The

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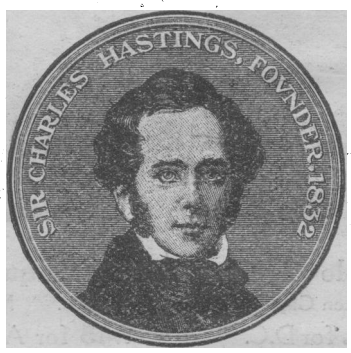

Including an Epitome of Current Medical Literature.

WITH SUPPLEMENT.

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Enlargement of the Blind Spot.

The second disorder to be discussed is a more purely ocular one. It has a fairly high incidence, but its relation to primary nasal infection is little appreciated. It is first manifested purely as a disturbance of vision, most often unilateral, and there is found a blurring and loss of visual acuity in that part of the retina immediately surrounding the optic disc. A most important sign and a fairly constant one, is enlargement of the blind spot for white and colours, as determined by perimetric examination. This, in all probability, signifies an inflammatory lesion of the retinal fibres in the affected area. The enlargement of the blind spot is known as Von der Hoeve's sign, and is described by him as an important symptom of posterior accessory sinus disease, and where no other cause for the eye changes can be found he considers it an indication for operation on the sinuses. Another observer found in 102 patients suffering from ethmoidal and sphenoidal sinus disease enlargement of the blind spot in no less than 31 per cent. of cases. In my experience, however, the antrum is as often at fault. A case that came under my care recently illustrates very well how completely unsuspected is this underlying nasal infection.

R. H. was referred to me by my colleague Mr. S. T. Parker, to whom I am also indebted for the notes on enlargement of the blind spot. The patient complained that for three weeks she had had blurring of vision in the right eye. Mr. Parker found enlargement of the blind spot, and sent her to me for examination of the nasal sinuses. There was nothing in her history suggestive of sinus disease, and examination of the nose only revealed a marked deflection of the septum to the left. There was no trace of pus in the nose or nasopharynx. A skiagram, however, revealed a marked opacity in the right antrum, and exploratory puncture under local anaesthesia found thick mucopus. Under a general anaesthetic I drained the antrum into the inferior meatus by the intranasal method. A considerable amount of pus was evacuated at the time, and some discharge persisted for several days after the operation. No organisms could be grown from the pus on ordinary media.

In two weeks there was marked improvement in vision in the affected eye, and a month later it was almost completely restored, only a slight deficiency being recorded by the perimeter.

While the connexion between ocular disease and sinus disease is certain, the path along which the infection travels is not so clear. It is presumably a direct one, both parts being almost always affected on the same side. It is probable that the ocular element is not in fact an infection, but the result rather of compression by inflammatory exudate at the back of the orbit. The latter assumption is supported by the rapid improvement which follows adequate treatment of the primary nasal trouble. In a number of cases no direct evidence of sinus disease can be found, but frequently there is a history which indicates some such trouble perhaps months before. One girl had pain and swelling in one side of the face with profuse discharge of pus from one side of the nose, following a bathe in a well-patronized swimming bath. I have no doubt she had an acute antral infection, yet her visual defect only became apparent some six months later. I have found a similar coincidence in other cases, and it appears that sometimes, at any rate, the progress of the trouble from the nose to the optic nerve elements is so slow that the original focus may have cleared up before the advent of the eye symptoms.

Phlyctenular Conjunctivitis and Blepharitis.

The third and last group to which I am going to refer includes cases, chiefly in children, of phlyctenular conjunctivitis and blepharitis. Although they almost always come for treatment via the ophthalmic department, children frequently attend the throat clinic for recurrent sore throat, and complain that each attack is associated with inflammation and soreness of the eyelids. These cases are often intractable to all forms of local treatment, as they are secondary to a remote focus usually in the tonsils. The results of tonsillectomy in this disorder are so uniformly good that the operation should be undertaken even in the absence of any apparent tonsillar disease. The tonsils should be removed by formal dissection.

One or two points of interest come out in the examination of the tonsils in these children. They are quite frequently very small and look innocent, even on section after enucleation. Further, there is most often a complete absence of palpable glands in the neck, and this is the more striking as the vast majority of children presenting themselves at the throat clinic have some cervical adenitis.

In the absence of any demonstrable anatomical connexion it must be assumed that the tonsils in these cases contain some toxin which circulates in the blood stream and lowers the vitality of the conjunctivae, which are already infected from purely local sources. Any effective resistance is thus hampered, and the condition becomes chronic.

I have not attempted in these notes to describe in any detail the symptoms and treatment of the diseases enumerated. My purpose has been solely to draw attention to relationships which must be fully appreciated in order to provide the scientific treatment so essential for cure.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

THE TREATMENT OF TETANUS.

WHILE the prophylactic dose of antitetanic serum has tended to make the incidence of tetanus an increasing rarity, it may still happen to anyone to have to treat a case, and the problem of the correct treatment suitable to various cases must be approached through the accumulated experience of the few instances available. The treatment of the wound by thorough disinfection is the first consideration, and, if suitable, complete excision is indicated. Where excision is impossible then continuous irrigation with oxygen-producing agents may prevent the production of any additional toxins.

For the control of the spasms the injection into the spinal canal of hypertonic salt solution, after removal of cerebro-spinal fluid, will give approximately twenty-four hours' remission of symptoms. Under chloroform anaesthesia about 10 c.cm. of cerebro-spinal fluid is removed slowly, and 2 c.cm. of 25 per cent. magnesium sulphate solution in distilled water is injected. To overcome the effect of those toxins already exerting their harmful influence, massive doses of antitoxin should be given. This may be administered by subcutaneous, intravenous, or intrathecal injection, preferably by all three methods. I have used with success in an adult case injections of 10,000 units into the spinal canal, after removing a similar amount of fluid, as an initial dose, and injections by intravenous and subcutaneous route of the same dose as well, making 30,000 units in all. These measures may be repeated more than once, at daily intervals, if there is an increase, or so long as there is no abatement of the severity of the symptoms of spasms and trismus, etc.

Experience gained with adults during the war does not afford any guidance in dealing with tetanus in children, and as there are so few cases in which the treatment and dosage are on record, I am venturing to record the result I obtained in a recent case, showing the dose used and the unusual reaction observed afterwards.

A medium-sized boy, aged 12, had a lacerated wound of the left leg, 5 inches long, transverse to the long axis, as a result of falling from a tree on April 5th. The wound was disinfected and treated with boric fomentations, but became septic. On April 15th he was seen by a colleague, who observed a well-marked condition of trismus, with stiffness of the back. I saw the patient with him later in the day, and removed the boy to hospital.

After admission, under general chloroform anaesthesia, the wound was thoroughly inspected and cleaned, and it was found to extend throughout its length 3 inches from the skin edges into the subcutaneous space. Carrel-Dakin irrigation was therefore arranged from the inside limits of the infected area, and the wound was dressed with gauze soaked in hydrogen peroxide solution. The healing of this presented no unusual feature. After dealing with the wound, lumbar puncture was performed and 10 c.cm. of fluid was drained, and an injection of 8,000 units of antitetanic serum given; 6,000 units were given by subcutaneous injection.

On April 16th the general condition of the boy was satisfactory; no spasm had occurred, but the trismus and the pain and stiffness of the back were unchanged. An intravenous injection of 7,000 units of antitetanic serum was given, and an injection of 1/6 grain of omnopon was sufficient to allay the pain in the back. On

April 17th another intravenous injection of 7,000 units was given. The trismus was unchanged, but the stiffness and pain in the back were less marked and were easily controlled by omnopon. On April 18th the trismus condition was noted to be relaxing, and gradually became less day by day. On April 26th the patient suddenly commenced to register a temperature of 103° F., but complained of no symptoms or malaise, and no signs of any trouble could be found in any of the organs. This high temperature remained unchanged day and night until May 1st, when it fell by lysis. Throughout this period the patient felt perfectly well. He was discharged from hospital on May 10th.

I admit that this case must be regarded as an exceptionally mild one, but the following are points of interest:

1. Thorough irrigation with the Carrel-Dakin method can prevent the development of any further tetanus toxin when excision of the wound is impossible.

2. Massive doses of antitetanic serum should be administered as soon as possible; in the case of a boy those given proved efficacious and safe.

3. The reaction from antitetanic serum may take the somewhat unusual from recorded.

4. The injection of hypertonic salt solution was not required in this case, but I have used it in the severer type of case with most satisfactory results in relieving spasms, and I can strongly recommend it.

Cirencester Memorial Hospital. J. H. GROVE-WHITE, M.D.

A PARASITIC DERMOID CYST.

THE following clinical details of a case of dermoid cyst with no obvious connexion with an ovary appears to be worth recording, in view of the migration which would seem to have occurred.

A multipara, aged 44, was sent to me by Dr. Speight of Burscough. She had backache and a "bearing-down" pain, neither of which was relieved by rest. The symptoms dated roughly from her third confinement. She had had five labours, all of which had been normal and followed by normal puerperia. Examination revealed a slight degree of vaginal prolapse, and the presence of an irregular hard mass behind the uterus. This mass was considered to be either a calcified fibroid or a lithopaedion.

At operation the omentum was found to be lightly adherent to the abdominal wall; the mass was situated in the pouch of Douglas, where it was embedded in adhesions. These were easily separated, and the mass was shelled out; it was completely within the peritoneum. The left appendage was normal, but the right was represented by a small tubo-ovarian cyst. The specimen, when removed, was completely enveloped in a calcareous wall, and was 7½ cm. long. On opening a window in it sebaceous material and hair were seen.

The point of interest about the cyst is its origin. Since it lay within the pouch of Douglas, it could not be an extraperitoneal dermoid, and the fact that it was buried in adhesions and had no pedicle suggests that this was not its original site. The calcareous change in its wall supports this view, for it implies a deficient blood supply.

The common site for a dermoid tumour anywhere in this neighbourhood is certainly the ovary. Assuming this, three possible modes of origin may be considered: (1) From a supernumerary ovary. As there was no sign of any "ligament" running from the tumour to the uterus or inguinal canal (no remnant of a gubernaculum ovarii) this origin can be dismissed. (2) From accessory ovarian tissue. Had it arisen thus it would, in all probability, have been extraperitoneal. (3) Separation from the ovary in which it grew, probably by torsion of its pedicle. This appears to be the most likely explanation; the condition of the right appendage and the presence of omental adhesions are in favour of such a suggestion. Unfortunately, no sections were cut from the right appendage to determine whether any ovarian tissue was present.

Complete separation of ovarian dermoids from their point of origin appears to be of infrequent occurrence. It is mentioned by Senn[1] and older authors, but it has only been possible to trace a few specific cases in the literature. Spencer Wells[2] records a case, and refers to one reported by Atlee. Doran[3] notes a case described by Knowsley Thornton; in this patient one ovary was cystic and the other was represented by a short tag of fatty and partly calcareous tissue. Hermann[4] had a case in which, at the time of operation, both ovaries were intact; he considered that this tumour arose in an accessory ovary. This case is complicated by the fact that the tumour was in part pseudo-mucinous and in part dermoid. Reinprecht[5] reported a case, but does not give sufficient details of the appearance of the ovaries at the time of operation. Ernest Herman[6] appears to have had a case, and to have operated during labour, but the description leaves the reader somewhat in doubt. Miss Ivens[7] has reported a case in which the whole ovary was involved, and its previous existence represented only by a scar on the back of the broad ligament. Miles Phillips's case[8] was very similar to that of Miss Ivens. In Dartigue's case[9] the separation involved the whole appendage, and the tumour represented both tube and ovary.

It is noteworthy that where parity is mentioned the women were all multiparae, and that where the side is specified the right is the commoner. Pregnancy predisposes to torsion of the pedicle of ovarian cysts, and the normal obliquity of the pregnant uterus may cause it to have more effect on right-sided cysts.

Liverpool. ARTHUR A. GEMMELL, M.D., F.R.C.S.Ed.

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[7] Ivens, F.: *Lancet*, 1909, ii, 1206.
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[9] Dartigue: *Paris Chirurgical*, 1923, xv, 287.

GLANDULAR FEVER IN THE FALKLAND ISLANDS.

A SHORT note on an epidemic of glandular fever that occurred in 1926 in a very isolated community may be of interest. The cases numbered 87—52 males and 35 females. The incidence in the sex and age groups is shown in the following table.

Age Group.	Male.	Female.	Total.	Percentage.
Under 5	5	2	7	8
5–15	9	8	17	20
15–25	22	11	33	38
25–45	11	10	21	24
45–65	4	4	8	9
65 and over ..	1	—	1	1

The youngest person afflicted was a boy aged 2 years; the oldest a man of 70. The disease was characterized by the sudden onset of slight soreness and redness of the throat, difficulty in swallowing, and pain in the neck, accentuated by movement. Fever was present in all cases, the temperature ranging between 100 and 103° F. Painful bilateral adenitis of the neck appeared between the second and fourth days of the disease. The glands varied in size from that of a pea to a hen's egg, and were of a stony consistence. In eight cases the onset was very acute, with marked headache, nausea, vomiting, and prostration. In two cases the onset was marked by severe epistaxis. At an early stage of the disease five cases showed a nephritis of a mild type associated with pain in the lumber region. Recovery in all cases was uneventful. Four cases developed retropharyngeal abscess. One of these, a female aged 30, died owing to the sudden rupture of a large retropharyngeal abscess causing rapid asphyxia. In a boy, aged 8, the cervical adenitis went on to suppuration, and a large quantity of pus was evacuated on incising the affected gland. One patient only, a man of 29, showed a slight enlargement and tenderness of the spleen and liver. The average duration of the disease was about a month. Careful nursing and the administration of small doses of calomel was the method of treatment.

In isolated communities the lack of resistance to infectious disease and its incidence in age groups is of interest. Old and young alike have little immunity to the

so-called diseases of childhood. It has been my experience in a community where infectious diseases were previously unknown, or a mere legend, that the maturer people are as liable to infection as, and suffer more acutely than, the young. During this epidemic of glandular fever all the complications of the disease occurred in the third, fourth, and fifth age groups, with the single exception of the boy whose adenitis went on to suppuration.

Among several recent immigrants, men of the third age group from the South of England, none of whom gave a history of glandular fever, only two contracted the disease, although all without exception lived in precisely the same manner and in close association with the natives of the island, among whom the case incidence of the disease was very high.

J. Innes Moir, M.B., Ch.B., D.P.H.Aberd.,
Principal Medical Officer, Falkland Islands.

Reports of Societies.

SOME AMPUTATION PROBLEMS.

At the meeting of the Section of Orthopaedics of the Royal Society of Medicine, on November 4th, Mr. P. Jenner Verrall delivered the annual address from the chair on "Some amputation problems," after which he invited discussion. The discussion was a continuation of one held in the Section of Surgery in April last (*British Medical Journal*, April 12th, p. 693).

Mr. Jenner Verrall said that he proposed to deal in the main with the unusual, but he wanted first to state briefly what was the normal and ideal. Speaking of the lower limb, he said that a tilting-table prosthesis was to be avoided if possible, but it must be fitted for a stump of less than 5 inches measured from the great trochanter. An above-knee amputation should be at least 4 inches above the condyles, and preferably should leave a stump measuring 10 to 11 inches where the normal femur measured 19 inches, or 12 inches if the femur was longer. The ideal below-knee stump contained 7 inches of tibia. Flaps should be no longer than the diameter of the limb, and should contain no more muscle in their base than was needed as sheer tissue solely to ensure the blood supply. He expressed himself against alcohol injections into the nerves; they produced a perineural fibrosis which was bad in the long run. Haemastasis should be most complete, and there should be no hesitation in surrounding small portions of tissue with a circular ligature if there were small vessels which could not be picked up singly. Haemastasis being complete, he would advise that no drainage be employed. He would far sooner stitch up loosely, allowing space between stitches for oozing, than introduce a drainage tube, which, like other doors, could be passed through in both directions. Massage, where the stump was normal, was quite useless, and might be harmful as militating against rest and settling down. Re-amputations were more difficult than primary ones, owing, among other causes, to the pre-existing scar, also the congested and varicose condition of the parts. Of the three varieties of emergency amputation, guillotine, through-joint, and amputation with flaps left open, the last was rarely used, and he thought the first superior to the second. Undue retraction of the skin would be prevented by some form of extension, such as the admirable method described by Elmslie. If pus pockets were found in a case for re-amputation, although they might be quite sterile on bacteriological examination, it was not fair to take the risk, and re-amputation must be put off. One would always tend to err on the side of waiting too long, and it often happened that while waiting the amputation would heal and even the nerves which had been cut short at operation give no more trouble.

Mr. Verrall then proceeded to give his opinions on certain amputations. Beginning with the foot, he pointed out that one disadvantage of the Lisfranc operation was the loss of one arch of the foot; and with regard to the Chopart amputation, he gave certain reasons why it was a bad one in the adult. Coming next to the Syme, by which he meant the modern Syme with the elliptical incision, he would not deny the existence of many successful Symes, in both civil and military cases, but the Syme was far less certain of remaining perfectly satisfactory than was the mid-tibial amputation. It had been said that an unsatisfactory Syme was a Syme badly done, but he had seen many Symes go wrong which had been performed by surgeons whose skill was beyond question. It was generally admitted that a mid-tibial amputation should leave a 7-inch tibia and a slightly shorter fibula. In a muscular and well-nourished leg an anterior skin flap was good, but in atrophic legs, especially with old sciatic injuries, where the circulation was none too good, he preferred to make a postero-external flap, calculating the length so that after shrinkage the scar would lie transversely half an inch below the tibial level. The Stokes-Gritti amputation was still spoken of in literature as a good operation, but in his experience it was not, and Mr. Muirhead Little had very kindly allowed them to borrow from the Royal College of Surgeons an admirable portfolio of *x*-ray and other pictures from his collection, which, to the speaker's mind, showed every sort of misbehaviour of which the Stokes-Gritti was capable. Dealing with unsatisfactory stumps in general, Mr. Verrall declared that much trouble was caused by too early limb-fitting. In a perfectly clean amputation, where sepsis had never been present or had been prevented from developing, the fitting with the prosthesis might take place within three months; but in war cases and secondary amputations in civil life six months should be allowed to elapse. Below-knee pylons were very unsatisfactory, and above-knee pylons, though surgically bad, were economically good. But the pylon must be fitted by a limb-maker under surgical supervision, reproducing the pressure points which would remain in the permanent prosthesis to be fitted later. Coming to the problem of stiffness of the joints, he said that, in the case of the hip, ankylosis in good or bad position was almost an absolute bar to the fitting of a satisfactory limb. The alternatives were either to re-amputate to give the best stump for the tilting-table or to attempt the formation of a mobile joint. As no weight had to be borne on the joint, it would appear that a simple excision of the hip would suffice, but this was not satisfactory in his experience because the patient had no control over the prosthesis; it was the fulcrum that was lacking. Arthroplasty of the hip in amputation cases was excellent—more promising in stumps than in complete limbs. A hopelessly flexed hip should be left flexed, and the stump shortened to allow of the fitting of a tilting-table. The longest stump that could be so fitted was one of 6 inches; this was very unsightly. With regard to the treatment of neuromata, this was less and less important. Indiscriminate removal of neuromata was to be deprecated. Operations for a painful neuroma should be local. Circulatory defects in stumps were commonly due to excessive length or excessive volume of soft tissues. They might also be due to deep-seated circulatory defects. In certain stumps there was a vascular upset, nervous in origin, and exceedingly difficult to cure. He was more and more convinced that successive re-amputations which one saw in so many of these cases were harmful, and he refused to do them. Time and occupation were the only cure. The phantom limb was a simple problem; operations were to be avoided, and if the phantom were considered as definitely due to a neuritis, syphilitic or alcoholic or other, it was important to alter the line of treatment and to defer limb-fitting for a long period while the case was treated. Mr. Muirhead Little had mentioned the existence of pain felt in the stump during defaecation and micturition. This was not uncommon, and the reverse was often found—pain in the rectum or bladder when the limb was worn. This was due to unstable nervous reflex. Time again was the only cure, though in some cases pain was due to imperfect limb-fitting. Since the war there had been two admirable works on the operative side published in this country—namely, Elmslie on "Amputations" in Carson's *Modern Operative Surgery*, and Muirhead Little's *Artificial Limbs and Amputation Stumps*. The developments up to this date were an alteration in opinion as to the length of the thigh stump, the value of the Syme and of the Stokes-Gritti, the question of drainage in amputations, of treatment of the nerves, a consideration of the choice in the case of mid-tibial

valuation of societies had not yet been completed, but the result thus far did not show any reduction in the amount allocated for the provision of dental benefit.

In reply to Mr. Rhys Davies, on November 6th, Mr. GREENWOOD said that, under the regulations governing the provision of dental benefit, no distinction was made between employed and voluntary contributors. Before varying the regulations in this respect, he required to be satisfied that there were sufficient reasons to justify the variation, and such reasons had not yet been put before him.

Hospital Treatment of Pensioners.

Mr. F. O. ROBERTS, on November 10th, told Mr. Stephen that, after careful consideration, he had decided that Bellahouston Hospital could not justifiably be maintained beyond a date early in the New Year, so that the premises might be handed back to the Red Cross and the necessary reinstatements completed by the date of the expiry of the lease. He had arranged with the committee of Erskine House for the use of that hospital for the type of case at present treated at Bellahouston. The patients would be under the care of the same surgeon as heretofore. He had also made arrangements with the Glasgow Royal Infirmary for the immediate admission of any case requiring urgent emergency treatment. All out-patients would be treated at the Glasgow Area Clinic.

Mr. STEPHEN asked if the right hon. gentleman did not intend to have a hospital in Glasgow to serve the ex-service men in the West of Scotland. Mr. ROBERTS said he did not know much about that locality. What he had to do was to see that adequate treatment was provided for the men, and he was satisfied that the arrangements made with Erskine House as a general hospital would meet all requirements.

Mr. ROBERTS stated that the average number of disabled ex-service officers and men (apart from cases of mental disease in mental hospitals) for whom the Ministry of Pensions is providing institutional treatment, whether for wounds or diseases, is, in round figures, 4,000.

Opium.

Mr. CLYNES, on November 10th, told Mr. Mander that considerable progress had been achieved with the consideration of the proposals made at the preliminary opium conference which recently opened in London, and it was hoped to submit a report in a few days.

Mr. BENN, replying to Major Pole on November 10th, said that the Government of India had formulated a scheme for dealing with the preparation of opium in the Malwa States, and was discussing it with those States.

Medical Records of Children Leaving School.—Sir CHARLES TREVELYAN told Mr. Somerville Hastings, on November 6th, that, in view of administrative difficulties involved and the interval which was likely to elapse between the age at which a child was last medically inspected in school and the age at which the first application for medical benefit was made, he did not feel justified in advising local education authorities to transfer to local insurance committees, when so requested, copies of the medical records of children leaving school. It had been impressed upon local education authorities that school medical records should be treated as strictly confidential. He was unaware of any applications for these records. Dr. Vernon Davies asked if the records were available for certifying surgeons when they were examining the children. No answer was returned.

Tinfoil Cheese Wrappers.—Replying to Sir C. Cayzer, on November 6th, Mr. GREENWOOD said that the statement of an analyst of a local authority, quoted in a recent annual report of his department, that the practice of wrapping cheeses in tinfoil was a potential danger to the health of the consumer, was well founded. He did not propose to publish any qualification.

Poison Gas.—Mr. A. HENDERSON told Mr. Graham White, on November 10th, that twenty-seven States had both signed and ratified the Geneva Protocol of June 17th, 1925, undertaking to refrain from the use of asphyxiating or poison gases in war. Nineteen other States had signed, or otherwise acceded to, this Protocol, but had not yet ratified it.

Dublin Hospitals Sweepstake.—Questions have been asked in the House of Commons concerning the Dublin hospitals sweepstake. On November 10th Mr. PETHICK-LAWRENCE informed Sir W. Davison that his attention had not been called to the sums of money which were leaving this country for investment in the Irish Free State sweepstake.

Notes in Brief.

Mr. Greenwood told Major Pole, on November 5th, that fifty-two county councils in England and Wales had incurred expenditure on the provision of milk and meals for expectant and nursing mothers, and children under school age.

The number of certified mental defectives in England and Wales on January 1st, 1930, was 25,076. Of these, 1,591 were under guardians outside institutions. The number of beds available in institutions was approximately 24,000.

On October 1st last there were, approximately, 1,89[illegible],000 persons in Scotland insured under the National Health Insurance Act.

On November 10th Dr. Addison told Mr. Freeman that foot-and-mouth disease serum had no deleterious effect on the flesh of an inoculated animal subsequently slaughtered.

In 1929 some 140,000 children were provided with spectacles under arrangements made by education authorities in England and Wales. All local education authorities had the services of an experienced oculist, except the authority for the Isles of Scilly.

Mr. Roberts informed Major Cohen, on November 11th, that in the nine years, up to September 30th last, since the time limit was enacted, some 1,400 cases of late claim had been awarded pecuniary compensation by way of pension or otherwise, and in about 500 cases surgical treatment had been provided.

Universities and Colleges.

UNIVERSITY OF LONDON.

MR. G. E. VILVANDRÉ has been recognized as a teacher of radiology at the London Hospital Medical College, and Dr. E. W. Fish as a teacher of dental surgery at St. Mary's Hospital Medical School.

The following appointed and recognized teachers have been assigned to the Faculties indicated: *Medicine:* Dr. A. Leitch (professor of experimental pathology, Cancer Hospital), Mr. H. T. Gray (teacher of surgery, Hospital for Sick Children), and Dr. D. N. Nabarro (teacher of bacteriology, Hospital for Children). *Medicine and Science:* Dr. C. R. Harington (reader in pathological chemistry, University College Hospital Medical School).

It has been decided that recognition of the Cancer Hospital as a school of the University shall be continued until October 1st, 1931.

A course of five lectures on "Diseases of bacteria" will be given by Mr. F. W. Twort, superintendent of the Brown Animal Sanatory Institution, in the theatre of the Royal College of Surgeons of England, Lincoln's Inn Fields, W.C., on December 1st, 3rd, 5th, 8th, and 10th, at 4 p.m. Admission is free, without ticket.

NATIONAL UNIVERSITY OF IRELAND.

UNIVERSITY COLLEGE, DUBLIN.

THE following candidates have been approved at the examination indicated:

THIRD M.B.—*Part I:* *D. K. O'Donovan, *J. K. Feeney, *E. L. O. Murphy, *R. Hayes, †Irene A. Coster, †T. P. Eustace, †J. Reidy, †M. J. Murphy, †E. Fleming, †M. P. Gorman, †J. Duffy, †J. Fahy, J. F. Dawson, D. Deasy, J. P. Deasy, D. C. McCarthy, J. P. McCormack, C. A. McDonnell, J. McSorley, J. E. O'Donnell, T. D. Phelan, J. Russell, P. G. Ryan, D. F. Savage, M. F. Sheehan, J. Walsh. *Part II:* *T. A. Brady, †J. F. Sheehan, †T. Crowley, †P. J. O'Doherty, †J. Phelan, J. Diver, J. Duddy, Joan J. Kennedy, J. McDonnell, P. W. Rattery, J. F. Sheehan.

* First-class honours. † Second-class honours.

ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH.

A QUARTERLY meeting of the Royal College of Physicians of Edinburgh was held on November 4th, when the President, Sir Norman Walker, was in the chair.

Drs. Henry Leonard Wallace (Edinburgh) and William Brown, O.B.E. (Aberdeen), were introduced and took their seats as Fellows of the College.

Drs. Earle Macbeth Watson (Ontario), Wm. Archibald Mein (Bournemouth), Agnes Rose Macgregor (Edinburgh), and James Davidson (Edinburgh) were elected Fellows of the College.

The Hill Pattison-Struthers bursary in anatomy and physiology was awarded to Maurice Goldfar, and the Hill Pattison-Struthers bursary in clinical medicine to Robert Leitch Allan.

ROYAL FACULTY OF PHYSICIANS AND SURGEONS OF GLASGOW.

AT the annual meeting of the Royal Faculty of Physicians and Surgeons of Glasgow, held on November 3rd, the following officers were elected: President, Dr. John F. Fergus; visitor, Mr. R. Barclay Ness; honorary treasurer, Mr. J. H. MacDonald; honorary librarian, Dr. E. H. L. Oliphant.

ROYAL COLLEGE OF PHYSICIANS OF IRELAND.

AT the monthly meeting of the President and Fellows, held on November 7th, the following were duly admitted to the Fellowship of the College: John Lait, Edward Keelan, Frederick MacSorley.

The following were admitted as Members: Thomas Crawford Boyd, James Michael O'Donovan.

The Licence in Midwifery was conferred upon A. K. Shem.

SOCIETY OF APOTHECARIES OF LONDON.

THE following candidates have been approved in the subjects indicated:

SURGERY.—C. L. Ferguson, H. R. Fosbery, V. R. O. Lahanmi, S. Lokecz, J. M. L. Love, E. H. W. Lyle, E. O. Parsons, L. C. H. Sykes, P. Wade.

MEDICINE.—R. F. T. Finn, B. C. Ghose, C. R. Graham, M. Halpérine, T. C. Keble, R. D. Newton, C. G. Nicol, G. S. Rozario, C. P. Seeley.

FORENSIC MEDICINE.—E. J. Jones, R. D. Newton.

MIDWIFERY.—H. Glynn, C. R. Graham, J. Irger, W. A. Naidu, H. I. Newman.

The diploma of the Society has been granted to Messrs. M. Asaad, R. F. T. Finn, B. C. Ghose, H. Glynn, C. R. Graham, M. Halpérine, T. C. Keble, J. M. L. Love, H. I. Newman, R. D. Newton, C. G. Nicol, C. P. Seeley.

Medical News.

THE Nobel prize in medicine for 1930 has been awarded to Professor Karl Landsteiner of Vienna, who since 1922 has been engaged at the Rockefeller Institute, New York, in the study of blood groups.

THE annual dinner of the Old Epsomian Club will be held at the Hotel Great Central, Marylebone Road, on Thursday, December 11th, at 7.30 o'clock.

THE annual dinner of the Chelsea Clinical Society was held at the Rembrandt Rooms on October 28th under the chairmanship of Dr. F. J. McCann. The attendance was excellent, 96 members and guests being present, the latter including Lord Riddell, Sir Thomas Horder, and the presidents of five kindred medical societies. The first dinner meeting of the session will be held at the same place on Tuesday, November 18th, when Dr. Anthony Feiling will open a discussion on the treatment of headache. All communications should be addressed to Mr. A. Rugg-Gunn, F.R.C.S., 49, Harley Street, W.1.

A MEETING of the Medico-Legal Society will be held at 11, Chandos Street, W.1, on Thursday, November 27th, at 8.30 p.m. Dr. F. C. Martley will read a paper on the importance of blood-grouping tests in paternity cases; a discussion will follow.

AT the meeting of the Royal Microscopical Society to be held in the Hastings Hall, B.M.A. House, Tavistock Square, W.C., on Wednesday, November 19th, at 5.30 p.m., the following papers will be read and discussed: Mr. R. J. Bracey, "A universal tube length and cover-glass correcting lens system for use with microscope object-glasses"; Dr. W. E. Cooke and Mr. C. F. Hill, "Microscopical studies in pernicious anaemia—I, The haemoglobiniferous cells."

THE second meeting of the session of the British Institute of Radiology will be held at the institute on November 20th, at 8.30 p.m. Dr. G. Simon will read a statement on the use of diathermy in pneumonia, and Dr. A. Müller will describe an *x*-ray generator with a rotating water-cooled target. On the afternoon of the following day the radiological department of Charing Cross Hospital will be open to inspection by provincial medical members, and later there will be an informal discussion at the institute on the movements of the intestinal tract, which will be illustrated by a cinematograph film.

A NEW course of post-graduate lectures at the City of London Maternity Hospital, City Road, E.C., will commence on November 20th, at 5 p.m., when Dr. J. A. Willett will discuss the importance of ante-natal care. The lectures will be continued on succeeding Thursdays at the same hour till February 19th, 1931, with the exception of December 25th and January 1st.

THE Fellowship of Medicine announces that in connexion with the M.R.C.P. examination lectures will be given at the Medical Society of London, 11, Chandos Street, Cavendish Square, at 8.30 p.m. on Tuesday, November 18th, by Dr. T. Izod Bennett on the conception of nephrosis, and on Friday, November 21st, by Dr. W. J. Adie on diseases of the nervous system. Tickets are obtainable from the Fellowship or at the lecture hall. A free lecture will be given at the same place on Monday, November 17th, at 4 p.m., by Mr. L. C. Rivett, on recent advances in gynaecology and obstetrics. The following free demonstrations will be given: at the Golden Square Throat Hospital on November 17th, at 2 p.m., by Mr. F. C. Ormerod; at King's College Hospital, Denmark Hill, on November 19th, at 2 p.m., by Dr. M. Critchley (neurology); and at the Royal Northern Hospital, Holloway Road, on November 19th, at 6 p.m., on gonorrhoea in the female, by Dr. Violet Russell (for women graduates only). A special course will begin on November 17th at the City of London Hospital, Victoria Park, continuing for two weeks, and occupying the whole of each day with demonstrations and lectures on diseases of the heart and lungs. At the West End Hospital for Nervous Diseases, Welbeck Street, there will be a daily course at 5 p.m. for four weeks from November 17th. The subjects of the remaining courses in 1930 are: proctology, November 24th to 29th; dermatology, December 1st to 13th; and diseases of infants from December 1st to 13th. The 1931 list of special courses is now ready, and may be obtained on application to the secretary of the Fellowship, 1, Wimpole Street, London, W.1.

THE list of medical mayors elected on November 10th include Dr. Arthur Hawkyard as Lord Mayor of Leeds, Dr. W. S. Sobie as Mayor of Oxford, and Dr. R. F. Bury re-elected Mayor of Leamington.

THE National Homecroft Association, which has as one of its aims the carrying into practical effect of the teachings of the late Dr. George Vivian Poore, author of *Rural Hygiene*, is holding a meeting on Thursday next, November 20th, at 3 p.m., in the Church House, Dean's Yard, Westminster. Dr. F. G. Crookshank will take the chair, and Professor J. W. Scott will outline the steps taken to realize the project of a memorial to Dr. Poore. So far more than £250 has been subscribed towards the proposed memorial, and a further sum of £200 has been promised. Inquiries and subscriptions may be addressed to Professor Scott at the offices of the association, 38, Charles Street, Cardiff.

THE Woodside Nerve Hospital at Muswell Hill, of which we published some particulars in our issue of November 1st (p. 741), was opened by Princess Helena Victoria on November 8th. In declaring the hospital open the Princess expressed her opinion that such an institution would meet a real want and would amply justify the care and expenditure incurred. Lord Blanesburgh, chairman and treasurer, said that the hospital was for the benefit of cultured people of slender means. It was hoped that with the assistance of the larger fees of some patients it would be possible to treat a number of people without resources. Sir James Purves-Stewart said that the hospital would not be run as a business proposition but as a contributory benevolent institution.

AT a meeting of the National Baby Week Council, held on November 12th, a discussion on the necessity for routine medical inspection of the child from the age of 1 to 5 years was opened by Dr. Eric Pritchard, chairman of the executive committee, who was followed by the joint honorary secretaries of the council, Dr. D. H. Geffen, medical officer of health for Enfield, and Mrs. Sophia Friel, M.D. The prizes awarded in the council's essay competition for domestic science pupils were presented.

ST. BARTHOLOMEW'S HOSPITAL contributed to the Lord Mayor's Show, on November 10th, a pageant emphasizing the services rendered by the hospital throughout the world. Celebrated teachers and students of the past were also portrayed in the procession, and there were references to the part played by St. Bartholomew's in past centuries, and also to the claims of its extension fund.

THE Minister of Health has issued a circular (No. 1153) describing the form in which county borough councils and authorities of areas with a population over 20,000 may submit quinquennial statements of their proposals for dealing with the housing conditions in their areas, and for providing new housing accommodation as required by Section 25 of the Housing Act, 1930. In the preparation of their statements, which must be submitted to the Minister before the end of December next, councils are reminded that their medical officers of health have been advised (Circular 1119) to include special housing information in their annual reports for the current year. (The contents of this circular were referred to in the *British Medical Journal* of June 28th, p. 1194.) The dominant figure of the statement will be the estimated number of houses which councils are able to provide to meet the requirements of their districts, whether they are to be used as additional houses or for rehousing purposes. In considering the need for new accommodation special regard must be given to the waiting lists of applicants for houses, which will probably include persons residing in houses whose demolition is contemplated by the Act.

DR. C. P. BLACKER, *M.C.*, has been appointed general secretary of the Eugenics Society as from November 1st, 1930.

DR. EMILE F. HOLMAN, professor of surgery at Stanford University, has been awarded the Samuel D. Gross prize for his research on abnormal arterio-venous communication.

AT the recent opening of the Banting Research Institute the Doctorate of Laws of the University of Toronto was conferred on Dr. Thomas S. Cullen, professor of clinical gynaecology at Johns Hopkins, in recognition of his work on cancer.

THE issue of the *Wiener medizinische Wochenschrift* for November 1st is dedicated to the Vienna paediatrist, Professor Hochsinger, on the occasion of his seventieth birthday, and contains articles dealing exclusively with diseases of children.

ON the occasion of its tenth annual meeting the German Society for Diseases of the Digestive System and Metabolism has founded a Boas prize of the value of 1,000 marks. The subject is the bacterial and non-bacterial origin of diseases of the pancreas. Candidates should send in their essays by April 1st, 1931, to the general secretary, Professor R. von den Velden, 30, Bambuga Strasse, Berlin, from whom further information can be obtained.

A MEMORIAL tablet has been affixed to the house where Paul Ehrlich was born at Strehlen in Silesia.