on October 14th.

Although the time that has elapsed is insufficient to enable it to be said that the cure is permanent, the notes provide some definite evidence of the value of antimony as compared with emetine in this particular case.

In conclusion, I may state, being myself the patient referred to, that I should recommend treatment by antimony tartrate or sodium antimony tartrate intravenously to any fellow-sufferer from bilharzia, rather than emetine, confident that the latter is not likely to produce the same local and general improvement in health which I have experienced.

Regarding the dangers of the antimony tartrate injection, whilst it is undoubtedly necessary for the doctor who undertakes the injection to work with due regard to the fact that the injections are made into the blood stream, personally I experienced no inconvenience during the course of treatment, but in point of fact, owing to the exigencies of my profession, I carried on with my work as usual.

London, W.C.1. A. H. HARKNESS, M.R.C.S., L.R.C.P.

DISAPPEARANCE OF THE RADIAL PULSES DURING DEEP INSPIRATION.

THE following observation was made fortuitously during the routine examination of a patient, J. E. H., a male, aged 45, of broad thick-set type with square shoulders and a high barrel-shaped chest. With the observer's finger on the pulse the patient was asked to take a deep inspiration. At the height of inspiration the pulse wave disappeared momentarily from the wrist, to return on expiration. When a deep breath was taken and held at its height the pulse remained absent until the breath was let go. The pulse waves in the radial, brachial, and axillary arteries of both sides were affected; and the phenomenon occurred both in the standing and lying positions. The pulse in the carotids was unaffected, and the heart beat was unchanged save for slight respiratory arrhythmia. The cause was anatomical, and lay in compression of the subclavian artery between the first rib and clavicle at the height of inspiration. Owing to the conformation of the chest the space between these structures was greatly limited. A physical peculiarity of this kind may be a common occurrence. I have never observed it before, nor do I remember ever having heard it mentioned or seen it recorded.

Harrogate. W. EDGECOMBE, M.D., M.R.C.P., F.R.C.S.

Reports of Societies.

MALIGNANT DISEASE OF THE COLON.

A DISCUSSION on the surgical treatment of malignant disease of the colon, which Sir Berkeley Moynihan afterwards described as the most informing surgical discussion he had ever attended, took place at the Medical Society of London on December 6th, with the President, Sir WILLIAM HALE-WHITE, in the chair.

Sir BERKELEY MOYNIHAN, in opening, said that the inaugural symptoms of carcinoma of the colon were (1) pain, which was sometimes scarcely more than discomfort; (2) intestinal irregularity, taking generally the form of diarrhoea if the growth was in the right colon, and constipation if it was in the left, the reverse conditions being excessively rare; (3) change in the faeces, the presence of blood being important as distinguishing a carcinoma from diverticulitis; (4) anaemia, the type known as pernicious anaemia, and treated as such by the physician, being often traceable to growths either in stomach or colon, especially ascending colon; (5) palpable tumour, or, more often, the feeling of the heaped-up masses of faecal matter behind the growth. *X*-ray examination by means of the bismuth meal had proved misleading; a good deal of help was forthcoming, however, from barium enemata. The characteristics of in carcinoma of the rectum were the irregularity in outline as seen in the *x*-ray picture, the constancy in position, and the unalterability under manipulation or after the administration of antispasmodics. So far as pathological anatomy was concerned, growths in the colon were slow, long restricted to the intestinal wall, showed great reluctance to affect and great lethargy in affecting the glands,

Improvement of health is more important in the long run than destroying germs. In this case it is the moral health—the education of the higher inhibitive powers—upon which the diminution of venereal disease will depend, and societies like the Alliance of Honour seem to me to be tackling the question in a more right and proper spirit than the Society for the Prevention of Venereal Diseases.—I am, etc.,

London, S.E., Dec. 4th. H. B. GLADSTONE, M.D.

THE STATUS OF ORTHOPAEDIC SURGERY.

SIR,—Among the most interesting and valuable remarks of Sir Robert Jones (published on November 20th) there occurs an expression of opinion which seems to me so detrimental both to orthopaedic surgery and to the hospital patient that I beg to lodge a protest.

After suggesting the group of cases which a modern orthopaedic surgeon should be prepared to treat, he goes on to say that the general surgeon may very properly urge that if so large a group of cases be taken from his wards much valuable teaching material would be lost to him, and he answers this hypothetical objection by saying:

"The general surgeon should have an absolute right to treat any case and as many of any type of cases as he desires. The orthopaedic surgeon is alone to be limited as to type. The general surgeon should not be limited by any definition of any sort."

Now, nothing could be arranged more unfairly for the orthopaedic surgeon, nor more unsatisfactorily for the patient. I say unfairly, because in actual practice under such a system only the uninteresting and tedious and difficult cases will reach the orthopaedic surgeon, while the rarities and the "good" cases will all be retained; and I say unsatisfactorily, because the patient wants to receive treatment from the expert right away, instead of waiting until after the general surgeon has made one or more unsuccessful attempts at it.

I should like further to protest against the low view which Sir Robert Jones seems to take of his speciality when he says—

A well organized orthopaedic department should prove a pleasant dumping ground to many a skilful and conscientious surgeon.

Nothing of the sort, Sir; it should be a privilege for the surgeon to be allowed to send a case to the orthopaedic department, and, if I may carry on the metaphor, the department should be a garden of growing flowers, not a waste of mouldering rubbish that nobody wants.—I am, etc.,

London, W., Nov. 27th. PAUL BERNARD ROTH.

SELF-ADMINISTRATION OF NITROUS OXIDE GAS.

SIR,—With reference to this subject, and in answer to Dr. Holmes's invitation for report upon any other known case, I beg to record the following:

Just previous to the war, while practising in a provincial town, I was called by a dentist's caretaker to see the page-boy. I found him sitting in the operating chair, dead, with the gas-mask still over the face. He had evidently been playing with the apparatus, had become unconscious while sitting in the chair, and fallen forwards and sideways, jamming the mask between the left-hand arm of the chair and his face, in which position it was found. The gas cylinder had emptied itself.—I am, etc.,

Colnbrook, Nov. 13th. A. L. HEISER.

TROPICAL FLEAS.

SIR,—In the *Journal of the Royal Sanitary Institute*, September, 1919, vol. 40, No. 1, Mr. A. W. Bacot, a very well known entomologist, has given a list of fleas found on rats and the countries in which these fleas are found. He describes *Pulex irritans* as world-wide. Dr. Alcock, in his book, *Entomology for Medical Officers*, says *P. irritans* is as cosmopolitan as its host, and Patton and Cragg mention that it is found practically all over the world.

I believe that these gentlemen are incorrect. In my paper on the etiology of rheumatic fever from a tropical point of view, published in the *Transactions* of the Society of Tropical Medicine and Hygiene, January, 1920, I laid stress on the fact that neither *Pulex irritans* nor *Ceratophyllus fasciatus* has been found in the Malay Peninsula, and gave reasons for believing that neither of them occurred anywhere in the tropics at or about sea level.

Dr. Jordan, of the Rothschild Museum, Tring, was able to show me only two specimens of *P. irritans* from the tropics—one from New Guinea at an elevation of 10,000 ft., the other from India, just on the edge of the tropics.

My theory that rheumatic fever is flea-carried is founded on the geographical distri ution of the disease and of *P. irritans* and *C. fasciatus*. If I am wrong about the distribution of these fleas, though I incriminate *C. fasciatus* primarily, my theory falls to the ground.

I would therefore be much obliged if the evidence on which the statements rest that *P. irritans* is ubiquitous could be published in the BRITISH MEDICAL JOURNAL.—I am, etc.,

J. TERTIUS CLARKE.

Tampin, Malacca, Straits Settlements, Oct. 31st.

Obituary.

DR. GEORGE W. W. ASHDOWN of Ripley, Derby, who died on November 25th, was born at Northampton in 1857. He received his medical education at the University of Edinburgh, where he graduated M.B., C.M. with commendation in 1880 and M.D. in 1883, when he was commended for his dissertation. After holding the post of resident physician to the Edinburgh Royal Maternity and Simpson Memorial Hospital he commenced practice at Tetbury, Glos., and removed to Ripley in 1903, where he held the posts of M.O.H. Ripley Urban District, and certifying factory surgeon, and was also on the staff of the Ripley Cottage Hospital.

DR. HAROLD EDWARD OWEN, who held a commission as captain in the New Zealand Medical Corps, died in the Military Hospital at Trentham, New Zealand, on November 18th. He was the second son of the late Thomas Edward Owen, surgeon, of Plymouth, formerly of Totnes, was educated at the London Hospital, and after taking the L.R.C.P.Lond. in 1888, went to New Zealand, where he was in practice at Raetihi, Upper Wanganui, and was honorary surgeon to the Taihape Hospital.

Universities and Colleges.

UNIVERSITY OF OXFORD.

THE following dates have been appointed for the conferring of medical and other degrees:

Friday, December 17th, at 10 a.m.; Thursday, January 20th, 1921, a 10 a.m.; Saturday, February 12th, at 2.30 p.m.; Thursday, March 3rd at 10 a.m.; Saturday, March 19th at 10 a.m.

The Sidney Ball lecture, 1921, will be delivered by M. Émile Vandervelde, Minister of Justice of Belgium.

The final edition of the University Roll of Service will be issued during the present month.

UNIVERSITY OF CAMBRIDGE.

AT a congregation, held on December 4th, the following medical degrees were conferred:

M.D.—G. D. Read.
M.B., B.CH.—M. K. Robertson.
M.B.—J. H. Burn, F. R. G. Heif.

UNIVERSITY OF LONDON.

A MEETING of the Senate was held on November 17th. A letter was read from the President of the Board of Education announcing that, subject to conditions indicated, the Government were making arrangements to conclude the purchase of the site in Bloomsbury for the headquarters of the University.

The following were recognized as teachers of the University in the subjects and at the institutions indicated:

Westminster Hospital Medical School (Bacteriology): Dr. J. A. Braxton Hicks. *St. George's Hospital Medical School (Pathology)*: Mr. Robert Donaldson. *London Hospital Medical School (Forensic Medicine)*: Mr. George Jones. *Middlesex Hospital Medical School (Medicine)*: Dr. George E. Beaumont. *London School of Medicine for Women (Dermatology)*: Mr. Haldin Davis. *University College Hospital Medical School (Surgery)*: Mr. C. C. Choyce.

Mr. C. S. Gibson, O.B.E., M.A., was appointed to the University chair of chemistry tenable at Guy's Hospital Medical School.

The title of Professor of Medicine of the University was conferred upon Dr. T. R. Elliott, C.B.E., D.S.O., F.R.S., of University College Hospital Medical School.

Dr. Herbert Tilley and Sir William Milligan have been appointed internal and external examiners respectively for the M.S. Examination, Branch IV, Oto-rhino-laryngology. Dr. Newton Pitt, O.B.E., has been appointed a member of the council of St. Thomas's Hospital Medical School. Sir Charles Ballance, K.C.M.G., C.B., and Sir William Collins, K.C.V.O., have resigned their membership of the Senate and External Council respectively.

Essays or dissertations on hyperthyroidism and its surgical treatment, for the Rogers prize, value £100, should be received by the Vice-Chancellor by April 30th, 1921.

UNIVERSITY OF EDINBURGH.

THE undermentioned candidates have passed the clinical examination for the degree of M.D.:

S. Arnott, W. M. Biden, D. A. Cadman, H. P. Caithness, T. L. Clark, F. A. E. Crew, L. S. P. Davidson, A. V. Dill, F. Dillon, J. D. Don, H. B. Dykes, J. W. Gray, G. H. Gunn, J. B. Kirk, M. Lipschitz, D. A. Miller, H. J. Parish, J. M. D. Scott, E. T. A. Stedeford, C. W. Stump, R. M. Wishart, G. G. Wray, H. D. Wright.

The Services.

LIEUT.-COLONEL H. R. KENWOOD, C.M.G., will deliver his presidential address to the Navy, Army, and R.A.F. Hygiene Group of the Society of Medical Officers of Health on Friday, December 17th, at 5 p.m., at the house of the Society, No. 1, Upper Montague Street, W.C.1. All past and present officers interested in naval and military hygiene are invited to attend.

THE name of Surgeon Commander E. Cameron, R.N., has been brought to the notice of the Secretary of State for War for valuable and distinguished services rendered in connexion with military operations in Somaliland.

DEATHS IN THE SERVICES.

LIEUT.-COLONEL WILLIAM HENRY ODLUM, Indian Medical Service, of Cappancur, Tullamore, died in the Meath Hospital, Dublin, of injuries received in a motor accident on November 25th, aged 47. He was educated in Dublin, at the Meath Hospital, where he was resident medical pupil, and took the L.R.C.P.and S.I. in 1898. He served in the South African war as a civil surgeon from April 18th to November 14th, 1900, and on the latter date took a commission as lieutenant in the R.A.M.C. On December 18th, 1907, as a captain, he exchanged into the I.M.S. At the time of his death he had just been promoted to lieutenant-colonel on attaining twenty years' service. He served in the South African war from May, 1900, to the end of the war in May, 1902, in the operations in the Orange River Colony, was present in the actions at Biddulphsberg, Bethlehem, Wittebergen, Witpoort, Ladybrand, and Caledon River, was mentioned in dispatches in the *London Gazette* of November 15th, 1901, and received the Queen's medal with three clasps and the King's medal with two clasps. He had also served in the recent war, and was mentioned in dispatches in the *London Gazette* of June 22nd, 1915. Before he came home on furlough he was in command of the Indian station hospital at Jhansi.

Medical News.

SIR AUCKLAND GEDDES attended the first meeting of the fifteenth International Congress against Alcoholism, recently held in Washington, and the British Government was represented at the remaining meetings by a member of the staff of the Embassy at Washington.

DR. J. W. BALLANTYNE of Edinburgh has been elected an honorary member of the American Child Hygiene Association. It was founded in 1909 as the American Association for the Study and Prevention of Infantile Mortality, but two years ago changed its name to conform to its enlarged activities. The Association holds an annual meeting and publishes transactions; it also issues a magazine entitled *Mother and Child*.

A MEETING of the Harveian Society of London will be held at No. 11, Chandos Street, Cavendish Square, on December 16th at 8.30 p.m., when a discussion on the Future of the Poor Law Infirmary will be introduced by Dr. C. M. Wilson and Dr. Charles Buttar, who will be followed by Mr. E. W. Morris (House Governor, London Hospital) and others.

DR. H. SALOMON, of Leicester, has been awarded a Government grant for successful vaccination in his district, and Dr. W. Millar, of Welton, East Yorks, has been awarded a grant for the sixth time.

A MEETING of the Society of Superintendents of Tuberculosis Institutions will be held at 122, Harley Street, at 4 p.m., on Monday, December 13th, when reports will be submitted by committees on standards of medical and nursing staffs and on the co-ordination of tuberculosis statistics. A discussion will also take place on a scheme of sickness insurance for ex-patients.

LIEUT.-COLONEL C. I. ELLIS, C.M.G., M.D., R.A.M.C.(T.), of Torquay, has been made a Knight of Grace of the Order of St. John of Jerusalem for services rendered to the Order.

AT the November session of the Central Midwives Board for England and Wales, with Sir Francis Champneys in the chair, eleven midwives were removed from the roll. Dr. Fairbairn and the secretary were nominated as representatives to give evidence as to the training of midwives in respect of the prevention of ophthalmia neonatorum before the Committee on the Causes and Prevention of Blindness, and Dr. Pilliet was invited to attend. Dr. Cuthbert Lockyer having tendered his resignation as one of the Board's examiners for the London centre, the vacancy was filled by the appointment of Dr. Malcolm Donaldson. It was decided to approve the principle of payment by the Board, at its discretion, as from January, 1921, of the expenses of officials or other persons attending as witnesses on behalf of the prosecution at the hearing of penal cases.

THE House of Lords, on December 3rd, decided a case in which the Fife Coal Company appealed against a judgement in the Court of Sessions. A miner had met with an accident and was paid compensation, at first for total and afterwards for partial incapacity. The company sought to terminate the payment of compensation on the ground that the miner's continued incapacity was due to unreasonable conduct, consisting in a refusal to undergo a surgical operation; his refusal was in accordance with the advice of his own doctor. The House of Lords dismissed the appeal, the Lord Chancellor observing that there might be a nice balance in the mind of a sagacious man which advice he would accept when one set of doctors recommended one course and his own doctor another.

THE December meeting of the Newcastle-upon-Tyne and Northern Counties Medical Society was held on December 3rd in Newcastle-upon-Tyne. In the afternoon an address was delivered in the Connaught Hall by Sir William Macewen, Regius Professor of Surgery in the University of Glasgow. His subject was "Remarks on Carcinoma of the Extremities of the Alimentary Tract, Tongue, and Rectum." The address, which was illustrated by lantern slides, was most interesting and original, and was listened to by a large and attentive audience. In the evening the annual dinner of the Society was held in the Barras Bridge Assembly Rooms. Dr. J. W. Smith presided, and the guests were Professor Sir William Macewen and Professor David Drummond, the President-elect of the British Medical Association for 1921. Considerably over 100 medical men were present, and a most enjoyable evening was spent.

THE Probate Court has declared in favour of a will made by the late Dr. Charles A. Mercier, about the form of which there was some doubt which the Public Trustee considered should be set at rest. One of the testamentary dispositions concerned the establishment of a professional chair of rational logic and scientific method. The testator bequeathed all his property to the Public Trustee to carry out this and other trusts. To the Royal College of Physicians of London he left the two silver-gilt Swiney cups which had been awarded to him, and also a set of great fire-irons of fifteenth century Italian workmanship.

THE London County Council has decided to promote legislation to enable it to pay coroners a fixed salary. This proposal forms part of a larger scheme for amending the law relating to inquests, but the present time is not judged favourable for submitting to Parliament the complete scheme. A fixed salary for coroners would involve the transfer to the Council of the obligation to pay certain expenses of office which are now met indirectly through the coroner's gross salary, and at its meeting last month the Council resolved to include in its application for further powers the power to appoint and pay deputy coroners and to exercise reasonable control over the employment by a coroner of a deputy.

IN an action for damages against a chemist, heard at the recent Leeds Assizes, the plaintiff alleged that he had suffered serious injury owing to a lotion prescribed for ear disease being inaccurately dispensed. The amount of carbolic acid which should have been present was 6.2 per cent.; the amount found on analysis was 10.2 per cent. It was suggested that the carbolic acid had accumulated at the bottom of the bottle. The jury awarded the plaintiff £500 damages.