delivery in a labour that had been induced. Most of the deaths during premature labour that he knew of had been due to such a procedure. Nature moulded the head much better than the obstetrician could with the use of instruments. There was very little harm, so long as some progress was being made, in allowing the second stage to continue beyond the classical time, and a premature head was more likely to suffer from rapid extraction than one at term. He agreed that with an estimated conjugate of 3¼ inches and under induction of labour was contra-indicated, not only because of the great foetal mortality at birth which had been mentioned, but also from the fact, which they should all bear in mind, that, according to the statistics of the Tarnier Hospital in Paris, taking those children who were born apparently healthy, nearly 80 per cent. were dead within a year. He always tried to induce at not less than thirty-six weeks, and otherwise as late as possible up to term. Several speakers had mentioned the importance of the relative sizes of the parents. A good example of this was that in African, and probably other semi-savage tribes, difficulty due to disproportion between the head of the child and pelvis of the mother was practically unknown, and in most of the cases in which such obstruction had been encountered by medical men, it was due to a white man having impregnated the black woman. Some of the speakers had stated that they placed no reliance on external measurements of the pelvis. The commonest form of abnormal pelvis in London was that of general contraction, and the most difficult cases he had met with were in those who had not been to an ante-natal centre and in whom the head entered the pelvis, so that everything was thought to be all right. Later, however, it was found that the head would not pass out of the pelvis. He thought a knowledge of the external measurements of the outlet of the pelvis was very important. Such measurements might be very difficult or impossible to take accurately, but an idea could be obtained by a comparison with one's fist or a tape measure, and so a warning of the greatest importance might be given. He never examined a patient vaginally with the object of ascertaining the size of the pelvis before the thirty-sixth week. In the first place, no object was gained, since if the head would not enter the pelvis then it was a case for Caesarean section; and secondly, an examination before this time might be followed—*post hoc*, not *propter hoc*—by a premature labour or miscarriage, for which the doctor would surely be blamed.

DR. RHODA ADAMSON, in replying, said that when she was not certain whether the head would enter the brim or not she generally tied a tight binder before making an examination under an anaesthetic. Quite a number of her patients were never submitted to vaginal examination at all; she preferred herself, and taught her students, to rely more upon examination per rectum. She agreed with the President that no extensive examination was advisable before the thirty-sixth week. In regard to the methods of effecting induction, she had not found castor oil and quinine effective before the thirty-eighth week. She confessed she was rather frightened at the ante-partum use of pituitrin. Up to three years ago she had used bougies, since then she had used a stomach tube. If, as sometimes happened, a patient could not be induced by these methods, the alternative was Caesarean section. It was very difficult to obtain the accurate weights of babies at birth; she had found the weight of the child generally increased up to the mother's thirtieth year and then remained stationary or decreased. She had had two patients who delivered themselves spontaneously after Caesarean section.

MR. BANISTER, in his reply, took strong exception to the saying, "once a Caesarean, always a Caesarean." In quite a number of cases where Caesarean section had been performed for the first baby, subsequent children had been born easily with induction. With regard to contraction at the outlet, this was very definite but comparatively rare. Of 900 cases of contracted pelvis, in 8 only was the contraction at the outlet the predominant feature. A head in the vagina with the patient under an anaesthetic would enable an estimation of the condition at the outlet to be formed, though it would not give a measurement in inches or centimetres. He looked upon a breech with extended legs occurring in a primipara with pelvic contraction as a sure indication for Caesarean section. He advocated external measurement of the pelvis at an early date, but every vaginal examination on the pregnant woman must be justified and no such examination should be done earlier than the thirty-fifth or thirty-sixth week. He was strongly opposed to rectal examination being used in place of vaginal. He had employed most of the methods for inducing labour. At full time castor oil and quinine gave a fair measure of success, but it was useless for the induction of premature labour. He relied upon Krause's No. 12 gum-elastic bougies, usually inserting three. With the patient in the lithotomy position, after the usual toilet had been carried out, the bougies could be easily passed directly into the cervix, which had been drawn down by a vulsellum. No douching or plugging or other after-treatment was necessary or advisable. The time for labour to be completed was on the average fifty-four hours in primiparae and forty-seven hours in multiparae. Since the introduction of the 10 per cent. solution of pituitrin he had had good results by injecting 1/4 c.cm. every hour till 1 c.cm. had been given in cases where no pains came on within ten hours of the insertion of the bougies.

Memoranda:
MEDICAL, SURGICAL, OBSTETRICAL.

THE FILLED DEAD TOOTH AS A SOURCE OF STREPTOCOCCAL BLOOD INFECTION.

THIS case is recorded not merely because I have so far been unable to find a similar case in the literature, nor yet because it is interesting, but with the object of discovering other cases and so establishing its identity. A symposium on this subject will be held at the Post-Graduate Hostel on October 28th, when it is hoped that cases will be brought forward either personally or in writing.

The patient was a male, aged 29. The history probably dated from May, 1919. An attack of follicular tonsillitis was clearing up, when one evening there were peculiar pains in the left ankle. The following day these had ceased, but the ankle was swollen and pitted on pressure. The patient did not go to bed until "tightening" pains of the lower part of the right chest and considerable constitutional disturbance, temperature 101.5°, ensued. No urinary symptoms or albuminuria were present. The pains in the chest gradually disappeared in six weeks, but the oedema increased, extending up the leg, but never affecting the toes. There was no further pain in the ankle nor was there effusion, though it was put in plaster for four weeks on that supposition. Many diagnoses were made, of which the most likely was thrombosis of the posterior tibial venae comites.

The tonsils were removed one month later, and the appendix, which had become acutely inflamed, four months later. During the next four years the ankle frequently showed a slight oedema, though a crêpe bandage was worn constantly and usually sufficed to restrain it.

In August, 1923, the first of the attacks of erysipelatoid occurred. A feeling of malaise and a temperature of 101° developed in about half an hour. Profuse vomiting occurred, lasting about twenty-four hours. The inguinal glands then became extremely painful, and in a further twelve hours the whole distribution of the saphenous vein was hot, painful, red, and swollen. The vein itself showed no signs of inflammation, not being hard; the affection was apparently of the accompanying lymphatics. The thigh and knee were fixed, preventing all walking. In a month the leg was quite normal.

Similar attacks occurred in June and August, 1924. In January, 1925, there was a mild attack; vomiting was much less noticeable, however. A second, even milder, attack occurred in May, when three injections of streptococcal vaccine were administered at four-day intervals; radiant heat was used during the attack. In August a very severe manifestation occurred, though vomiting and glandular involvement were slight. The leg was tender; all movements of toes and ankle were exquisitely painful; the course of the flexor tendons round the ankle was red, tender, and swollen. Mr. W. McAdam Eccles saw the case and suggested a dental focus of origin and advised having the teeth *x*-rayed, which was done, although unsatisfactorily.

In February, 1926, another attack occurred, but no vomiting; 40 c.cm. antistreptococcal serum was given. In April and June other attacks similar to the previous one developed. Dr. H. G. Adamson saw the patient; treatment by *x* rays was instituted, and the affected areas painted with a solution of silver nitrate in spirit. He advised re-examining the teeth, which was done at University College by Mr. Melville; the films were referred to Mr. J. T. Carter. His diagnosis of an abscess at the root of the

second molar tooth was confirmed by Dr. Human, pus welling up from the infected root on removal of an apparently perfect filling. A strong antiseptic dressing was applied in July, and unless in eight weeks' time all sign of rarefaction has disappeared the tooth is to be removed. All the other teeth show large healthy pulp cavities. The tooth in question had not had root treatment, though three others had been so dealt with.

It is too early to predict a cure, but the patient has felt very much better since treatment to the tooth. One of the least explainable features was a distinct reduction in the slight permanent swelling of the ankle after an attack.

I suggest as a working theory that the first trouble was a venous thrombosis which, lowering the natural resistance of the limb, paved the way for the deposition of streptococci from the septic focus. The parts rendered vulnerable by previous attacks readily succumbed to a large dose of organisms set free from the tooth from time to time. They bore no direct relation to the first attack, which was venous in origin. The case, if it proves to be of dental origin, bears out the statement in a recent article[1] that it is the filled dead tooth which has not had its root treated, in otherwise healthy mouths, which is oftenest the source of constitutional symptoms.

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A CASE OF DIFFUSE TARSITIS.

LOCALIZED inflammatory infections of the tarsal plates of the eyelids are extremely common—for example, in Meibomian infections—but the following case of diffuse inflammation throughout the whole of a tarsal plate and confined to the plate is worthy of record.

A man, aged 22, consulted me, stating that a small swelling had appeared on the lid several months previously, but that during the month prior to the consultation it had increased rapidly. There was no pain and no tenderness. His chief concern was the disfigurement caused by the swollen lid, which was found to be greatly enlarged throughout its whole length; the swelling was slightly accentuated at the junction of the inner three-quarters with the outer quarter. Viewed from the side the lid had the appearance of a pendulous sac. The skin of the lid, which was somewhat tense, could be easily picked up from the underlying tarsal plate, was bluish, due to compression of the venous return. The conjunctival vessels were engorged, especially over the accentuated swelling at the junction of the inner three-quarters with the outer quarter. The lower margin of the tarsal plate could be easily felt along its whole length, and the plate itself could be grasped by placing a thumb and forefinger at each end. By exerting a little pressure the plate could be felt as an elastic body with a large amount of "spring."

The accentuated swelling was incised on the conjunctival surface, but pus was not found, neither could any softened tarsal plate be removed with the sharp spoon. Hot fomentations were applied for one week, and as the swelling of the lid had not subsided it was again incised at the site of the previous incision. A small bead of pus was evacuated and also a small amount of softened tarsal plate. Since then the swelling has gradually diminished, the skin folds becoming visible in two weeks.

Two months after the second incision the lid had resumed its normal colour, and only a slight enlargement could be discerned on close inspection.

The diffuse inflammation in the plate itself was doubtless due to the primary infection in the Meibomian gland.

E. NICHOLAS HUGHES, M.R.C.S., L.R.C.P., D.O.M.S.,
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OVERDOSE IN SPINAL ANALGESIA.

REPORTED cases of overdose in spinal analgesia are so rare as to be worthy of record. For inducing spinal anaesthesia I had been using Barker's solution made up in 2 c.cm. ampoules, each ampoule containing 0.1 gram of stovaine and 0.1 gram of glucose in 34 minims of fluid. The average dose for an adult was 1.2 c.cm.—that is, 0.06 gram of stovaine, varying slightly with the age and physique of the patient, and the nature and the extent of the operation. When the supply of the preparation was exhausted the dispenser replaced it by another made up according to Chaput's formula, containing stovaine 0.1 gram, sodium chloride 0.1 gram, in distilled water 1 c.cm., which was the quantity each ampoule contained. I was informed that two ampoules of the new preparation contained the same amount of stovaine as one of the older, and acted on that information in the two cases here recorded.

[1] E. Sprawson, *Lancet*, August 7th, 1926, p. 300.

CASE I.

A boy, aged 11, suffering from right inguinal hernia. He received 1.2 c.cm of the solution (that is, 0.12 gram of stovaine instead of 0.06 gram), so that he had twice the usual dose. He became pale, retched, vomited, and showed all the signs of shock; the systolic blood pressure fell to 80 mm. of mercury. On the third day after the operation he was reported to have developed incontinence of urine, and I discovered that he had retention with overflow. A catheter was passed every eight hours, and soon afterwards the patient developed cystitis and haematuria. At times there was incontinence of faeces. Evidently there was complete paralysis of the bladder, with partial paralysis of the rectal sphincter. Electricity was applied to the spine, strychnine was given hypodermically, and urinary antiseptics and tonics were administered. After three weeks, control of micturition was partially regained, the cystitis and haematuria subsided, and the general condition greatly improved. Finally he recovered complete control of the bladder and the rectum, though he was left with frequency of micturition. I saw the boy again well over a year after the operation, when he was perfectly fit.

CASE II.

The second patient, who was operated upon the day after the first one, was a girl, aged 19, admitted with acute appendicitis and abscess formation. She, too, received an overdose, as I had not by that time discovered the error. She exhibited a similar series of symptoms to those of the first patient, except that she did not develop cystitis. She suffered, at first, from frequency of micturition, but regained control in three weeks. I recently heard from her to the effect that she was perfectly fit and well.

The interest in the two cases is that a double dose of stovaine injected, owing to a misapprehension, into the spinal theca produced severe shock with retching, vomiting, and a marked fall in the blood pressure; and temporary, but complete, paralysis of the bladder centre in the cord, resulting in retention of urine with overflow and partial paralysis of the rectal sphincter, causing incontinence of faeces.

London, W.1. M. SOURASKY, M.D.Leeds, F.R.C.S.Ed.

DIFFUSE ADENOCARCINOMA OF THE COLON.

THE following case of this condition occurred in our practice.

A man, aged 64, was first seen by us on July 10th. He stated that he had suffered two years ago from distension of the abdomen, flatulence, and vague pains. He was seen at that time by a surgeon who suspected colitis or malignant disease and recommended laparotomy, which was refused. He had since suffered intermittently from the same symptoms, which became more severe; he lost weight (about 3 st.) and observed lumps in the abdomen, which were described as "being here one day and gone the next." When seen by us he was weak from loss of weight and inability to take food, and suffered from pain all over the abdomen, diarrhoea, which consisted of blood-stained mucopurulent debris, and occasional sickness. The abdomen was generally distended, the bowel standing out in typical ladder pattern in both iliac fossae. A definite mass could be felt, about the size of the fist, round the umbilicus; it was elusive and receded from the palpating hand. In the epigastrium was a hard mass running transversely along the line of the transverse colon. Gurgling and splashing could also be elicited all over the colon. The abdomen was opened in the mid-line and a malignant condition was found inside the lumen of the bowel, involving the whole length of the colon from the caecum to the rectum; the muscular coat of the bowel could be freely moved over the mass inside, and polypoid masses could be felt even in the rectum.

The condition was taken to be one of a diffuse adenocarcinomatous infiltration of the mucous and submucous coats of the bowel, and the only action taken was a lateral anastomosis of the lower end of the ileum with the pelvic colon, with the idea of obviating the inevitable obstruction which must occur were nothing done.

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J. S. MACBETH, M.B., Ch.B.Ed.
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ADRENALINE IN CARDIAC ARREST.

WE read with interest the memorandum on adrenaline in cardiac arrest published on August 28th (p. 388). A fortnight ago we had a similar experience.

A boy suffering from a Colles's fracture was given an anaesthetic. When the fracture was set, and fully a minute after ceasing to administer the anaesthetic, the boy ceased breathing and the heart stopped beating.

Artificial respiration was without result. We then injected about 1/2 c.cm. of 1 in 1,000 adrenaline solution into the heart, and in fifteen seconds it was beating again.

The boy was apparently dead for at least sixty seconds.

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T. D. FITZPATRICK, M.B.
Cross Cop, Morecambe.

PRIMARY ABDOMINAL TORSION OF THE GREAT OMENTUM.

MR. ERNEST COWELL[1] recently directed attention to the subject of primary abdominal torsion of the great omentum. He suggested that the condition is probably not so uncommon as the literature would lead the observer to believe. In this connexion the notes of the following case are of interest.

A man, aged 46, of somewhat obese habit, was admitted to hospital after two days' illness. The onset was not acute; a dull pain began to the right of the umbilicus, and gradually increased in intensity. There was no vomiting, and the bowels acted as usual. The tongue was dirty. The temperature was 97.2° F. and the pulse rate 86. There was tenderness to the right of the umbilicus, and rigidity of the right rectus in the lower half. There was no tenderness over the gall bladder. An indefinite mass was palpable to the right of the umbilicus, and was regarded as an inflamed appendix wrapped up in omentum. Rectal examination afforded only negative information. The temperature and pulse rate were not inconsistent with the case being one of appendicitis. A diagnosis of subacute appendicitis was made, and operation performed forthwith.

Operation.—The abdominal cavity was entered through a right paramedian incision, the right rectus having been retracted medially. Free fluid, slightly smoky, was present in excess in the peritoneal cavity. The appendix was healthy. On sweeping the index finger upwards a mass was encountered, attached by light adhesions to the anterior parietal peritoneum. The incision was extended upwards and a piece of omentum, purplish-red, was drawn out. It was not attached to the gall bladder, which presented no sign of disease. The mass was about the size of a green fig, and was undergoing red infarction. It arose from the right-hand edge of the omentum, and lay in close relationship to the hepatic flexure of the colon. At first sight it seemed to protect a lesion of the bowel, and suggested the presence of an inflamed diverticulum. However, the mass was readily isolated, a twisted pedicle defined and ligatured, and the necrotic tissue cut away. Finally, the appendix was removed.

Recovery was uneventful, and the patient went home in a fortnight. It was not possible to untwist the pedicle to estimate the number of turns. No cause was assignable to account for the torsion of the omentum.

This case is similar to the one recorded by Mr. Cowell, and may fairly be taken to represent the type. In endeavouring to distinguish, before operation, between torsion of the omentum and acute appendicitis the following considerations are of value.

1. The onset of the illness is not usually so acute as that of appendicitis.
2. Pain and tenderness are located slightly higher than is usually the case with appendicitis.
3. With torsion of the omentum pain is not so severe, and tenderness is not so exquisite.
4. The twisted mass of omentum is, in many cases, palpable, and at a slightly higher level than a normally situated appendix wrapped in omentum.

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INFLUENZA ANTIGEN IN THE TREATMENT OF ENCEPHALITIS LETHARGICA.

AN interesting and valuable article by Dr. Crofton of Dublin on the causation and treatment of encephalitis lethargica appeared in the JOURNAL of March 27th, 1920. Dr. Crofton holds the opinion that the influenza bacillus is the cause of the disease, and in his communication adduces evidence in favour of this by giving the history of several cases of the malady which were cured by pure influenza antigen. To the perusal of his article are owing the highly gratifying results which followed the same method of treatment in the case of two patients suffering from the disease who have come under my observation.

CASE I.

A gardener, aged 58, had an attack of influenza in the second week of May, 1924. This complaint was very prevalent in the village in which he lived; two other members of his household (wife and lodger) had suffered from it not long before. Soon after getting about he began to complain of increasing weakness, and on May 20th he was found to have diplopia. These symptoms increased and then somnolence began to show itself. He would fall asleep at any time but was restless at night. He was treated with Easton's syrup, suprarenal extract, hexamine, and influenza vaccine (Parke, Davis and Co.), of which three hypodermic injections were given. The patient grew steadily worse, and on June 25th seemed to be in a highly critical state. Incontinence of urine and faeces was present, somnolence was very pronounced, and ptosis was almost complete, the patient being unable to see anything unless an eyelid was raised. External strabismus of the right eye also showed itself and some time later the Parkinsonian facies; both of these have become permanent. There was also marked mental aberration, the patient occasionally thinking that he was busy "working with wood." An injection of influenza antigen, made from pure influenza bacilli isolated from cases who had or had had influenza, was given that day. Three days later incontinence of urine was present only when the patient was asleep, while he had more restful nights. On July 5th the fourth injection of antigen was given. The ptosis had now greatly diminished. Five days later, when the fifth injection was given him, he could count fingers correctly, while on July 22nd slight ptosis was present in the right eye only, he was able to walk about the room, and his mental condition was normal. Incontinence of urine had occurred only once, and that in sleep during the preceding week. On July 29th he was able to sit in his room for half an hour daily. The somnolence, which had been passing off gradually, was now slight; he might sleep for half an hour or so twice a day. The incontinence of urine had completely disappeared. From this time onward the patient continued to improve, though slowly. In the middle of October he was able to walk out of doors, and in January, 1925, to resume light gardening work, which he has been able to carry on to the present time.

CASE II.

A girl, aged 9, in the end of last May was rather suddenly seized with illness, the clinical features of which were drowsiness, severe headache, vomiting, and obstinate constipation. Some time later other signs appeared, double optic neuritis, Kernig's sign, Brudzinski's "sign of the neck," and the temperature rose to 101°. There was leucocytosis of 42,800. On June 17th the patient was seen by Dr. Turton of Hull, who performed lumbar puncture. The cerebro-spinal fluid proved to be the same as Mustretat and Rodriguez state is found in encephalitis lethargica—namely, "the study of recorded results gives a definite impression that the formula of cerebro-spinal fluid in encephalitis lethargica is normal or nearly so."

On July 1st a hypodermic injection of one million pure influenza antigen was given; seven days later, when a second dose, the same in amount as the first, was administered, improvement was noted, Kernig's sign and Brudzinski's sign being less pronounced. Four more injections followed on July 14th, 18th, 23rd, and 28th, the dosage on these occasions being 1, 1½, 2, and 3 million respectively. Improvement was steadily maintained. On July 18th Kernig's sign and Brudzinski's sign had disappeared, while the child was taking its food well and putting on flesh. On July 23rd little headache remained, and that only occasionally. On July 28th the discs were normal. After the last injection convalescence proceeded with great rapidity and the patient was able to walk in the garden on August 2nd, and about a fortnight later was in possession of her usual health and activity.

Driffield, E. Yorks. JOHN R. KEITH, M.D.

STRANGULATED INGUINAL HERNIA IN AN INFANT SIXTEEN DAYS OLD.

ACTUAL strangulation of an inguinal hernia during the first few weeks of life appears to be sufficiently infrequent to warrant the following record. Somewhat similar cases were reported by Dr. Simmons in the JOURNAL of July 24th, 1924, and by Miss Herzfeld in that of October 11th, 1924.

A male infant, born prematurely in the seventh month, was noticed to have a right inguinal hernia. This was kept reduced without difficulty, but the bowels did not act satisfactorily, and the breast feeds were not well taken. At 11 a.m. on the sixteenth day after birth the hernia was found to be irreducible, and soon after this the child vomited. Hot fomentations and postural treatment were applied, but without success.

At 4 p.m. the same day I was asked by Dr. W. H. Milligan of Lytham to see the case with a view to operation. The infant, which weighed only 5 lb., was fretful and crying most of the time. The temperature was 99° and the pulse 130. In the right groin there was a tense cystic swelling, the size of a pigeon's egg, which was obviously very tender. Gentle attempts at reduction were unsuccessful. No testicle could be felt in the scrotum on this side. In view of the danger of delay it was decided to operate at once. The induction of very light chloroform anaesthesia was undertaken by Dr. Wilfrid Milligan of Ansdell. Before the incision was made 40 c.cm of normal saline was injected subcutaneously into each flank. The sac when opened was found to contain a quantity of dark blood-stained fluid, and about five inches of small intestine, black and covered here and there by flakes of lymph. The obstruction was relieved, and the bowel flushed repeatedly with hot saline lotion. As soon as the bowel showed a slight inclination to revive it was returned to the abdominal cavity. The sac, which was of the funicular type, was ligated and one catgut suture passed through the external abdominal ring.

The baby was put back to the mother's breast, and apart from the passage of a blood-stained motion on the following day recovery was without incident.

The interesting feature about the case was the advanced degree of strangulation—actually bordering upon gangrene—which had occurred so soon after impaction. The case also illustrates the urgent necessity for operation immediately palliative methods have failed.

Blackpool. G. H. BUCKLEY, M.B., Ch.B., F.R.C.S.Ed.

[1] Cowell, E.: *Brit. Journ. Surg.*, xii, 738.

Medical News.

THE next international congress of surgery will be held at Warsaw in July, 1929, under the presidency of Professor Hartmann of Paris.

THE new baths at Leamington Spa will be opened on Saturday, October 9th, by Sir H. Kingsley Wood, M.P., Parliamentary Secretary, Ministry of Health. The ceremony will take place in the Royal Pump Room at 3 o'clock.

THE opening ceremony of the winter session at King's College Hospital Medical School (University of London) will be held on Friday, October 1st, at 2.30 p.m. The introductory address will be given by Sir Humphry Rolleston, Bt., K.C.B., M.D., Regius Professor of Physic in the University of Cambridge. The annual dinner of past and present students will be held at 7 for 7.30 on the same day at the Criterion Restaurant, Piccadilly, W.1, with Dr. Frank H. Jacob in the chair.

THE inaugural address at the Westminster Hospital Medical School will be delivered on Friday, October 1st, at 3 p.m., by Sir Archibald E. Garrod, K.C.M.G., F.R.S., Regius Professor of Medicine in the University of Oxford. The proceedings will take place in the board room of the hospital, and tea and coffee will be served afterwards.

THE Association of Special Libraries and Information Bureaux will hold its third conference during the week-end September 24th to 27th at Balliol College, Oxford. Papers are to be given on various problems affecting the collection and distribution of information by experts, including Dr. de Vos Van Steenwijk, of the League of Nations, and Mr. Kaiser, of the Engineering Societies' Library, New York, who will speak on systematic indexing. The British Medical Association will be represented by its Intelligence Officer, Miss A. L. Lawrence, M.A., LL.B.

DURING and after the second week of October three series of clinical lectures illustrated by cases will be given at the Maudsley Hospital, Denmark Hill, S.E.5, at 2.30 p.m. On Mondays Dr. W. Moodie will lecture on the relations of mental disorder to physical conditions, on Wednesdays Dr. Edward Mapother on neurotic and psychotic syndromes, and on Fridays Dr. W. S. Dawson on mental symptoms and their genesis. In addition a discussion on cases in the Mental Hospital is held in the wards every Tuesday at 11.30; and monthly, on the last Friday of each month, at 4.30, at which a group of patients from one of the London County Council Mental Hospitals is shown. These lectures and discussions are open to medical practitioners without fee. Posts as clinical assistant can be obtained on application to the medical superintendent. The course of lectures and practical instruction for the diploma in psychological medicine will be held at the Maudsley Hospital, beginning in January next. The lectures and demonstrations are given in series, and either group can be attended separately. The fee for the course is ten guineas, or for a single series two guineas, payable to the Fellowship of Medicine, from which office (1, Wimpole Street, W.1) copies of the syllabus may be obtained.

THE lectures arranged by the British Institute of Philosophical Studies for the forthcoming session, beginning October 4th, include ten lectures on medical psychology by Dr. T. W. Mitchell and a course on general psychology by Professor C. W. Valentine. In the Lent term Dr. C. Delisle Burns will lecture on the philosophy of social life, and Professor J. S. Mackenzie on social values, and the Dean of St. Paul's has promised to give a course of six lectures on the philosophy of religion in the summer term. The syllabus of lectures can be had on application to the Director of the Institute, 88, Kingsway, W.C.2.

THE sixth French Congress of Industrial Chemistry will be held at Brussels from September 26th to 30th, under the presidency of Dr. Glibert, when questions of industrial hygiene will be discussed in the sixth section. Further information can be obtained from the General Secretary, 65, Rue du Canal, Brussels.

A COMPREHENSIVE course dealing with cancer will be held at Strasbourg from October 18th to November 6th, and will include practical work in the use of x rays, radium, and diathermy; the general principles of treatment; lectures on cancer affecting different parts of the body; and clinical demonstrations. The fee is 250 francs, and further information may be obtained from Dr. Gunsett, Hôpital Civil, Strasbourg.

A MEMORIAL tablet has recently been placed on the house in the Luisenstrasse, Berlin, formerly occupied by the Reichgesundheitsamt, where Koch discovered the tubercle bacillus.

COUNCIL meetings of the Medical Women's International Association were held in Prague on August 26th and 29th. The President, Lady Barrett, took the chair, and reports of the activities of the various national associations were presented by the respective national corresponding secretaries. The most recently formed association was that of Hungary; and Hungarian delegates attended the meetings for the first time, and presented an excellent report. In addition to the other business of the council, medical meetings were held at which the subjects of tuberculosis and pregnancy, and women as police surgeons were considered. Representatives from the Czecho-Slovakian Ministry of Health attended these and took a prominent part in the discussions, a full report of which will be published in the current number of the *Medical Women's International Journal*. The president gave a dinner on the night preceding the council meeting, at which she welcomed the Lord Mayor and other officials and delegates. The association was also fortunate in having been invited to hold all the meetings in the Old Town Hall. The Lord Mayor and town councillors received the delegates and entertained them at a luncheon party; and the State Railways and Ministry of Health arranged a full programme, granting facilities to visit various spas, hospitals, and institutions.

THE list of candidates for election to the Royal Infant Orphanage, Wanstead, E.11, is now open. Children of both sexes who have lost both parents or the father only, and who are under 7 years of age, are eligible and are received from all parts of the United Kingdom. Applications should be addressed to the secretary at the orphanage.

Letters, Notes, and Answers.

All communications in regard to editorial business should be addressed to ***The EDITOR, British Medical Journal, British Medical Association House, Tavistock Square, W.C.1.***

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QUERIES AND ANSWERS.

DR. CHARLES LANE SANSOM (Port Health Office, Calcutta) writes in reply to "P. S. H." (JOURNAL, July 31st, p. 235), who asked for a method of killing fleas in his home: I was bothered with fleas in South Africa—tried sulphur and chlorine fumigation and other means, and failed until I used calcium hypochlorite. This was spread all round the rooms and brushed into the centre, and in a short time all the fleas disappeared.

X-RAY TREATMENT OF RINGWORM.

DR. H. HALDIN-DAVIS (London, W.) sends the following reply to the query by "T. E. R." in our last issue (p. 511): For the most part aluminium filters are used in the x-ray treatment of ringworm in America because there, owing, I understand, to the dryness of the atmosphere, the Sabouraud pastille does not work so well as it does here and on the continent of Europe. Here there is no need for filtered rays if the pastille be properly used. The difficulty is to judge the tint correctly under varying conditions of light. This difficulty is much lessened if a Lovibond tintometer be used; it is made by Lovibond of Salisbury, who are specialists in colorimetry. I have used it in over 700 cases without a mishap. I have never used filtered rays myself, but I understand that when they are employed the pastille is exposed to the filtered rays and brought to 4/5 tint B, as with unfiltered rays. In America they employ other methods of measurement of the dose, owing, as stated above, to the unreliability of the pastille.