

**Dangers of Drainage.**—It is essential to stress the dangers of drainage generally in Assam, as clear-water slowly running drains form excellent breeding places for *A. minimus*. Clear-water malariogenic borrow-pits should not be connected up with the object of draining them, as thereby they are made more dangerous. Our method of dealing with borrow-pits is to break the impervious pan forming the base of the borrow-pits, to assist percolation, then to fill it with cut jungle or line refuse if sufficient soil be not available in the vicinity.

#### Shade

The terms "shade" and "jungle" are not synonymous. Jungle may refer to dense virgin forest, low bush or scrub, or even long grass, and may be patchy or dense. The only questions which concern the malariologist are whether it produces dense shade and covers watercourses or not.

We use the word shade in this paper as it is the real factor underlying our malaria problem. Shade may be absolute, dense, or partial. Absolute shade implies darkness due to the complete interception of rays of light—this is obtained by subsoil drainage. Dense shade implies the elimination of that degree or gradation of light under which vegetation containing chlorophyll can survive, and is inimical to the habits of *A. minimus*. Partial shade allows the growth of chlorophyll-containing vegetation, and is as dangerous as complete exposure to sunshine.

One practical test in the field of dense shade is the absence of grass beneath the shade. Vegetation used as shade should be biologically adapted to the terrain—for example, plants physiologically suited to aerated soil will not grow in swamps, and vice versa. The plants selected should be unsuitable as food for animals and should be strong enough to withstand being uprooted by storms. After planting hedges and swamps it is necessary to control with paris green until dense shade is established, as during the intermediate stages breeding places are not eliminated as long as sunshine can reach the water.

In Assam *A. umbrosus* and *A. aitkeni* are found in degrees of shade which are inimical to *A. minimus*, but to date we have never found even these species in really dense shade. It would appear that the habits of the two former species are greatly regulated by the effects of temperature, since during the colder periods of the year they have been found breeding in unshaded areas. This is especially noticeable in the case of *A. aitkeni* at high altitudes, as in Shillong.

#### Other Measures

Treatment of infected cases and of gametocyte carriers is a common-sense measure. Site selection is of primary importance. Watson<sup>1</sup> in Malaya and Christophers in the Andaman Islands showed that malaria was absent, or nearly so, in villages or estate coolie-lines which were over half a mile from the breeding places of dangerous mosquitos. In the past lines have been constructed in close proximity to malariogenic streams or swamps, often without any thought of possible unhealthiness. The policy in the future is obviously to avoid such mistakes which have been unwittingly made in the past, and to select more healthy sites for human habitations. Removal of existing lines to better sites is sometimes the most economical method of dealing with particular malaria problems, especially where embankments and bridges have created unnatural conditions and have made control by temporary or permanent measures extremely difficult or expensive.

**Tanks.**—In some areas abandoned clear-water tanks are the cause of much malaria, and in many cases it is now impossible to fill these. To obviate recurring expenditure on larvicides, we are experimenting with iron oxide organisms and other substances, with the object of introducing sufficient contamination to eliminate *A. minimus*. For tanks which are being used as a drinking-water supply, bamboo turzas at the margins are being tested with the object of producing dense shade.

**Kutcha Wells.**—Needless ones should be filled in, or in any case oiled until filled. Those required as drinking-water supplies should be covered.

**Natural Enemies.**—We consider that fish, water beetles, pond skaters, water-boatmen, may-fly and dragon-fly larvae, and other natural enemies are rarely of much practical value. Anopheline larvae are often found quite plentifully in grass and weeds in water teeming with so-called natural enemies, which would indicate that what can be shown in the laboratory does not always take place to any extent in nature.

**Embankments.**—The flooding of ravines by building embankments or bunds across the outlet with the object of burying seepages is especially dangerous in areas where the water is clear, and we do not recommend it.

**Sluice Gates.**—The method of attempting to produce velocity of current by sluice gates is likely to form pockets, and water is apt to flood over the banks and form pools, thereby creating fresh breeding places. This method is also fraught with danger and is rarely applicable.

It will be seen that to appreciate the fundamental factors underlying malaria control account must be taken of rainfall distribution, and the effect of transpiration, evaporation, percolation, and run-off, of soil composition, and the physical features of a district, also of the direction and strength of prevailing winds, temperature and humidity, distance of breeding places, etc. Former popular beliefs that dirty water and dense virgin jungle, hitherto called dank, rank, etc., were the sources of malaria in Assam have been shown to be erroneous, as also the idea that the pioneer who clears or drains is necessarily benefiting mankind. No longer will the phrase "clearing the dense virgin jungle" have about it a resounding note of pioneering heroism, as we now know that the anopheline mosquito, which transmits our malaria, does not breed under dense shade, or in water which appears to be noisome or revolting, but in clear water exposed or partially exposed to sunshine. In future the control of malaria in Assam will mean less interference with nature and a realization of the fact that the green beauty of vegetation covering rivers, streams, and swamps can be allowed to remain with improved health to mankind.

#### REFERENCE

- <sup>1</sup> Watson, Sir Malcolm: *Prevention of Malaria in the Federated Malay States*.

## Memoranda MEDICAL, SURGICAL, OBSTETRICAL

### ACUTE LOCALIZED PHLEGMONOUS ENTERITIS COMPLICATING PREGNANCY

The following case recently came under my care at the Bedford County Hospital.

The patient, a domestic servant aged 20, was admitted to hospital at 10.30 p.m. on June 1st, 1932, with the history that, except for a mild attack of abdominal pain three years ago, diagnosed as appendicitis, she had enjoyed good health. There had been amenorrhoea since January, 1932. At 6 a.m. on June 1st while in bed she was seized with violent abdominal pain; two hours later she vomited, and the pain and vomiting continued all day. In the evening pain also developed at the top of the right shoulder. On examination she was flushed and a little cyanosed, the tongue furred, temperature 102.4° F., pulse 130, respiration 34. The abdomen was tender and resistant all over, but not distended; these signs were most marked in the right iliac region. The whole lower abdomen was dull on percussion, and there was shifting dullness in the loins. The uterus was enlarged to the size of a five months' pregnancy.

#### Operation

The abdomen was opened through a right pararectal incision, and a quantity of turbid inoffensive fluid escaped. A large mass occupying the right side proved to be an acutely

inflamed segment of small intestine. The mesentery was much thickened, and the bowel above slightly distended. About 20 inches of bowel were resected, and a lateral anastomosis performed. A drain was placed down to the junction, and the wound sutured. Progress was satisfactory until distension became pronounced on the fourth day; this fortunately responded readily to treatment, and by the sixth day the patient was comfortable and taking nourishment well. Two days later there was a faecal discharge from the wound, but this ceased on the tenth day. Pus continued to drain until the fourteenth day, when the wound had healed except for a superficial sinus. At the end of three weeks the patient was allowed up, the wound having healed completely. There were no signs that the pregnancy had been affected by the abdominal condition.

#### *Pathological Report*

The specimen consists of about 20 inches of ileum with adjacent mesentery. In part of its length the bowel has been slit along the free border and partly everted. For about 6 inches the mucous membrane is greatly swollen by oedema and the valvulae conniventes are pale and thickened to half an inch in width in some instances, obstructing the lumen of the bowel. In the lower part of the affected area there is marked haemorrhagic extravasation into the swollen mucous membrane, especially along the mesenteric border, where the membrane is raised into rounded projections. Above the affected area the mucous membrane is normal, but the bowel is slightly dilated; below it the wall of the bowel is oedematous for several inches. There is no definite ulceration. The mesentery corresponding to the inflamed length of bowel is enormously distended with inflammatory exudate and haemorrhage. It forms a firm mass 2 inches in thickness and 5 inches in length, curved in correspondence with the curve of the bowel, which is stretched over its convex border. At a distance of 2 inches from the border of the intestine the swelling abruptly ceases, the proximal part of the mesentery exhibiting merely slight oedema. Where part of the mesentery has been removed the section shows extensive haemorrhage and a spongy nature of the rest of the tissue, due to distension of the lymphatics and oedema. The peritoneal surface of the ileum and mesentery is discoloured by haemorrhage and exhibits fibrinous exudate in places. Microscopical examination of the wall of the bowel shows enormous distension of the lymphatics of the mucous and submucous layers, together with abundant haemorrhagic extravasation in places. In almost all parts of the section the tissue intervening between the dilated lymphatics is densely infiltrated with polymorphonuclear leucocytes. I am indebted to Mr. T. W. P. Lawrence for the pathological description.

F. W. GIFFORD NASH, F.R.C.S.  
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#### HENOC'S PURPURA SIMULATING ACUTE APPENDICITIS

In the case described below the difficulty arose from the fact that the child was very ill, with a dirty tongue, marked rigidity in the right iliac fossa, and constipation; and, in the absence of purpuric eruption and of haemorrhages from any other source, it seemed that the abdomen must be opened to investigate the condition of the appendix. The platelet count did not help. The other clinical features of the disease as described by Henoch—that is, pains in the limbs and swelling of the joints—were absent.

On July 4th, 1932, a boy aged 7 years was admitted to the children's ward. The history obtained was as follows. Two to three weeks previously the child had tonsillitis and otitis media, which cleared up. He was quite well until six days before admission, when he complained of abdominal pain—increasing in severity—loss of appetite, and vomiting after meals during the first two days of abdominal pain. The pain was apparently not localized. The child was constipated. No blood or mucus had been noticed in the stools.

The patient was obviously very ill: pale and wasted, temperature 98.4°, pulse 108, respiration 30, tongue coated. There was marked tenderness and rigidity in the right iliac fossa. No mass was felt by abdominal examination or per rectum. His skin presented no signs of purpura or other spots.

In view of the minor epidemic of paratyphoid prevailing at the time, this diagnosis was borne in mind, but the abdominal signs justified a diagnosis of acute appendicitis, and the abdomen was accordingly opened. At operation, clear free fluid was present in the peritoneal cavity; the appendix, though removed, did not appear to be pathological. The lower six inches of the ileum, however, was oedematous and haemorrhagic in appearance. Culture from the contents of the lumen of the appendix showed absence of the typhoid group.

On the second and fourth days after admission the Widal reaction was negative. Faeces were negative for typhoid group—no blood present. Urine showed a trace of albumin—no casts seen. Blood count: haemoglobin, 95 per cent.; red blood corpuscles, 4,800,000 per c.mm.; colour index, 0.9; white blood corpuscles, 5,800 per c.mm.; polymorphs, 65 per cent.; lymphocytes, 27 per cent.; monocytes, 5 per cent.; eosinophils, 3 per cent.; platelet count, 400,000 per c.mm. (approx.).

On the sixth day after admission the patient had an attack of haematuria. On the seventh day—that is, thirteen days from the onset of the illness, a purpuric eruption appeared on the arms and legs, principally around knees and elbows. There was no eruption on the trunk. On the fourteenth day (after admission) there was a recurrence of haematuria with an attack of abdominal pain. A diagnosis of Henoch's purpura was made, and this diagnosis would have accounted for all the symptoms from the onset. The child subsequently made an uninterrupted recovery.

I wish to express my thanks to Dr. Donald Paterson for permission to publish this case.

ELIZABETH T. DAVIES,  
M.R.C.S., L.R.C.P.,  
House-Physician to the Children's  
Department, Westminster Hospital.

#### CONGENITAL HYPERTROPHY OF THE BLADDER WITH POLYCYSTIC KIDNEYS

The following case is, I think, of sufficient interest to be worthy of record.

Mrs. W. was delivered of a male infant at the Municipal Maternity Hospital, Swansea, on June 23rd, 1932. The baby was very limp at birth. He gave one feeble cry, and after one or two breaths respiration ceased. In spite of all the usual methods of artificial respiration and stimulation, he failed to respond. On examination the abdomen was markedly distended, the enlarged bladder being easily palpable. A presumptive diagnosis of congenital hypertrophy of the bladder was therefore made. On post-mortem examination the ureters were found to be greatly dilated and tortuous and looked like coils of small intestine. No obstruction of the ureters was found. The bladder was also enlarged and its wall hypertrophied. The surfaces of the kidneys were irregular from protruding cysts. On section, the kidneys were the site of numerous cysts of varying size, which contained clear fluid. The right kidney was very large and cystic, and no kidney tissue was visible on naked-eye examination. The left kidney was smaller, the major part being cystic and the rest consisting of apparently normal kidney parenchyma. The pelves of the kidneys were a little dilated, but only a very slight degree of hydronephrosis was present. No other abnormality was found; the liver and spleen were not cystic.

#### COMMENTARY

The case is interesting in that it is unusual to find congenital hypertrophy of the bladder associated with polycystic kidneys, and only a very slight degree of congenital hydronephrosis. Congenital hypertrophy of the

bladder occurs only in male infants. The theories advanced for its causation are as follows:

1. John Thomson attributes it to "the existence *in utero* of a state of incoordination between the sphincter and detrusor muscular apparatus of the bladder." The condition therefore is analogous to congenital pyloric stenosis.

2. Proust, Young, Froutz, and Baldwin attribute the condition to congenital valvular obstruction in the posterior urethra and state that the urethra and internal sphincter above these folds of mucous membrane are dilated. These folds, however, are probably not the primary cause, but result from the hypertrophy, and aggravate the condition. Thus the condition can again be compared to congenital pyloric stenosis, in which folds in the mucous membrane result from compression by the surrounding muscular tissue.

The condition can therefore be explained by the above two hypotheses working in conjunction with one another. It is interesting to note that the mother gave a history of having lost, in 1930, her only other child—a boy aged 6 weeks—from congenital pyloric stenosis. Defective co-ordination *in utero* was probably an important factor in both cases.

The question of the pathogenesis of polycystic kidneys is still under dispute. Virchow's theory holds that the disease is due to chronic interstitial inflammation—probably arising *in utero*—the cysts being retentive in type, and resulting from obstruction of the tubules of the kidneys. The multilocular cystadenoma theory advances the view that the cysts are degenerative in origin, while the congenital theory ascribes the condition to an imperfect fusion between the excretory and secretory germ elements.

The congenital theory seems the most acceptable as it points to defective development. The evidence in its favour is especially strong in this case, where it is associated with another congenital abnormality in the bladder hypertrophy.

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#### DIAPHRAGMATIC HERNIA IN THE NEWBORN

I recently attended a woman in her confinement, and, apart from acute hydramnios coming on in the last fortnight of pregnancy, associated with the sudden appearance of albuminuria, nothing untoward had occurred to mar an uneventful gestation. This was her third pregnancy, her first-born being a red-headed, apparently healthy boy, who, however, died on the second day of scarlet fever, when less than 2 years old; her second is alive and well, aged 3 years. This woman, aged 31, a year previously had had stiffness in the arms and legs lasting about ten days, transient right homonymous hemianopia lasting a few hours on two occasions, diplopia lasting two hours on one occasion, paraesthesia in the hands and feet, and difficulty in speaking, all being associated with slight pyrexia. Another ocular symptom was "a very distinct (after) image" of me standing by the bedside after I had left it, lasting a few seconds. Examination of the central nervous system at that time revealed rigidity of the fingers, and on one occasion a doubtful lessening of sensation to wool on the left side of the face. All the tendon reflexes were normal and equal, and the plantar responses were always flexor; the pupils reacted to light and accommodation, and the optic discs were normal. Her blood Wassermann was negative, and her cerebrospinal fluid was found to be chemically and bacteriologically normal and gave a negative Wassermann reaction. Although these symptoms were suggestive of disseminated sclerosis, on eminent authority she has been regarded as an hysteric.

On May 7th of this year she gave birth to an apparently normal healthy full-term boy. Labour, although prolonged, was natural, no manipulation or instrumentation being necessary. The child breathed naturally from the first, and required no resuscitation; this continued for twenty-four hours, after which difficulty in breathing gradually developed. The lungs appeared to be collapsed; the apex beat, which had been in the normal place formerly, was felt on the right side of the chest; no air entry could be heard into the left lung, and very little into the right. Intratracheal intubation was tried without effect, and the child died thirty-six hours after birth. Post-mortem examination revealed an abnormality in the diaphragm on the left side, there being a triangular-shaped opening postero-lateral to the oesophageal hiatus, and in area about the size of a shilling, through which nearly all the small intestine and part of the caecum, which was abnormally mobile, had herniated into the thorax, nearly filling it. Both lungs were collapsed, but it was possible to show that each had contained air. The heart and mediastinum were displaced by the mass of intestines to the right and upwards. There was no peritoneal hernial sac.

There is no doubt that when the child was born very little if any of the bowel had herniated through the opening, as was shown by the normal filling of the lungs, but it is probable that with the first inspiratory effort a coil of small bowel was drawn through into the thorax, and, although breathing was not at first impeded, each successive inspiration caused a continuation of the process, eventually created dyspnoea with consequent forced inspiration going on to the eventual complete filling of the potential space of the thorax with abdominal viscera, to the exclusion of all air entry to the lungs.

The sequence of events in this case was so striking, and was so adequately explained by the post-mortem findings, that I thought these notes might serve some useful purpose if published. Diaphragmatic hernia is uncommon, and is, as a rule, diagnosed only with difficulty; it usually takes a chronic course, the symptoms being more abdominal than respiratory, but here quite the reverse was the case, the course being very acute, causing death in a few hours, and the symptoms being entirely respiratory.

Redhill, Surrey.

L. J. BARFORD, D.M.

#### RUPTURED ECTOPIC GESTATION

The following case seems worthy of record in view of the obscurity of the symptoms, and because it serves to illustrate the inadvisability of temporizing with supposed cases of appendicitis, in the female at all events, even though the symptoms are suggestive of a subacute or subsiding abdominal condition.

A married woman, aged 25, 4-para, was admitted on August 24th, 1932, with a diagnosis of appendicitis. All children were alive and healthy, ages ranging from 6 years to 19 months; normal labours. There was no history of leucorrhoea or other signs of pelvic disease. Menstruation normal, the last period having occurred at the usual time a few days prior to admission, and was quite normal. On the afternoon of August 22nd she had felt slight pain across the lower abdomen; this pain soon became localized to the right iliac region. Soon after the onset of the pain she vomited a little greenish fluid. There was no vaginal bleeding. She continued her household work. Next day there was diarrhoea and frequency of micturition. The pain became severe that night, and on the 24th she was sent to hospital.

On admission she was rather flushed. Temperature 99.2°, pulse 102, respirations 24. There was slight tenderness in the right iliac region on deep palpation. The abdomen was opened by Battle's incision. There was a considerable amount of fresh blood-clot, and a little free bleeding in the right side of the pelvic cavity. A ruptured early ampullar pregnancy was found, and the affected right tube was adherent to the adjacent gut. The clot was removed and the affected tube ligatured and excised. The appendix was slightly injected,

but it was decided to leave it, in view of possible risk of infection of fragments of clot. The abdomen was closed without drainage, and the patient is rapidly recovering.

I am indebted to Mr. Stronach for permission to report this case.

REGINALD C. WEBSTER, M.B.

Mansfield and District Hospital.

## Reports of Societies

### FRACTURES OF THE LOWER JAW

At the meeting of the Medical Society of London on October 24th, with Sir JOHN BROADBENT, president, in the chair, the subject for discussion was "Fractures of the lower jaw."

Mr. WARWICK JAMES, in some opening remarks, based mainly on experience gained in the treatment of war injuries, said that fractures of the lower jaw fell into two distinct groups: fracture of the body, involving the tooth sockets, and fracture of the bone beyond the tooth-bearing area. Fractures belonging to the former group were generally compound; those of the second group were rarely compound, and more closely resembled fractures of other bones. A fracture followed the application of a force greater than the bone was able to resist, but special cases occurred in which, owing to disease or other cause, quite a small force resulted in fracture. The majority of fractures of the mandible occurred in young adults; this applied not only in war cases, but in most motor-car and motor-cycle injuries; in children this fracture was not common. The displacement which caused much difficulty was elevation of the posterior fragment if the fracture was in the molar region, and especially if there was comminution of the bone. The fractures varied from those of simple type with little displacement to those of great comminution and loss of tissue, both hard and soft. Certain complications might be present. Dislocation of the condyle might occur and be easily overlooked, and fracture of the skull, the maxilla, and other injuries might add considerably to the difficulty of treatment. The commonest sites of fracture were in the canine and molar regions and through the neck of the condyle. In multiple fractures it was unusual for the neck of the condyle to escape, and fracture of the neck was associated with displacement of the mandible towards the site of the fracture. Mr. James showed photographs illustrating the typical appearance of the patient with severe fracture—the rigidly held head and the open mouth with the saliva running out. The danger of infection of the respiratory tract was a serious menace if coughing could not take place. In such cases treatment must be directed to cleaning up the mouth and fixing the fragments in such a manner that the tongue had free movement without causing pain. The most important principle to emphasize was continuity of living tissue through the mandible. The teeth must not be considered as separate entities. The fact that the fracture which involved the tooth sockets was invariably compound made it important to consider the possibility of necrosis, and every precaution must be taken to avoid infection. If the fractured parts were brought into perfect apposition it was remarkable how little necrosis supervened. Removal of a tooth was justified only if it interfered with the restoration of the fragments, or, being fractured, was a cause of acute pain which could not be relieved. The socket from which a tooth had been removed was a frequent site of necrosis. The mouth differed in its healing capacity from most parts of the body, and a compound fracture of the jaw was certainly less serious than a corresponding fracture of other bones. Wherein lay the greater degree of immunity he could not say, possibly in the saliva itself. In order to procure the best results every possible fragment of bone or tooth should be retained unless actually detached. If bone had been lost the remaining fragments should be placed as far as possible

in their correct positions, and the soft tissue extended so that folding or puckering was prevented. The treatment of all fractures of the mandible consisted of two stages—namely, the restoration of the fragments to the normal position, and their maintenance in that position. The making of a splint was not always easy; the taking of the impression might cause pain, and the introduction of the splint might cause disturbance to the occlusion, so that to avoid an imperfect result great care was necessary. Dislocation of the condyle was not easy to correct, and it was always wise to await a radiograph. Mr. James exhibited a number of splints and fixing wires of the kind he commonly used.

Sir HAROLD GILLIES said that the chief complications met with in fractured mandible were non-union, mal-union, delayed union, much loss of bone substance, obliteration of the buccal sulcus, and facial deformities. Frankly, the first essential for the surgeon when he got a case of fractured mandible was to call in a dental surgeon, and he hardly dared speak about splints, but he would draw swords with Mr. Warwick James with regard to the wires which Mr. James preferred to cap splints. A considerable proportion of his own war cases were treated with cap splints, which kept the whole jaw firm, and could be fitted without an anaesthetic. On the whole he favoured cap splints as a method of fixation. When one tooth was in a separated fragment a cap splint would hold it in excellent position. With regard to mal-union, he thought one ought to be bold enough to undo a malunion and reunite the fragments in good position, either with or without the interpolation of a bone graft. If the patient had a functional result, and especially if there were no teeth in the lower jaw, the matter of appearance only came into play. Patients came with an ugly-looking jaw, which could to a certain extent be modified by the interpolation of grafts. Many of the cases of deformity resulting from malunion in fractured jaws could be improved by a buccal inlay, especially when a piece of bone had been missing in the middle of the jaw. Delayed union and non-union were the same in the mandible as in any other bone. The leaving of teeth in the line of fracture was to be utterly condemned. To leave in a tooth in the line of fracture showing any signs of absorption around the roots was to invite further necrosis and to delay any union, or even to make for non-union. He agreed that if a jaw was much comminuted, and pieces of bone could only be utilized by a tooth which was in the line of fracture, the tooth might be left in, but only for as long as was necessary to keep that bone in position, and that was not very long. All pieces of loose bone and fragments between the ends of the bones should be removed, as well as the teeth. Cases of much loss of bone substance, say where the loss was more than half an inch, could probably be treated *ab initio* with the idea that a bone graft was necessary, and bone grafting had now been done by so many people and so successfully that it was an absolutely established procedure. He showed a short cinematograph film illustrating the insertion of a buccal inlay; not, however, in a case of fracture, but in a case of great loss of tissue owing to lupus. The film illustrated his technique for skin grafting into the buccal sulcus. In every case of bone grafting of the mandible, the buccal ridge was not sufficient for the dentist to fit a proper plate, without which the object of the bone graft was incomplete. The operation shown was merely to incise the buccal mucous membrane along the junction between cheek and jaw, deepen it to the requisite size, fill it up with some sterilized mould, cover the mould with skin graft, and hold it in position with a specially applied splint. At the end of a fortnight one could be absolutely certain that the whole cavity would be epithelialized and capable of bearing a denture indefinitely.

Mr. PERCY COLE declared his hearty agreement with Sir Harold Gillies in his preference for the cap splint to the wire for teeth. In his own cases the cap splint had been universally employed, and he found nothing against it. With regard to the extraction of teeth, perhaps Sir Harold had taken up a position of compromise to which most of them now tended. During

peritoneum is so seldom invaded apparently by the vaginal route when the nature of some of them is considered.

Besides five cases from which various unclassified bacteria were isolated, twenty-four grew staphylococci (two *S. pyogenes aureus*, one in pure culture), four produced rods having the cultural characteristics of *B. welchii*, eighteen gave *B. coli communis*, while eighteen gave non- or late-lactose-fermenting Gram-negative bacilli. Of Gram-positive rods, one case showed a non-virulent *C. diphtheriae*, and nineteen grew organisms which were grouped by their fermentative reactions as diphtheroid (though distinguishable from *C. diphtheriae* by their colony formation), twenty-six as xerosis, and nine as of Hoffmann type, while two were unclassified.

In two cases the vagina was sterile, but each had been syringed with an antiseptic solution within the preceding six hours.

Four children convalescent from other diseases, but with no vaginal discharge, were examined in the wards of University College Hospital, with the following results: pneumococci were not found in any of the cases, streptococci in two, *Staphylococcus albus* in three, xerosis type in three, Hoffmann type in four, *B. coli* in one, Gram-negative rod in one.

—I am, etc.,

ERNEST A. WOOD, M.D., M.R.C.P.

St. Leonards-on-Sea, Oct. 21st.

## Obituary

Dr. BERNARD O'CONNOR of Old Square, Lincoln's Inn, who died on October 7th at the age of 83, received his medical education at Cork, Dublin, Edinburgh, and St. Mary's Hospital, London. He graduated M.D., M.Ch., L.M. (R.U.I.) in 1872, became M.R.C.P. in 1880, and obtained the D.P.H. in 1893. He had held the appointment of physician to the North London Hospital for Consumption (Mount Vernon), was consulting physician to the Convent of Refuge, and physician to the Westminster General Dispensary. He had been a pupil of Lord Lister, and was one of the first to demonstrate the new methods in a London hospital. He was the author of a book on the antiseptic treatment of surgical wounds, with special reference to carbolic acid, and of various papers in medical periodicals. Another direction in which he was a pioneer was the open-air treatment of pulmonary tuberculosis. He was subsequently called to the Bar, practising at the Old Bailey and at the Middlesex, Westminster, and other sessions. He was also a member of the Irish Bar. In 1895 he stood as Nationalist candidate at the West Birmingham parliamentary election against Mr. Joseph Chamberlain, having previously contested the Western Division of Clare. In the British Medical Association he was for some years an active member of the Metropolitan Counties Branch, and of its committees. He came to the fore as a debater, especially at the time of the discussions on the National Health Insurance Bill.

We have to announce the death, on October 13th, of Dr. D. M. MACLEOD of Wakefield. Dr. Macleod was a bachelor, and was educated at Tobermory Public School and Watson's College, Edinburgh. He had his medical education at Edinburgh University, and obtained the M.B. in 1900. He was medical officer to the P. & O. Line for two years, and then succeeded his uncle, Dr. MacArthur, in general practice in Wakefield, where he spent the remainder of his life.

After some years of ill-health, which somewhat crippled his activities, Dr. D. HETHCOTE died at his home in Darlington on October 9th. Douglas Hethcote was born in 1872, and passed through his medical training at Newcastle-on-Tyne, graduating M.B., B.S. Durham in 1899. For some time subsequently he practised at Newsham, near Barnard Castle, where he won many

a friendship among the farming community. He was a civil surgeon in South Africa during the Boer war, and was for several years assistant to Dr. J. Walby, who then practised at Catterick. For the last twenty-four years Dr. Hethcote had resided in Darlington, and he took part in the activities of the British Medical Association in that Division until failing health prevented him. He earned and gained the respect of all his colleagues.

The following well-known foreign medical men have recently died: Dr. MAURICE NICOLLE, professor at the Institut Pasteur and formerly director of the laboratory of microbiology at Constantinople; Dr. FRITZ STEINMANN, professor of the surgery of accidents at Bern, aged 60; Geheimrat Dr. JOHANN OELLER, formerly professor of ophthalmology and director of the eye clinic at Erlangen, aged 82; and Professor S. E. SOKOLOV, director of the surgical clinic at Odessa.

## Universities and Colleges

### UNIVERSITY OF CAMBRIDGE

At a congregation held on October 21st the following medical degrees were conferred:

M.D.—\*F. H. McCay, \*E. A. Hawke Grylls, T. S. Goodwin.  
M.B., B.CHIR.—\*F. H. King, \*R. B. Pringle, \*J. H. Bentley, W. McO. Macgregor, V. T. Thorne, C. S. Lewis, W. McN. Niblock, C. E. Taylor.  
M.B.—\*E. B. Murrell, B. C. Nicholson, R. A. Jones, D. J. R. Steen.  
B.CHIR.—\*J. L. S. Scott, \*M. Westwood, W. W. Sargent.  
\* By proxy.

### UNIVERSITY OF GLASGOW

A congregation was held on October 22nd, when the following degrees were conferred by the Vice-Chancellor, Principal R. S. Rait:

M.D.—J. G. Graham, A. Markson, A. G. Mearns, J. H. Wright, W. H. Watson, J. M. Henderson.  
CH.M.—J. G. Harrower.  
M.B., CH.B.—The list of recipients of the M.B., Ch.B. degrees was printed in our issue of October 15th (p. 735).  
The Brunton Memorial Prize, awarded to the most distinguished graduate in medicine for the year 1932, was gained by W. M. Nichols.  
The West of Scotland R.A.M.C. Memorial Prize, awarded to the candidate with the highest aggregate marks in medicine, surgery, and midwifery in the Final M.B., Ch.B. examination held during 1932, was gained by A. C. Lendrum.

### ROYAL COLLEGE OF SURGEONS OF EDINBURGH

At the annual meeting, held on October 19th, the following officers were elected: *President*, Mr. John W. Dowden; *Vice-President*, Dr. J. Haig Ferguson; *Secretary and Treasurer*, Mr. John Wm. Struthers; *Representative on the General Medical Council*, Mr. Alexander Miles; *Convener of Museum Committee*, Dr. Arthur Logan Turner.

The following twenty-nine successful candidates, out of ninety-seven entered, have been admitted Fellows:

Deborah M. Alcock, N. J. Bakhru, W. S. Brindle, J. H. Casewell, C. G. Crawford, R. Everett, J. A. C. Fleming, Isabella Forshall, I. Goldberg, J. I. R. Gray, T. E. Holland, R. McK. Honey, J. J. Jennings, Phyllis I. Kaufmann, H. Kaye, K. Knowles, R. B. Lumsden, H. I. McClure, H. M. Martin, C. F. Mayne, J. J. O'Reilly, R. J. Parry, C. O. F. Rieger, E. Sandner, D. P. Settna, L. A. H. Snowball, J. S. Sutherland, B. Than, G. E. Waterworth.

### CONJOINT BOARD IN SCOTLAND

The following candidates have been approved at the examinations indicated:

FINAL PROFESSIONAL.—M. D. S. Jayawardana, K. W. Harcourt, D. McN. Beaugie, A. McN. Aitken, A. B. Morrison, R. D. Johnston, R. L. Sutton, V. T. Naidu, D. Cameron, S. D. Senapathin, T. D. L. Bolan, A. Muir, M. G. Naidoo, J. Ossip, A. Macdonald, M. A. Abdalla, G. R. Tisseverasinghe.  
DIPLOMA IN PUBLIC HEALTH.—D. M. Alston, Elizabeth R. Jamieson, Jessie M. Jamieson, J. L. Hunter, J. Comrie, Jessie R. Wilson, A. St. J. Moffat. (Part I): T. K. Kuruvilla, H. Caplan, R. A. Read, Barbara C. Welsh, A. C. Scott, Jean W. R. Paton, Rachel B. Nelson, M. D. Macqueen, W. M. P. McDonald, J. L. Smith. (Part II): J. F. Hamilton.



## The Services

### R.A.M.C.: COLONEL COMMANDANT

The King has approved the appointment of Major-General O. L. Robinson, C.B., C.M.G. (retired pay), late R.A.M.C., as Colonel Commandant R.A.M.C., in succession to the late Lieut.-General Sir Charles H. Burtchaell.

### DEATHS IN THE SERVICES

Lieut.-Colonel Henry Jagoe, R.A.M.C. (ret.), died in London on October 5th, aged 87. He was born in County Cork on November 8th, 1844, and was educated at Trinity College, Dublin, where he graduated as M.B. and Ch.B. in 1867. Entering the Army as assistant surgeon on October 1st, 1867, he became surgeon on March 1st, 1873, when the rank of assistant surgeon was abolished, and surgeon major on October 1st, 1879, retiring with an honorary step as brigade surgeon on October 26th, 1887. He served in the Afghan war in 1878, was mentioned in dispatches and received the medal, and in the Zulu war of 1879, receiving the medal and clasp.

Lieut.-Colonel Alfred Paul Hart, R.A.M.C. (ret.), died at Burnham-on-Sea, Somerset, on October 6th, aged 75. He was born on November 25th, 1856, and was educated at Aberdeen, where he graduated as M.B. and C.M. in 1879, also taking the M.R.C.S. in 1880. Entering the R.A.M.C. as surgeon on February 5th, 1881, he became lieutenant-colonel after twenty years' service, and retired on December 6th, 1902. He served in the South African war from 1899 to 1902, and received the Queen's medal with three clasps, and the King's medal with two clasps. He also rejoined for service in the war of 1914-18, from May 22nd, 1915.

## Medical News

At the annual dinner of the Royal Society of Medicine, to be held at the May Fair Hotel, Berkeley Square, W., on Thursday, November 17th, at 8 p.m., Sir Thomas Barlow will be presented with the gold medal of the society. The toast of "The Royal Society of Medicine" will be proposed by Sir Hilton Young, and Sir William Rothenstein will respond for the guests.

The annual dinner of the Society of Medical Officers of Health will be held at the Hotel Victoria, Northumberland Avenue, W.C.2, on Thursday, November 17th, at 7.15 p.m.

The annual meeting of Fellows and Members of the Royal College of Surgeons of England will take place at the College, Lincoln's Inn Fields, W.C., on Thursday, November 17th, at 3 p.m.

The annual Manchester medical dinner will be held in the Grand Hotel, Aytoun Street, Manchester, on Wednesday, November 23rd. Tickets (price 15s. 6d) can be had on application to Mr. K. J. O'Connor, honorary secretary, Medical School, Manchester.

At the meeting of the Royal Sanitary Institute to be held at 90, Buckingham Palace Road, S.W., on Tuesday, November 8th, at 5.30 p.m., discussions on cyanide fumigation of ships will be opened by Mr. J. D. Hamer, and on the control of insects on foodstuffs and other raw materials by fumigation, by Professor J. W. Munro and Dr. A. B. P. Page.

A general meeting of the Caledonian Medical Society will be held at B.M.A. House, Tavistock Square, London, on Wednesday, November 23rd, at 2.30 p.m., when the president, Dr. John Matheson, will give his address. The annual dinner will be held afterwards in the May Fair Hotel, Berkeley Street, W., at 7.30 p.m. Members intending to be present at the dinner must inform the London secretary, Dr. A. Cumming Grant, 122, Bedford Court Mansions, W.C.1, before November 16th.

The Biochemical Society has arranged the following meetings for 1932-3: November 18th, London School of Hygiene and Tropical Medicine; December 16th, the Laboratories, Messrs. J. Lyons and Co.; February 17th, Lister Institute; March 17th, University College (annual general meeting).

The Royal Society of Tropical Medicine opened its new session on October 20th with a demonstration and papers. On Thursday, November 17th, a clinical and laboratory meeting will be held at the Hospital for Tropical Diseases, Endsleigh Gardens, W.C., at 8.15 p.m. Meetings will take place monthly, and the session ends with the annual general meeting on June 15th, 1933.

Dr. R. G. Canti will give a cinematograph demonstration on the cultivation of living tissue cells, at the Royal Institution, 21, Albemarle Street, on Friday, November 18th, at 9 p.m.; and Dr. E. N. da C. Andrade will give a course of lectures on rays and radiations on Tuesdays, from November 1st to 22nd, at 5.15 p.m.

A course of post-graduate lectures will be given at the Paddington Green Children's Hospital on Sunday mornings from November 6th to December 18th inclusive. Two lectures will be given at each session. The fee for the course is £1 1s.; individual lectures may be attended.

The third of a series of lectures on renal disease, arranged by the Fellowship of Medicine and Post-Graduate Medical Association, will take place at 11, Chandos Street, W., on November 1st, at 4 p.m., when Dr. Arnold Osman will lecture on nephritis and nephrosis; these lectures are free only to members of the Fellowship. There will be a course in practical pathology at the Brompton Hospital from November 10th to December 1st, on Thursdays from 11.45 a.m. to 1 p.m. The course will deal with laboratory methods and the interpretation of results, and arrangements will be made for members of the class to perform the tests themselves. The second of three demonstrations on clinical pathology, especially suitable for M.R.C.P. candidates, will be given at 10, Bedford Square, W.C., on November 2nd, at 8.30 p.m. There will be a demonstration of selected cases of general interest at the Lambeth Hospital, Brook Street, S.E., on Friday, November 18th, at 2 p.m. Six lecture-demonstrations on diagnosis and treatment of chronic rheumatism will be given at the British Red Cross Clinic for Rheumatism, Peto Place, N.W., on Tuesdays and Thursdays from November 22nd to December 8th, at 8.30 p.m. A course in medicine, surgery, and gynaecology will be held at the Royal Waterloo Hospital from November 7th to 26th.

The freedom of the municipal borough of Morecambe was conferred on October 20th upon its medical officer of health, Dr. J. W. Watterson, who is also a county alderman of Lancashire. He is the third to receive this distinction, his immediate predecessor on the roll being Mr. Lloyd George.

The new extension to the Royal Victoria and West Hants Hospital, Bournemouth, was opened by H.R.H. Prince George on October 19th. It provides a new out-patient department, operating theatre, and specialist departments, in addition to beds for paying patients with limited means. The extension has cost £120,000, and it was announced that only £14,000 remained to clear the building from debt. Such a result, Prince George said, reflected great credit on Bournemouth and the surrounding area, inasmuch as it was only five years ago that the Prince of Wales inaugurated the fund for the construction and equipment of the building.

The annual meeting of members and the council meeting of the International Society of Medical Hydrology were held in Paris on October 16th, at the conclusion of the International Rheumatism Congress, which had been attended by a large number of its members from many countries, including South Africa and the United States of America. In the absence of the retiring president, Professor Thayer (Baltimore), the chair was taken by the president vicegerent, Dr. van Breemen (Amsterdam), until the election of the new president, Dr. Paul Ferreyrolles (La Bourboule and Paris). On the retirement of Dr. C. W. Buckley (Buxton) as treasurer, Dr. Lionel Calthrop (Radlett, late of Harrogate) was elected in his place. It was decided to hold the next business meeting of the society at Toulouse in October, 1933, at the time of the Congrès International d'Hydrologie, and the next scientific meeting at Zürich in January, 1934.

The inaugural meeting of the Abernethian Society of St. Bartholomew's Hospital will be held in the Medical and Surgical Theatre of the hospital on Thursday, November 3rd, at 8.30 p.m., when Lord Moynihan will give an address on "Medicine and surgery in ancient times."

At the first French Congress of Gynaecology, held at the Paris Faculty of Medicine on October 3rd, under the presidency of Dr. F. Jayle, Professor Recasens, dean of the Madrid Faculty of Medicine, read a paper on the progress of gynaecology during the last fifty years, and Drs. Jayle and Hallion discussed the relation between the hypophysis and the ovary.

The third Public Health Congress and Exhibition, under the presidency of Sir E. Hilton Young, M.P., Minister of Health, will open at the Royal Agricultural Hall, London, N., on November 14th, and continue for six days. The exhibition will be representative of firms specializing in the various requirements of health services, and will provide an opportunity for delegates to see the latest apparatus and equipment for use in their respective departments. A special type of demonstration roadway is being laid down on the premises upon which street-cleaning and other vehicles will carry out various evolutions. The congress, which is organized by a council of representatives from the leading associations of local government, will be the occasion for the discussion of, amongst others, the following subjects: housing, infant welfare, smoke abatement, fumes from motor vehicles, occupational therapy in mental hospitals, physical treatment, water supply, sewage, public cleansing, nursing, and preventive medicine. The exhibition offices are 13, Victoria Street, S.W.1. All inquiries should be sent to that address.

The Parliamentary Secretary to the Ministry of Health, Mr. G. H. Shakespeare, M.P., has appointed Mr. Kenneth McGregor to be his private secretary.

Numerous cases of typhus have recently occurred in the suburbs of Vienna.

The number of persons in Germany who committed suicide in 1930 was 17,880, as compared with 16,115, 16,036, 15,974, and 16,480 in the previous four years.

## Letters, Notes, and Answers

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

ORIGINAL ARTICLES and LETTERS forwarded for publication are understood to be offered to the *British Medical Journal* alone unless the contrary be stated. Correspondents who wish notice to be taken of their communications should authenticate them with their names, not necessarily for publication.

Authors desiring REPRINTS of their articles published in the *British Medical Journal* must communicate with the Financial Secretary and Business Manager, British Medical Association House, Tavistock Square, W.C.1, on receipt of proofs.

All communications with reference to ADVERTISEMENTS, as well as orders for copies of the *Journal*, should be addressed to the Financial Secretary and Business Manager.

The TELEPHONE NUMBERS of the British Medical Association and the *British Medical Journal* are MUSEUM 9861, 9862, 9863, and 9864 (internal exchange, four lines).

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The address of the Irish Office of the British Medical Association is 18, Kildare Street, Dublin (telegrams: *Bacillus, Dublin*; telephone: 62550 Dublin), and of the Scottish Office, 7, Drumsheugh Gardens, Edinburgh (telegrams: *Associate, Edinburgh*; telephone: 24361 Edinburgh).

### QUERIES AND ANSWERS

#### Seborrhoea of the Scalp

"E. S. C." writes: I should be grateful if any fellow practitioner could suggest a remedy for a female patient, aged 12 years, who suffers from excessive oiliness of the scalp and hair. The usual remedies have been tried without success.

#### P.U.O.: ? Diagnosis

Dr. JOHN SMITH (Maidstone) writes: I should be grateful if any member could suggest a diagnosis and treatment in the case of an old lady (73) who has been running a temperature of 98.6° to 99.8° for over two months. The temperature has proved resistant to the usual salicylates, aspirin, quinine, and iodine compounds. There is no obvious focus of sepsis. The urine is normal chemically, and sterile bacteriologically. The faeces are normal. The blood count is normal for red and white cells. Widal's test is negative. The pulse rate varies from 84 to 96, and the patient complains simply of fatigue and capricious appetite.

#### Olive Oil

"G.P." inquires about the medicinal qualities of olive oil. Is it beneficial in colon troubles? If given after food, does it not counteract the effect of the hydrochloric acid in the stomach, which is so essential for the proper digestion of food in the small intestine?

#### "Ferri Perchlor." in Skin Disease

Dr. F. CORY (Leeds) writes: I was interested to notice (*Journal*, October 8th, p. 698) that my suggestion (April 23rd) has been forstalled by Dr. J. H. Garrett, who advocated ferri perchlor. in ringworm of the scalp only. Sixty years ago I first used perchloride of iron as an application in dogs suffering from mange, with rapid cure. I should be glad to hear from any of your readers the result of the application of ferri perchlor. fort. in other skin diseases.

#### Softening the Beard

"J. H. B." writes: If "W. B. D.," in spite of incredulity, will try cold water (which does not make the skin tender, while it softens the skin just as well as hot if the lathering be prolonged and thorough) and a heavy razor of the first quality, stropped on a Worth strop (consisting of sections of leather set on edge, and procurable at 351, Oxford Street, London), he will, I believe, obtain the best shave possible.

#### Income Tax

##### Use of Car

"M. R. S." inquires what income tax deductions are allowed to a doctor "who buys and uses a car for his profession."

\*\* No deduction is due for the original cost of acquiring the car as that expenditure is capital outlay. But an annual deduction can be claimed for the depreciation arising from wear and tear, usually reckoned at 20 per cent. of the cost price in the first year, and thereafter on the value as written down by the allowances. All running costs, petrol, oil, tyres, repairs, etc., are allowable, as are also general charges, licence and insurance costs, and the expense, if any, of garaging the car. It should, however, be borne in mind that if the car is used for private as well as professional purposes some deduction has to be made from the total to arrive at the allowable amount. Usually that deduction is calculated at a percentage of the total—say, 15 to 20 per cent., etc.

##### Allowance for Obsolescence

"P. S." is allowed £110 per annum for motor car expenses, to include depreciation. His present car was bought on July 1st, 1929, and he is now selling it for £30 and buying a new one for £230. What additional claim can he make?

\*\* He should make a claim for "obsolescence allowance" in respect of the old car, the amount of the claim being regarded as a professional expense of the current year, and therefore as affecting the income tax liability for the next financial year—1932-3. The claim should be calculated as follows: if £x was the cost of the original car and £y the aggregate of the depreciation allowances for 1930-1 and 1931-2, then the amount of the obsolescence claim is £x - (£y + £30). For 1932-3 the "depreciation" allowance should be 20 per cent. of £230 = £46.

##### Change of Office or Employment

"University Teacher" inquires what effect, if any, promotion from lecturer to professor will have on the basis of liability to assessment.

\*\* The relevant section of the Income Tax Acts—Section 45 of the Finance Act, 1927—does not deal specifically with "a change," but separately—that is, under Subsection (5), "where a person ceases to hold an office or employment," and under Subsection (4), where "the person