the mask is taken away altogether and the next pain awaited. The patient should not go unconscious. If she does the mask has been too closely applied. She should remain sufficiently conscious to respond to instructions to bear down, to be able to say or indicate when a pain is coming on ; and if the chloroform is used to this extent only, almost perfect analgesia is produced in at least 95 per cent. of normal labours, and the patient remembers, and apparently feels, nothing of pain or of the actual birth of the child. Chloroform administered in this way can be used throughout labour without detriment. In order to test this thoroughly I have a series of cases recorded over three months showing time during which capsules were administered.

Queen Charlotte's Hospital during April, May, and June, 1933

Total number of cases receiving capsules...				...	342
Patients receiving capsules for less than 2 hours				...	226
,,	,,	,,	2 to 3 hours	...	38
,,	,,	,,	3 to 4 ,,	...	16
,,	,,	,,	4 to 5 ,,	...	16
,,	,,	,,	5 to 6 ,,	...	9
,,	,,	,,	6 to 7 ,,	...	6
,,	,,	,,	7 to 8 ,,	...	5
,,	,,	,,	8 to 9 ,,	...	3
,,	,,	,,	over 9 ,,	...	23

Of those cases receiving capsules for over 9 hours, 20 out of the 23 terminated in forceps delivery.

It is noticeable in how few cases the capsules were administered for more than five hours, and it is particularly interesting because I was urging the two resident anaesthetists to get me a series of one hundred cases in which capsules had been administered for at least ten hours. In most of this series of 342 cases, capsules were started when the cervix was dilated to the size of a florin, but very few of them lasted more than five hours longer before they delivered themselves. Of the twenty-three cases of over nine hours, twenty were posterior positions, or closely fitting heads which required forceps delivery ; and this fits in with our experience that analgesia markedly shortens the duration of labour by relaxing the soft parts, and only in those cases where there is a real obstetric difficulty will labour last over twelve hours, even in primigravidae.

Now during this period at Queen Charlotte's there have been two disasters among these 342 cases. One patient, who had had capsules for fourteen hours, subsequently developed puerperal sepsis. Sixty-six capsules were used during this time. The presentation was right occipito-posterior, and the forceps was used to complete delivery. She had a positive blood culture, but did eventually recover, and I do not doubt that several " category (*a*) " listeners will be quite convinced that her sepsis was entirely due to the lowering of resistance by this prolonged administration of chloroform.

Another patient died ; she was a primigravida, who had had thirty-seven capsules over a period of five and three-quarter hours, and delivered herself of a living child weighing 8 lb. 10 oz. In doing so she sustained a second degree laceration of the perineum. The capsules were discontinued and the placenta was expelled about twenty minutes later. Some ten minutes later anaesthesia was produced by chloroform out of a drop bottle in order to insert stitches. As she reached the stage of anaesthesia her tongue fell back into her pharynx and she stopped breathing. The tongue was pulled forward and breathing was re-established, but only for a very short time. At the post-mortem examination she was found to have a fatty heart, and no smell of chloroform was detected in the tissues. Here again " category (*a*) " will be convinced that death was due to the capsules, but I am sure that it was the deeper anaesthesia which allowed the tongue to fall back, and the resulting partial asphyxia which stopped the diseased heart.

To sum up, these capsules are intended for the use of midwives. They are only meant to be used during the second stage of labour or perhaps during the end of the first stage also if the pains are particularly strong. They are not meant to be an anaesthetic, only an analgesic. They are not intended to be used for the application of forceps or the insertion of stitches, although in some cases they may produce sufficient analgesia for the latter operation.

Memoranda

MEDICAL, SURGICAL, OBSTETRICAL

CHRONIC BILATERAL SPONTANEOUS PNEUMOTHORAX

(With Special Plate)

On examining the literature one is struck by the comparatively few reported cases of acute bilateral spontaneous pneumothorax. Hans Kjaergaard, in his book *Spontaneous Pneumothorax in the Apparently Healthy*, draws attention to the very few cases of chronic spontaneous pneumothorax reported, his reference being to unilateral cases, but does not mention chronic bilateral pneumothorax in his survey of this obscure condition. This latter condition must be excessively rare, as I have been unable to find a solitary reference to it after an exhaustive search of the current literature. On this account I have been prompted to report one such case, which came under my care in June, 1932.

Case Record

A married man, aged 49, enjoyed perfect health up to the age of 42, when he noticed the first symptom of the present illness. His occupation as an electrician did not entail any laborious work, whilst during his leisure hours he took part in amateur theatricals. He was married, but had no family. There was no history of venereal disease, or of abortions or miscarriages, nor was there a family history of tuberculosis. He stated that his illness commenced seven years previously with a cold resembling " flu," which left him, after a few days of malaise, with a slight cough. A certain amount of dyspnoea accompanied the residual cough, but was for some time not sufficient to cause him any respiratory embarrassment whatsoever. Gradually, however, the dyspnoea became worse, and over a period of two to three years the hitherto unproductive cough became accompanied by a muco-purulent expectoration, and as a result he decided to consult his doctor. A diagnosis of bronchial asthma was made, and he was treated by means of autogenous vaccines prepared from his sputum. Several courses of vaccine therapy were employed over a period of years without any noticeable improvement in his condition. Instead, he became more and more dyspnoeic, his cough more troublesome, his sputum more profuse, while his general condition slowly deteriorated.

He consulted me with a history, as he said, of " asthma " of seven years' duration, but as there was complete absence of spasmodic dyspnoea this diagnosis was eliminated. His breathing was markedly distressed, whilst the slightest exertion was sufficient to produce an alarming duskiness of his face, almost amounting to cyanosis. Although he was unable to walk more than two hundred yards without resting he was sufficiently tenacious to continue his occupation, though in a greatly restricted capacity, but was with reluctance compelled to abandon his theatrical aspirations. His sputum did not contain tubercle bacilli, was profuse and muco-purulent, but not fetid. His main concern was his gradually increasing breathlessness, which was now almost suffocating and at times alarming. He was of small stature, with a pale, drawn, expressionless face. His hands were cold, but the fingers were not clubbed. His respirations were short and quick, and on attempting to remove his clothes for examination he became so terribly distressed and cyanosed that I thought he was about to die.

Examination revealed the superficial veins on his chest to be dilated, and immediately suggested an obstructive origin for his condition. The apex beat was not displaced, the heart sounds were normal, and there were no murmurs. Percussion showed hyper-resonance in the upper halves of both chests, whilst breath sounds were distinctly tubular over this area. Breath sounds were more or less normal below this. These clinical findings suggested bilateral collapse of the upper lobes, and as the progress of the condition was insidious, a slowly growing neoplasm suggested itself as being a possible cause accounting for the bilateral collapse and the obstructive vascular signs. A radiogram (see Plate), however, revealed a partial pneumothorax on both sides. The patient was admitted to hospital, where I ascertained the intrapleural pressures. On the left side they were: + 6 : - 2, and on the right + 4 : - 2. There was practically no resistance to the pneumothorax needle penetrating the pleura. No air was allowed to enter or escape from the pleural cavities whilst these pressures were being ascertained, and before further investigations could be carried out the patient died suddenly and unexpectedly about ten hours after the intrapleural investigations. Permission for a necropsy could not be obtained.

Commentary

This case was apparently one with a valve opening. The history is completely devoid of an acute onset, but the abrupt termination may possibly have been due to a superimposed acute pneumothorax. Cases of chronic spontaneous pneumothorax have been described by Adams, Brunner, Magnus-Levy, and others, but these have been confined to unilateral cases. Some of these had persisted for many years. Levy's case set in at childhood and was present for twenty years. The case described above had apparently been present for seven years.

Hans Kjaergaard states of chronic spontaneous (unilateral) pneumothorax: "The characteristic feature is the very contrast between the marked pneumothorax with the great displacement and the comfort of the patient." This is equally true of cases of artificial pneumothorax where the collapse has been maintained for some months. In my case there was practically no displacement, due apparently to the bilateral lesion, but the respiratory discomfort was extreme. Examination of the radiograms shows that the combined collapse would not be equivalent to a complete unilateral pneumothorax ; yet why the marked dyspnoea? One can only assume that the partial pneumothorax on each side caused a reduction in the aeration capacity of the unaffected part of the lung by pressure, and so accounted for the respiratory distress.

As I have been unable to find a similar case in the literature I regard this as being rather unique, and would be glad to learn of any other such cases that I may have overlooked in my examination of the records of this condition.

Joseph Lewis, M.R.C.P.I.,
Assistant Honorary Physician and Honorary Pathologist, Mercer's Hospital, Dublin.

CONGENITAL BRONCHIECTASIS

(With Special Plate)

In March, 1932, at the Oxford Meeting of the Tuberculosis Association,[1] we called attention to cases we had seen of this disease, and showed films demonstrating the dilatations outlined with lipiodol. The one quoted below is a good example of this condition, of which we have now collected nine cases. The history and physical signs are so characteristic that in the last six instances we have suspected the condition at the first physical examination.

M. K., aged 11 years, had had a cough since birth. Recently the cough had become productive of one or two drachms of sputum daily. No haemoptysis. Past history: uncomplicated whooping-cough. On admission the child was pale, but well developed. Left chest, slightly shrunken. Percussion note, impaired slightly. Auscultation revealed fine crackles over the whole of the left lung. No abnormal signs in right lung. Heart, slight displacement to the left. The skiagram was reported as showing left-sided fibrosis. On careful examination of it a cystic system could be made out. Lipiodol injection showed up multiple cysts. Bronchoscopic examination showed an increase in the number of bronchi leaving the main left bronchus. After the induction of an artificial pneumothorax the skiagram shows that a complete pneumothorax has been obtained, and the cystic condition is seen more plainly. Cysts can be seen protruding from the surface of the lung. At the thoracoscopic examination the lung appeared to consist of nothing more than a collection of cysts bound together by the visceral pleura. The tissue between the cysts and the cyst wall was palish pink and free from pigment.

We consider this condition to be of congenital origin for the following reasons:

1. The clean-cut circular type of bronchiectatic dilatations we have never seen in cases in which we have definite evidence that an inflammatory lesion was the cause of the dilatations.

2. As we have pointed out elsewhere,[2] the ability to produce a complete artificial pneumothorax in these cases is good evidence that the bronchiectasis is not due to past inflammatory and fibrotic lesions.

3. The absence of pigment on the lung surface, as seen with the thoracoscope, is evidence in a town dweller that the alveoli in that side are absent.

As in this case past inflammatory disease, which might have caused the disappearance of alveoli, is excluded, a fair presumption is that the alveoli were congenitally absent.

References
[1] *Tubercle*, 1932, xiii, 531.
[2] *British Medical Journal*, 1933, i, 762.

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A. J. Scott Pinchin, M.D., F.R.C.P.
Physicians, City of London Hospital for Diseases of the Heart and Lungs.

HAEMATURIA IN CHILDHOOD ASSOCIATED WITH ACUTE MASTOIDITIS

This case is reported because of the unusual sequence of events and the comparative rarity of the condition.

Ian H., aged 4 years, was first seen in May, 1933, in the out-patient department at the Princess Louise Hospital for Children. There had been pain in the left ear two days previous to his attendance at hospital. On examination there was a profuse aural discharge, mastoid tenderness, and a temperature of 101.8° F. Acute mastoiditis was diagnosed and the patient admitted for operation. During the routine pre-operative preparation marked haematuria was discovered. The mother on being questioned affirmed that the child had never passed blood before, and the case was therefore referred to a medical colleague for advice. It was decided that, as the ear was discharging freely and the child could be kept under constant supervision, its best interests would be served by delaying operation. Under treatment the tenderness over the mastoid disappeared, and the temperature subsided to a degree above normal, but the haematuria continued with but little abatement for fourteen days. The tonsils were examined, and appeared to be healthy, but a smear taken grew a haemolytic streptococcus, and so enucleation was performed. Almost within a few hours the haematuria cleared. The aural condition still gave rise to anxiety, and so a fortnight later a conservative mastoid operation was performed. A culture was taken, and again the haemolytic streptococcus was demonstrated. The patient made a slow but uneventful recovery, and was discharged from hospital

just eight weeks after admittance. The post-auricular wound was soundly healed and the ear was dry.

In reviewing this case I feel that in future I shall not regard an associated haematuria with an acute mastoid as any bar to early operation, and although many acute infections will cause haematuria in children—especially tonsillar infections—it is unusual to be able to demonstrate the causal organism both in the tonsil and in the mastoid. I am sure the tonsils were the original site of infection, but I think there would have been no haematuria without the infection in the mastoid.

E. Carew-Shaw, F.R.C.S.
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Bolingbroke Hospital.

London, W.1.

Reports of Societies

CANCER OF THE SCROTUM

At a meeting of the Liverpool Medical Institution, held on October 12th, with the president, Dr. H. R. Hurter, in the chair, Mr. J. Cosbie Ross read a short paper on carcinoma of the scrotum.

Mr. Ross pointed out that although this was a condition particularly amenable to surgical intervention, it was as a subject, largely neglected in the textbooks. After discussing the aetiological factors, with special reference to the early work of Butlin, and the more recent work of the Manchester school, Mr. Ross concluded that in his short series of cases, none of which were associated with mule-spinning, the predisposing cause was chronic irritation by the clothes, stiffened by oil or dirt, or by the rigidity of the material. Two out of five scrotal tumours proved, on microscopical section, to be basal-celled carcinoma undergoing squamous-celled evolution, so that in a certain proportion of cases the sequence appeared to be rodent ulcer→transitional tumour→epithelioma. This was supported clinically, as in one case an epithelioma and a transitional tumour were present together on either side of the median raphe. The name "transitional tumour" was suggested for these intermediate growths, which, of course, were found in other parts of the body. Treatment of both primary growth and inguinal glands should, it was stated, be by surgical excision rather than by radiotherapy, which had proved disappointing for a variety of reasons. It was not necessary, however, to remove both growth and glands *en bloc*, as cancerous spread in this region was by lymphatic embolism and not by permeation. Excision of the fatty glandular mass in the groin should be wide, and should include glands situated just internal to the anterior superior iliac spine, as the lymphatic trunks draining the anterior aspect of the scrotum near the raphe ran directly to these glands. Mr. Ross considered it advisable to deal with the glands in all cases of "transitional tumour." In the discussion which followed, Professor Leyland Robinson drew attention to the points of resemblance between scrotal tumours and neoplasms of the vulva. The scrotum and vulva were homologous structures, and their lymphatic drainage systems were alike: excision of the growth was preferable to radium in both, although it was difficult to obtain primary union of the flaps. It had also been suggested that the irritation of mineral oils was an important factor in the production of vulval, as in scrotal, cancer, but the clinical evidence brought forward in support of this view had not been sufficiently tested by control cases taken from areas in which mineral oils were not in common use. In this respect Mr. Ross's cases were particularly interesting, as none of his patients had been submitted to the irritation of soot or mineral oil. Dr. T. B. Davie drew attention to the observation of Ewing and others that the malignant growths of the scrotum were almost invariably poorly differentiated epitheliomas, and that they rarely showed the multiple "cell-nests" of a well-differentiated or acanthomatous epithelioma. He commented on the occurrence of two rodent ulcers in the five cases recorded by Mr. Ross, and suggested that their occurrence here was a reminder of the fact that in the median raphe of the scrotum occurred one of those lines of embryological junction of epithelium which, in the face area, afforded the usual site of origin of rodent ulcers.

Diuretics in Cardiac Oedema

Dr. I. Harris, Mr. R. Shutt, and Dr. E. L. Rubin contributed a paper on the action of some diuretics in cardiac oedema.

An investigation was described which was undertaken with a view to ascertaining the effect of different drugs on salt excretion of the kidney. Salyrgan and ammonium chloride were the drugs dealt with. It was found that salyrgan improved diuresis as well as increasing salt excretion, but it might do one or the other. In either case the oedema diminished. Blood chloride was invariably diminished under salyrgan. Due probably to the oedema, haemoglobin was also diminished, proving that there was a condition of hydraemia. This condition was found not only within four hours, but also within twenty-four hours after the administration of salyrgan. The bases potassium, sodium, magnesium, and calcium were diminished four hours after the injection, but were normal after twenty-four hours. The urine contained an enormous amount of base—particularly potassium and sodium—after salyrgan. In some instances of oedema there were enormous increases in the excretion of base, even three and four days after the administration of salyrgan. In other cases the effect only lasted twenty-four hours. The efficiency of salyrgan was improved after ammon. chlor., and sometimes after a salt-free diet. Salyrgan had a double action: it was a tissue diuretic, taking fluid from the tissues and bringing it into the circulation, thence to be excreted by the kidney, and it also acted *on* the kidney—otherwise the improved excretion of urine for concentrated salt could not be explained. Ammon. chlor. had a similar action to salyrgan, its effect being due to acidosis; it brought into action a mechanism to counteract the abnormal acidity. This mechanism set free base, particularly potassium and sodium. These were excreted by the kidney, and the base took the water with it. Unlike salyrgan, the blood chlorides were invariably increased after ammon. chlor., and the haemoglobin was increased too, proving that there was hydraemia. Blood bases, however, were diminished when given under restricted fluid, and were normal if given under excessive fluid. Ammon. chlor. acted better under restricted fluid than under excessive fluid. The urine contained large quantities of sodium and potassium.

MID-STAFFORDSHIRE MEDICAL SOCIETY

The opening meeting of the second session of the Mid-Staffordshire Medical Society was held at Stafford on October 13th, with Mr. Nesfield Cookson in the chair. Mr. Victor Bonney, who opened the session, adopted the novel procedure of answering questions instead of giving a formal address. This resulted in an interesting meeting lasting several hours. Among other things, the speaker dealt in some detail with puerperal sepsis, including a historical review of the subject, and the relative importance of the extrinsic and intrinsic theories of infection, and while encouraging the use of all precautions against extrinsic infection, including the wearing of masks, he thought that the importance of intrinsic infection had hitherto been overlooked. In support of this contention he enumerated the various forms of streptococci which have their habitat in the female, and as the outcome of a direct question he agreed that blood stream transmission was a possibility in some instances. Mr. Bonney also discussed the various pelvimetric methods; the dangers and uses of radium in gynaecological practice, and the value of x rays in obstetric diagnosis, especially to determine if the legs are extended in a breech presentation; indications for version and the importance of an anaesthetic during this procedure, especially in primiparae; the futility of some modern medicinal methods of treatment in uterine and ovarian disease; and, in addition, he discussed the surgical measures at times demanded in obstetric practice.

JOSEPH LEWIS: CHRONIC BILATERAL SPONTANEOUS PNEUMOTHORAX

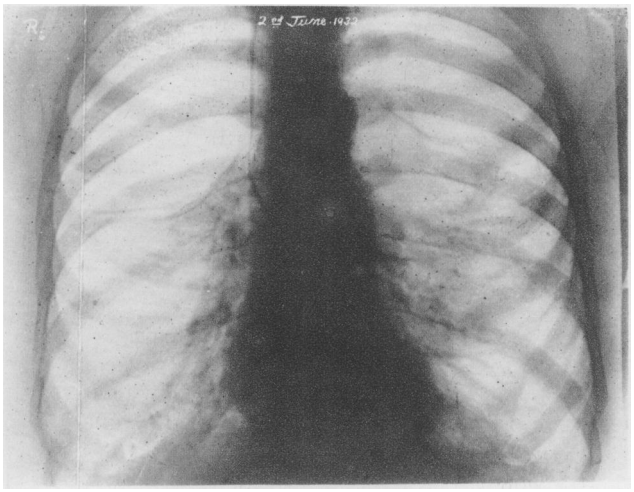

FIG. 1.—Showing partial pneumothorax on both sides.

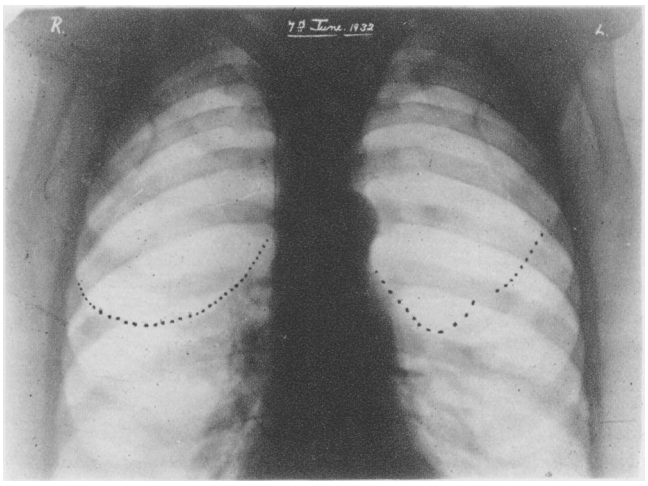

FIG. 2.—Five days later: showing increased collapse of lung.

R. V. MORLOCK AND A. J. SCOTT PINCHIN: CONGENITAL BRONCHIECTASIS

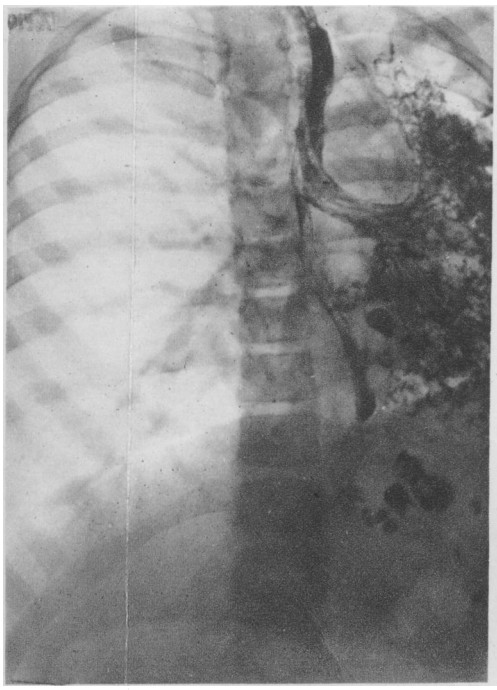

FIG. 1.—Antero-posterior view with lipiodol.

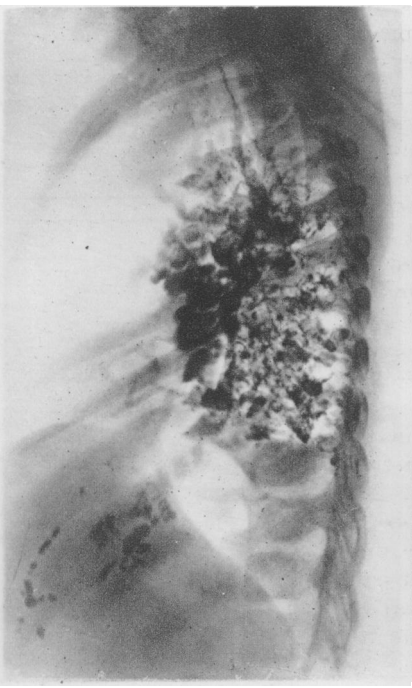

FIG. 2.—Lateral view with lipiodol.

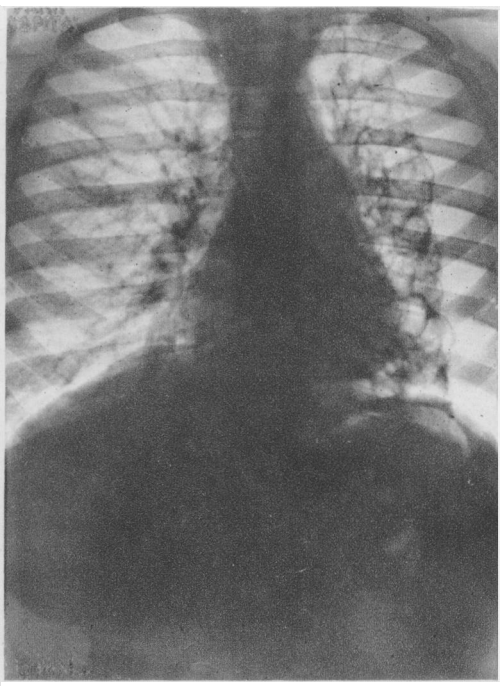

FIG. 3.—After artificial pneumothorax. Note translucen cystic appearance of collapsed lung.

Bequests for Medical Charities

SIR,—In sympathy with "Backbencher's" letter in your last issue, I write to say that I have already bequeathed more than the amount suggested to both Epsom College and to the Royal Medical Benevolent Fund. Even if this puts me *hors concours*, it might serve *pour encourager les autres*.—I am, etc.,

October 24th. GLOTTIS.

Universities and Colleges

UNIVERSITY OF CAMBRIDGE

Pinsent-Darwin Studentship in Mental Pathology

An election to the above studentship will be made in January, 1934. The studentship is of the annual value of about £225, and is tenable for three years. The student must engage in original research into any problem having a bearing on mental defects, diseases, or disorders, but may carry on educational or other work concurrently. Applications should be sent before January 1st, 1934, to the secretary, Pinsent-Darwin Studentship, Psychological Laboratory, Cambridge. Applicants should state their age and qualifications, and the general nature of the research that they wish to undertake. No testimonials are required, but applicants should give the names of not more than three referees.

UNIVERSITY OF LONDON

Mr. Harry Berry, B.Sc., has been appointed, as from January 1st, 1934, to the University Readership in Pharmaceutics, tenable at the College of the Pharmaceutical Society of Great Britain.

LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE

The first award of the Andrew Balfour Studentship at the London School of Hygiene and Tropical Medicine has been made to Dr. G. M. Balfour, who is taking the course of study for the Diploma in Tropical Medicine and Hygiene. The first award of the Fishmongers' Company Studentship in the public health class has been made to Dr. D. D. Payne. The new Chadwick Prize for the best student in the public health class has been divided between Dr. J. M. Henderson and Dr. B. O'Brien.

UNIVERSITY OF GLASGOW

A congregation was held on October 21st, when the following degrees were conferred:

M.D.—*A. L. Dunlop, †W. L. Forsyth, †E. E. Henderson, †A. C. Morrison, †J. A. Montgomery, †Margaret T. Tindal, R. S. Donaldson, Lillias B. Hardie, J. F. Lang, K. M. Rodger.

M.B., CH.B.—The list of recipients of the M.B., Ch.B. degrees was printed in our issue of October 21st (p. 760). In that list the names of R. McMillan and W. E. Masbie should read R. McM. Latta and W. E. Mathie; also F. E. Crawley, J. C. Dick, J. D. Fraser, J. Hutchison, S. Lazarus, J. B. Macdonald, and A. P. Robertson received their degrees "with commendation," as did H. B. Muir, whose name was omitted from the list.

The Brunton Memorial Prize, awarded to the most distinguished graduate in medicine for the year 1933, and 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 1933, were gained by G. Forbes.

* With high commendation. † With commendation.

UNIVERSITY OF DUBLIN

SCHOOL OF PHYSIC, TRINITY COLLEGE

The following candidates have been approved at the examinations indicated:

FINAL MEDICAL EXAMINATION.—(*Part I, Materia Medica and Therapeutics, Pathology, and Bacteriology*): J. N. P. Moore (passed on high marks), D. P. Burkitt, G. J. Dixon, Maureen C. E. Gore-Grimes, G. W. M. Elliott, F. T. P. Bergin, L. Fridjhon, D. H. T. Duggan, E. S. Dorman, R. F. Lurring, F. P. E. Smith, R. I. Shier.

M.D.—C. Bowesman, J. M. Hill, M. Nurock.

ROYAL COLLEGE OF SURGEONS OF EDINBURGH

At a meeting of the Royal College of Surgeons of Edinburgh, held on October 17th, with Mr. J. W. Dowden, president, in the chair, the following thirty-five successful candidates out of eighty-nine entered were admitted as Fellows:

W. G. Annan, H. B. Bagshaw, Gertrude C. Banks, L. N. Burnett, G. T. W. Cashell, L. F. Day, R. Evans, H. W. Farrell, R. Gardiner, W. G. Harding, W. W. Jeudwine, H. O. Johnston, H. B. L. Levy, Innis M. Macdonald, K. S. Macdonald-Smith, S. A. McFetridge, J. A. Noble, M. M. Parker, Susanne J. Paterson, S. Pinkinsky, J. A. Price, May W. Ratnayeke, W. R. Sloan, H. G. Somerville, H. A. Sweetapple, G. M. Thomson, I. B. Thorburn, A. C. Turner, E. B. Watson, D. K. Weston, C. S. Williams, L. S. Williams, N. P. Wilson, H. G. Wyatt, Man-Kwong Yue.

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

The annual meeting of the Royal College of Physicians of Ireland was held on St. Luke's Day, October 18th.

Dr. Francis Carmichael Purser was elected president and Dr. William Boxwell vice-president. The following were elected censors and examiners: medicine, Dr. Boxwell and Dr. C. J. Murphy; medical jurisprudence and hygiene, Dr. Freeman; midwifery, Dr. Solomons.

The following officers were elected for the ensuing year: representative on the General Medical Council, Dr. Moorhead; treasurer, Dr. H. Bewley; registrar, Dr. Kirkpatrick; librarian, Mr. R. Phelps. Representatives on the Committee of Management under the conjoint examination scheme: Sir John Moore, Dr. Kirkpatrick, and Dr. Winter.

CONJOINT BOARD IN SCOTLAND

The following candidates have been approved at the examinations indicated:

FINAL PROFESSIONAL EXAMINATION.—S. Hertz, S. Westmann, H. Fuld, F. Ewer, P. F. Meyer, Eleonore Bergmann, J. F. Trigg, G. D. W. Adamson, Mary Nanigian, E. K. Ledermann, F. Jacobsohn, W. C. Duthie, E. Lucas, W. Kupfermann, F. Lewy, P. Nathan, F. Muller, K. M. El Moshneb, A. Altmann, M. Gutstein, H. G. Garas, A. Lechner, H. Heller, W. Auerbach, M. W. U. Alwi, P. Rothschild, C. N. Dhlamini, W. L. McNamara, J. G. Lanni, F. L. Reardon, T. R. N. Parhar, K. Samson, O. Hartog, A. M. Allison, W. A. Christie, J. McGibbon, J. C. MacDougall, Ann W. M. Miller, J. W. Clark, F. J. Beaton.

DIPLOMA OF L.R.C.P.ED., L.R.C.S.ED., L.R.F.P. AND S.GLAS.—N. T. Segall, A. E. Landy, A. S. Weinstein, C. E. Gunatilleke, K. R. Perera, R. M. Scott, B. Kline, A. S. Walker, P. Rossman, A. K. Sharaf, A. A. Rehman, S. Weiner, A. J. Brenner, A. Morris, H. G. Braham, E. Saberski, D. E. Kabnick, R. O. Murray, P. Somasundram, J. Isaacs, J. Reynolds, N. Patterson.

D.P.H.—A. D. Frazer, Katherine R. Brown, J. E. Rankine, W. D. Mackinnon, Rachel B. Nelson, W. E. Faulkner, R. Hardy, G. F. Bradbury. (*Part I*): M. B. Griffith, J. E. Rankine, Marjorie Murrell, J. L. Swanston, W. R. Martine, Ruth M. Monro, J. Macfarlane, H. Somerville.

The Services

DEATHS IN THE SERVICES

Colonel Laurence Percival Brassey, Indian Medical Service (ret.), died at Harrogate on October 17th, aged 57. He was born on May 3rd, 1876, the son of Robert Percival Brassey of Cholmondeley, Cheshire, and was educated at Edinburgh University, where he graduated M.B., Ch.B. in 1900. Entering the I.M.S. as lieutenant on June 27th, 1901, he attained the rank of colonel on July 12th, 1930, and retired, on account of ill-health, on September 8th, 1932. He served in Egypt in 1914–15; in Gallipoli, where he was wounded, in 1915; and in Iraq in 1916–18, being twice mentioned in dispatches, in the *London Gazette* of January 28th, 1916, and August 27th, 1918. He had spent his service in military employ, and before his promotion was medical officer of the 91st Punjabis, at Bhamo.

Lieut.-Colonel Charles William Thiele, R.A.M.C. (ret.), died at Southsea on September 25th, aged 78. He was born on September 30th, 1854, and was educated at Aberdeen, where he graduated M.B., C.M. in 1880. Entering the R.A.M.C. as surgeon on July 30th, 1881, he became lieutenant-colonel after twenty years' service, and retired on March 21st, 1908. He served throughout the South African war of 1899–1902, and took part in the relief of Ladysmith, including the actions of Colenso, Tugela Heights, and Pieter's Hill, and subsequently in operations in the Transvaal and Orange River Colony, and received the Queen's medal with five clasps and the King's medal with two clasps. He rejoined for service in the war of 1914–18, from April 19th, 1915. On the introduction of compulsory service, in the beginning of 1916, he was appointed president of the Recruiting Medical Board at Manchester, and later on was in medical charge of the camp at Kimmel, near Rhyl, North Wales.

We regret to record the death, on September 28th, at Great Yarmouth, of Dr. Alfred Charles Mayo, at the age of 88. Dr. Mayo, who was born in 1845, received the diplomas M.R.C.S.Eng. and L.S.A. in 1870, and had been a member of the British Medical Association since 1873. He was president of the old East Anglian Branch of the Association in 1894, and acted as representative of the East Norfolk and North Suffolk constituency at the Annual Representative Meetings of the Association at Swansea (1903), Oxford (1904), Belfast (1909), London (1910), and London (special meeting) and Birmingham (1911). Dr. Mayo became president of the Norwich Medico-Chirurgical Society in 1888–9, and was mayor of Great Yarmouth in 1905. He was consulting surgeon to the Great Yarmouth Hospital, and a justice of the peace.

We regret to announce the death of Mr. Richard Bolton McCausland at Folkestone on October 9th. A former resident of Dublin, Mr. McCausland received the diploma L.R.C.S.I. in 1885, and in the next year graduated M.B. of Dublin University. He proceeded M.D. in 1895, and in the same year was elected a Fellow of the Royal College of Surgeons in Ireland. He was senior moderator in natural science at Trinity College, and at one time was a member of the Council, and honorary librarian, of the Royal College of Surgeons in Ireland. He had been visiting surgeon to Dr. Steevens' Hospital, Dublin, and was for some years a member of the British Medical Association. Mr. McCausland married the daughter of Professor C. E. Brown-Séquard (1817–94). who succeeded Claude Bernard in the chair of experimental medicine in the Collège de France, and was successively a professor in the Harvard and Paris medical faculties.

News has been received of the death of Dr. Alfred David Gorman of Blackburn, Lancs, following an operation for appendicitis. For some time after qualifying in 1917 he was in practice at Bathgate, West Lothian, Scotland, but he gave this up for post-graduate study in order to gain higher professional qualifications. He obtained the diploma of F.R.F.P. and S.Glas. in 1920, the M.R.C.P.Ed. in 1929, and the D.P.H. in 1931. Only last July he was elected a Fellow of the Royal College of Physicians of Edinburgh. In 1931 the corporation of Blackburn appointed him assistant medical officer of health and school medical officer, but in January of this year he resigned these posts in order to become a partner in private practice at Blackburn. Dr. Gorman was very popular with his colleagues and much beloved by the general public. His untimely death robs the profession of a gifted member in the midst of his usefulness.

We regret to announce the death on September 24th, following an operation, of Dr. Williams Cock, at Salcombe, at the age of 84. Dr. Cock received the diploma of M.R.C.S.Eng. in 1875, and L.R.C.P.Ed. and L.M. in 1876. While a student at Guy's Hospital he was a prosector at the Royal College of Surgeons of England. He retired in 1906, after over thirty years' work in Peckham, where he was a well-known and busy practitioner. Dr. Cock was an enthusiastic Freemason and a good worker for medical and local charities, and was for many years a member of the British Medical Association. He was a county magistrate for Devonshire. His wife died in November, 1932, and of their six children two sons and one daughter survive him.

The death occurred in Liverpool on October 12th, after a very short illness, of Dr. Ariel Ransford Stewart McElney. Dr. McElney, who was 29 years of age, was the daughter of Major Deacon and Dr. Mary Deacon of Waterloo, Liverpool, and received her education at Roedean School, Brighton. Proceeding to Liverpool University she graduated M.B., Ch.B. in 1928. After leaving the university she was a house-surgeon at the Liverpool Stanley Hospital, where she met her husband, Dr. J. H. McElney. She then took a post at the Bridgwater Hospital and for a short time before leaving for China was in private practice at Northwich. After her marriage in Singapore in 1930 she proceeded to Hong-Kong, where her husband was in private practice, and there obtained a Government post in connexion with maternity and child welfare centres. She leaves behind two young boys, the younger being only two months old. In 1932 Dr. McElney held the office of honorary librarian and treasurer to the Hong-Kong and China Branch of the British Medical Association.

The following well-known foreign medical men have recently died: Dr. Giovanni Carbonelli, a prominent medical historian, editor of the *Bolletino dell' Istituto Storico Italiano dell' Arte Sanitaria*, aged 74; Professor Heinrich Wolff, for many years director of the Hermannswerder Hospital at Potsdam, aged 61; Dr. Silvio Rebebo, professor of pharmacology and therapeutics at Lisbon; Dr. A. Chassevant, a Paris hygienist, aged 68; Professor K. Willmanns, a Heidelberg psychiatrist; Dr. Eric Leschke, professor of internal medicine in Berlin University; Dr. Thompson Seiser Westcott, a Philadelphia paediatrist, and part author with Dr. Louis Starr of *The American Textbook of Diseases of Children*, aged 71; Dr. Julius Gross, professor of children's diseases at Budapest; Dr. Ramon E. Ribeyro, professor of parasitology, and president of the National Academy of Medicine at Lima; and Dr. Carlos Bello de Moraes, professor of clinical medicine at Lisbon.

Corrigendum.—In the obituary notice of Mr. Charles Henry Hough in last week's *Journal* (p. 763) the name of his father should have read James (not Thomas) Hough, F.R.C.S.

Medical News

The annual dinner of the Royal Society of Medicine will be held on Thursday, November 16th, at 7.30 for 8 p.m., at the May Fair Hotel, Berkeley Square, with the president, Mr. V. Warren Low, in the chair. The Earl of Athlone and Sir Ernest Benn will be the Society's guests of honour.

H.R.H. Prince Arthur of Connaught will lay the foundation stone of the new nurses' home of Putney Hospital on Wednesday, November 1st, at 3 p.m.

A meeting of the Eugenics Society will be held at the rooms of the Linnean Society, Burlington House, Piccadilly, W., on Tuesday, November 7th, at 5.30 p.m., when Dr. H. L. Gordon will speak on "Amentia in the East African Native, Considered Psychiatrically and Socially." Sir Humphry Rolleston, Bart., will occupy the chair. Dr. Gordon, who is well known for his work in Kenya, has been making an inquiry, extending over seven years, into the nature of mental deficiency in the East African native. His results suggest that there are important differences between the average brain and average mind of the native and those of the European.

There will be a hearing on November 17th and 18th of a complaint which the Board of Trade has received under Section 1 (5) of the Safeguarding of Industries Act, 1921, that insulin and its salts have been improperly excluded from List H (iii) of articles chargeable with duty under Part I of that Act, as amended by Section 10 of the Finance Act, 1926. The hearing will commence at 10.30 a.m. in the Conference Room, No. 47, Second Floor, Board of Trade, Great George Street, S.W.1, and the tribunal will consist of the Hon. S. O. Henn Collins, K.C., the Referee, Professor F. G. Donnan, F.R.S., and Professor Samuel Smiles, F.R.S.

The council of Epsom College will shortly elect a girl to a St. Anne's Scholarship of £120 a year, tenable at some approved girls' boarding school. Candidates must be at least 9 and not more than 12 years of age on July 30th, 1934, and must be orphan daughters of medical men who, for not less than five years, have been in independent practice in England or Wales. Application must be made by December 16th, 1933, on a form to be obtained from the secretary of the college at 49, Bedford Square, W.C.1.

The Fellowship of Medicine (1, Wimpole Street, W.) has arranged a course in neurology, especially suitable for the general practitioner, at the West End Hospital for Nervous Diseases, from October 30th to November 4th. There will be a course in ophthalmology at the Central London Ophthalmic Hospital from October 30th to November 4th. A week-end course in obstetrics has been arranged at the City of London Maternity Hospital on November 4th and 5th. A course in urology for advanced post-graduates will be given at St. Peter's Hospital from November 6th to 18th. A week-end course in gynaecology will be held at the Samaritan Hospital on November 18th and 19th. Other forthcoming courses include medicine, surgery, and gynaecology at the Royal Waterloo Hospital, November 6th to 25th ; diseases of the chest at the City of London Hospital, Victoria Park, November 13th to 25th ; venereal diseases at the London Lock Hospital, November 13th to December 9th ; proctology at St. Mark's Hospital, November 20th to 25th. Individual clinics in various branches of medicine and surgery are available daily by arrangement with the Fellowship of Medicine.

The Society for Constructive Birth Control informs us that demonstrations of contraceptive technique for medical practitioners and senior medical students will be given at 108, Whitfield Street, W.1, on Wednesday, November 1st, at 2.30 p.m. Application should be made to the honorary secretary of the society at that address.

The September issue of *Watson's Microscope Record*, published by W. Watson and Sons, Limited, 313, High Holborn, W.C.1, contains several notes of practical interest to microscopists, including Part IV of a series on dark-ground illumination.

The issue of the *British Journal of Dermatology and Syphilis* for October contains the following papers connected with Willan, the father of British dermatology: "At the Public Dispensary, with Willan and Bateman," by Dr. Henry MacCormac ; "Willan and Bateman on Fevers," by Dr. J. D. Rolleston ; and "Some Personal Relics of Robert Willan," by Dr. H. Haldin-Davis.

The third biennial Conference on Mental Health will be held at Caxton Hall, Westminster, S.W., from November 22nd to 24th. It will be opened on the evening of Wednesday, November 22nd, by H.R.H. Prince George, President of the National Council for Mental Hygiene.

With reference to the Home Office announcement (*British Medical Journal*, September 23rd, p. 574) regarding the extension of control to methylmorphine (commonly known as codeine) and ethylmorphine (commonly known as dionin) and their respective salts, the Home Secretary gives notice that he is advised that pills and tablets that contain the drugs compounded with any other substance are to be regarded as preparations or compounds containing the drugs, and therefore outside the provisions of the Dangerous Drugs Acts.

At the quarterly court of the directors of the Society for Relief of Widows and Orphans of Medical Men, held on October 11th, with the president, Mr. V. Warren Low, in the chair, three new members were elected and the death of one reported. The sum of £84 10s. was voted for special grants to orphans who had reached the age of 16, to enable them to continue their education, and £625 was voted as a Christmas present to the widows and orphans in receipt of grants ; each widow over 75 years of age to receive £15, those under 75, £10, and each orphan £10. A widow of a member applied for relief, and was voted a yearly grant from the ordinary funds of £50, and one of £25 from the Brickwell Fund. She received at this Court £18 15s., being the amount of the grants for the last four months of this year. A widow, whose death was reported, and who had been in receipt of relief for four years, had received in grants from the society £300. Her late husband was elected a member in 1903 and died in October, 1929. He had paid in subscriptions £52 10s., the maximum amount that an ordinary member can pay in yearly subscriptions before becoming a life member. Relief is only granted to the necessitous widows and orphans of deceased members. Membership is restricted to medical men who at the time of their election are resident within a twenty-mile radius of Charing Cross. Full particulars and application forms for membership may be obtained from the secretary, 11, Chandos Street, Cavendish Square, W.1.

The Grocers' Company offers three medical research scholarships, each of £300 a year, with an allowance to meet the cost of apparatus and other expenses, tenable for one year, but renewable for a second or third year. The next election will take place in May, 1934. Applications must be sent in before the end of April, to the Clerk, Grocers' Hall, London, E.C.2, from whom a form of application and further information may be obtained.

Group Captain Henry Cooper, D.S.O., R.A.F.M.S.(ret.), clerk and registrar of the Society of Apothecaries, was admitted to the Freedom of the City of London on October 17th.

Dr. Friedrich von Müller, professor of internal medicine at Munich, has recently celebrated his 75th birthday.

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.

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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

Chronic Urticaria

"X X" writes: I should be glad to receive suggestions for the cure of a case of chronic urticuria, which has resisted all forms of treatment, including the administration of calcium, ephedrine, and luminal, and the injection of whole blood, peptone, and T.A.B. vaccine.

Trigeminal Neuralgia

"T. M." writes: I have a patient, a married woman, aged 43, who has suffered from this appalling condition for over twenty years. At first each side of the face was attacked on alternate occasions. Now the attacks come on weekly and last about two days—the first day on one side, and the second on the other side. Only the infra-orbital branches are affected. *X*-ray examination reveals nothing abnormal. Can anyone suggest any mode of treatment or give me information regarding results following alcohol injections?

*** Dr. Wilfred Harris's paper on the treatment of trigeminal neuralgia in the *British Medical Journal* of July 16th, 1932 (p. 87), dealt in considerable detail with alcohol injection in preference to open Gasserian operation.