symptoms became progressively worse, and in two months the patient had dropped from 9 st. 8 lb. in weight to 6 st. 10 lb.

Examination.—The patient was emaciated, there was tenderness in the epigastrium, and the left rectus was a little more resistant than the right. The stomach was not enlarged. There was no splashing and no hyperaesthesia.

X-Ray Report (Dr. W. H. Steele).—"This case was originally for *x*-ray of the chest, as she was thought to be suffering from tuberculosis. There was no evidence of lung trouble, and a barium meal was suggested. On screening, after swallowing a small quantity of barium emulsion, the stomach appeared normal, but after the emulsion passed through the first and second portions of the duodenum a shadow appeared in close relation to the lesser curvature of the stomach. After completion of the meal a film was taken, which clearly shows this shadow lying close to the left side of the third lumbar vertebra. This I diagnosed as diverticulum of the fourth portion of the duodenum. I was able to demonstrate clearly that the shadow was not connected with the lesser curvature of the stomach, thereby excluding the possibility of a penetrating gastric ulcer."

Operation.—On April 3rd, 1931, laparotomy was performed through a right paramedian incision. The stomach, first part of the duodenum, and gall-bladder appeared normal, and there was no sign of diverticula of the colon. On raising the transverse colon to examine the duodeno-jejunal junction, a fold of peritoneum was noticed running from the body of the pancreas downwards to the left across the duodenum, and terminating on the jejunum about two inches below the junction. When the fold was raised in forceps and pulled up, the first part of the jejunum stood out like a small pouch, and it was thought that this might have produced the shadow seen on the radiogram. The fold was then divided, and, with the duodenum exposed and lying alongside, the diverticulum was seen, appearing rather like a hernial sac. The apex of the diverticulum was next seized with forceps and stripped with a gauze swab, then the base was divided, and the resulting gap in the duodenum sutured transversely in two layers. The abdomen was closed without drainage. Vomiting ceased after the first day, and convalescence was uneventful.

DISCUSSION

Of all diverticula recorded in connexion with the intestinal tract, 1.6 per cent. are found in the duodenum, 15 per cent. of these in the third or fourth part (Kellog). Of those in the third or fourth part, to every eight found in females two are found in males. This may be due to the greater frequency of visceroptosis, and consequent duodenal stasis, in the female sex. Congenital and acquired varieties are described, and the latter is further subdivided into true and false.

In my case the diverticulum proper was composed of a thin layer of muscle with the submucosa and mucosa, and measured 2.9 cm. across the base and 2.4 cm. from the base to the apex. The serous coat was nowhere attached to the pouch, but a fold of peritoneum lay in front of it. In a case reported by Carnot and Peron, when the transverse colon and mesocolon were raised the diverticulum was seen hanging from the anterior surface of the duodenum, covered by all the layers of the intestine. But the majority of diverticula lie behind the peritoneum, and the peritoneum must be incised before the pouch comes into view. The pouches are usually empty, but fill during the passage of food, and may contain stones or foreign bodies. The sac may become inflamed and suppuration or gangrene may supervene. The symptoms in the case recorded here did not correspond to any of the five classical groups described by Bensaude, so it is doubtful if there is any definite symptomatology. In my case also the symptoms were initiated by the filling of the sac, and relief followed its emptying. The vomiting, which was such a predominant feature, may have been caused mechanically by pressure against the duodenum or from a drag on the jejunum by the peritoneal band, or perhaps reflexly by pressure on surrounding structures. The type of pain varies; it is described differently by different patients. The wasting was doubtless due to starvation and the constipation a result of the general dehydration. Inflammation may occur, with the usual symptoms of nausea, vomiting, pain, pyrexia, tenderness, and muscular rigidity. When diverticula are associated with other lesions the symptoms are those of the prevailing lesion. The physical signs are unreliable, but radiography affords a definite diagnosis. In this case the diagnosis was made before I saw the patient.

As regards treatment, Spriggs and Marxer report improvement in thirteen out of eighteen cases treated by medical methods, but I cannot see how medical treatment can be of much value if the symptoms are caused by the diverticulum. Diverticula which cause no symptoms should be left alone, but those which do cause symptoms should certainly be explored. The ideal treatment is excision, but if this is impossible the diverticulum may be invaginated. A short circuit of the diverticulum-bearing part of the bowel is to be considered. In this case, in which the diverticulum occurred in the fourth part of the duodenum, duodeno-jejunostomy might have been tried. Such a step would obviate any chance of atresia at the site of the lesion, and the consequent duodenal stasis. Where a diverticulum has been demonstrated by radiography it is not sufficient to examine the duodenum alone. Incision of the peritoneum is also necessary. The duodenum should be mobilized and a retroperitoneal examination made. Complications may call for immediate laparotomy, as in any other abdominal disaster. It has been said that in no case have symptoms been permanently relieved by operation on a duodenal diverticulum, and for that reason I have delayed publication until two years have elapsed since the operation. This patient to-day remains in excellent health, and there has been no return of the symptoms.

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Memoranda

MEDICAL, SURGICAL, OBSTETRICAL

A DIVERTICULUM OF THE DUODENUM

(With Special Plate)

The following case seems of sufficient interest to be worthy of record.

Mrs. F., a married woman aged 57, came to see me complaining of chronic want of appetite. She told me that she never knew what it was to feel hungry, and that she suffered from a constant lassitude, general weakness, and inability to perform her household duties. She also stated that she was liable, from time to time, to sudden attacks of acute vomiting and diarrhoea. All her life, from an early age, she has suffered from what she termed "bilious attacks," consisting of a sudden onset of acute vomiting and diarrhoea. This would come on without warning in the night, waking her out of sleep; relief would come in about four hours' time, and the next day she would feel listless and tired, but after twenty-four hours would be able to go about as usual. The attacks occurred with a fair regularity about every six weeks. They were never accompanied by any pain or colic, and there was never any indication when they were about to come on. Her appetite has always been poor; she never had any pain after taking food, nor any hunger pain beforehand. She has never been jaundiced or had any pain referred to the gall-bladder. Once she had a pain in the neighbourhood of the right groin, which she was told was due to her appendix.

There has been some pain over the left lower ribs and renal region, said to be due to a floating kidney. There have been no other illnesses. The patient has never had any children.

In appearance she is a tall and delicate-looking woman, thin and anaemic, with rather a worn expression. On examination the pulse and temperature were normal, the tongue was clean, and the heart and lungs were normal. Careful palpation of the abdomen revealed nothing abnormal. There was no tenderness in the right hypochondriac or epigastric regions. The right iliac region was very slightly tender, suggesting a morbid condition of the appendix. Otherwise all objective signs were absent.

The patient was subsequently advised to have a barium meal. The film (see Special Plate) shows a large air space, with a fluid level below, occupying the region of the second part of the duodenum. This is, in my opinion, a large diverticulum arising from the junction of the first and second parts of the duodenum. There is no ptosis of any of the viscera. The fluid portion is evidently stagnant, and is comparable to residual urine in the bladder in enlarged prostate. It is probable that the contents become toxic from stagnation, and that the attacks of vomiting, etc., are due to their being emptied from time to time into the intestinal tract, where they set up an intense irritation. Later examination revealed a gall-bladder which was found to fill and empty itself normally. The report also mentioned that the appendix did not fill properly, and was not to be made out, and with the tenderness (above mentioned) was in a pathological condition of a chronic nature.

I am indebted to Dr. Brewis of Scarborough, who is responsible for the films of the case.

CHARLES E. SALTER, M.D., B.S.,
F.R.C.S.Eng.

BIRTH ON THE RAILWAY TRACK

In the *Journal* of June 17th (p. 1090), a live birth on a railway track in India was recorded, whilst the train was travelling at twenty miles an hour. Other remarkable features of this birth were that the infant bounced on a steel rail and escaped injury from an oncoming carriage wheel, which severed and sealed off the umbilical cord. I am aware of the lavatory accommodation provided on Indian railways for the use of persons accustomed to the squatting posture, and I think that the circular aperture is not less than four inches in diameter. This aperture is for some unknown reason always placed over one or the other of the steel rails. On British railways the aperture occurs midway between the rails. Sometimes a movable trap-door operated by the flushing mechanism is placed at the outlet, but in the majority of carriage lavatories no trap-door exists. These preliminary remarks have an interesting bearing upon the live birth of an infant at Paddington Station, G.W.R., on August 9th, 1933.

THE PADDINGTON BIRTH

The 9.50 p.m. train had departed from Paddington No. 1 platform for Bristol and Plymouth when an infant with cord and placenta attached was seen lying between the rails. A midwife who was present breathlessly gave instructions to a ticket collector to place the placenta upon the chest of the infant (to avoid traction at the umbilicus) and hand it up to her. The infant complete with appendages was received upon a pillow, wrapped in rugs, and hurried by taxi to St. Mary's, where it was found to be uninjured and to weigh 7 lb.

The rest of the story is like a tale of adventure. The telegraph wires parallel to the railway hummed with excitement as they did on that memorable occasion when Tawell, the first criminal to be shadowed by telegraphy, was eventually apprehended at Paddington. Immediately the discovery was made the Great Western Railway authorities at Paddington telegraphed to Slough for the train to be stopped and searched for a parturient mother. The Slough police summoned a doctor and a nurse to the railway station, and when the train arrived inquiries were made "whether anybody required medical assistance." The spot where the infant lay at Paddington enabled the stationmaster to calculate from which carriage the infant had dropped, it being assumed that the train was stationary at the moment of birth. This particular carriage received the most attention at Slough. Furthermore, inquiries at Paddington cast suspicion on two women who approached a ticket collector and asked that they might be allowed to return to Bristol by this 9.50 train, as one of them had severe abdominal pains and "appendicitis was feared." The two women, being excursionists from Bristol, were due to return by the excursion train at 11 p.m., but owing to the reason offered their tickets were specially endorsed so that they could travel on the 9.50. Now it was unfortunate for all concerned that this tit-bit of information came too late for the searchers at Slough. Nobody volunteered for free medical treatment and the train was allowed to proceed. One of the ticket collectors at Slough, however, reported the existence of the two endorsed tickets on the train, and it was decided to effect a *coup* at Reading.

The police at Reading were now faced with a medico-legal problem. They mistakenly understood that the child was dead, was possibly a stillbirth, and therefore the only feasible charge could be that of "concealment of birth." Now "concealment of birth" being merely a misdemeanour, no arrest could be made. The train was stopped at Reading and all the passengers were asked to line up on the platform. The sign of blood upon the floor indicated the parturient mother, and the names and addresses of herself and her companion were taken. All were allowed to resume their seats and the train once more departed on its rather hesitant way. Further delay was still to come. Hard on the lights of the departing train there came the news that the infant was alive! The charge became more serious, and was advanced to "abandonment of the child"—for had she not abandoned her living child between the rails at Paddington? The charge assuming the magnitude of a felony, she could now be arrested. The train was stopped at Swindon, and she and her mother (as the other woman happened to be) were taken into custody. I understand from the railway authorities that the young mother was unmarried and that she had a very trying puerperium. When she faced the charge subsequently her defence was that she was in too much bodily and mental agony at the time of the birth to know what was happening. The case was dismissed.

This case is of unusual interest because of the rapidly moving culprit and the rapidly changing medico-legal position. I have made inquiries and find that the closet concerned had no trapdoor. The narrowest diameter of the vent negotiated by the foetus was exactly four inches, and the drop to the permanent way was about four feet. I am informed that the G.W.R. know of a case where a dead child had been found impacted in such a closet vent.

I am indebted to Mrs. Lucas, the midwife concerned, various employees of the G.W.R., and to members of the Slough police for essential details.

N. C. HYPHER, B.Sc., M.R.C.S., L.R.C.P.

EVIPAN SODIUM IN THE MANIPULATIVE TREATMENT OF SCIATICA

Evipan sodium, a barbiturate derivative manufactured by Bayer Products Ltd., has been used very extensively in this country and abroad for the purpose of producing complete anaesthesia of short duration—for example, fifteen to thirty minutes. The substance is put up in ampoules containing 1 gram, and a corresponding number containing 10.5 c.cm. of distilled water are supplied. A solution is prepared immediately before use by withdrawing the water and injecting 10 c.cm. into an Evipan ampoule. The salt is very soluble and forms a clear solution which is then introduced intravenously. The injection should be given slowly—that is, not more than 1 c.cm. in ten seconds, and the patient should during this time count aloud. Quite suddenly the voice falters over two consecutive numbers and the patient is asleep. For manipulative work I habitually give half as much again as the quantity required to induce sleep. In powerfully

built men the volume administered is about 7 c.cm. At this juncture there is complete muscular relaxation, stertorous and slow breathing, and quite often cyanosis. The last feature is transitory and need give rise to no alarm.

The especial value of evipan in manipulation, particularly when dealing with the spine and sacro-iliac joints, is the combination of complete relaxation which is essential to success and the freedom of movement given to the manipulator, whose patient has no longer to be followed in all three planes of space by a harassed anaesthetist.

It is still insufficiently appreciated that a great number of cases of sciatica are actually supplied by patients who suffer from referred pain arising from strains, adhesions, of fibrositis in the lumbo-sacral and sacro-iliac regions, and are not in fact examples of true sciatic neuritis. This "central sciatica" is responsible for a group of partially disabled individuals who suffer intermittently for months or years, and who can usually be cured by adequate manipulation *provided that their postural errors be subsequently corrected by remedial exercises.* It is failure to observe this precaution that has led many neurologists to discard manipulation as a therapeutic measure.

It is for the treatment of such cases that I want to emphasize the value of this new anaesthetic, which is certain and rapid in action, yet of short-lived effect and devoid of unpleasant after-sensations.

London, W.1. A. H. DOUTHWAITE.

Reports of Societies

WARD AND DORMITORY INFECTIONS

A discussion on ward and dormitory infections, including the exanthemata, took place at the Medical Society of London on November 27th, Sir WILLIAM WILLCOX presiding.

Dr. J. ALISON GLOVER said that ward infections, happily, no longer held the terrors which they did in a previous generation, but less obvious forms were still prevalent. The diseases in which ward infection had been reported in recent years might be divided into two groups: contagion and droplet infection. Some diseases, notably puerperal fever, obviously belonged to a mixed group, and probably most of the droplet infection group could be carried by direct infection, as, for example, by tableware. The contagion group included enteric fever, infantile diarrhoea, pemphigus neonatorum, among others, while droplet infection included pneumonia, influenza, and the important diseases associated with the haemolytic streptococcus. Of the contagion group enteric fever formed a typical example, and, despite its low incidence of recent years, this had been seen too frequently as a ward infection. Various factors had combined to cause ward infections of enteric fever, chiefly delayed or mistaken diagnosis, defective nursing technique, insufficient or faulty ward equipment, overcrowding, and the staff carrier. Ward infection in lying-in hospitals causing morbidity in the newly born, often accompanied by outbreaks of diarrhoea in the adult patients and staff, was still seen. The nursing technique in a lying-in ward was peculiarly exacting, and to maintain it at the necessary high level with a staff in which obstetric nurses were often far outnumbered by pupils in training was very difficult. Skilled planning and good design were required in every detail. Overcrowding in a lying-in ward operated disadvantageously, not merely by facilitating droplet infection from bed to bed, but by immensely increasing the difficulty and strain of nursing and the likelihood of lapses in nursing technique. His experience showed that an outbreak of pemphigus or other septic infection among infants or mothers in a maternity hospital was almost invariably preceded by overcrowding. With regard to pneumonia, Dr. Glover mentioned that some time ago he investigated an outbreak of influenza in a public school in which a good many cases were complicated by pneumonia. It appeared to him that half the cases of pneumonia were cases of influenza on admission and the pneumococcal infection was received in the sanatorium wards, some of which were not cross-ventilated, and all of which were overcrowded. As for streptococcal infections, the introduction of an epidemic strain of streptococcus provided an acid test of hospital efficiency. Its spread might be facilitated by influenza or epidemic coryza, but in any case such spread revealed a chink in the armour. It had been proved by serological methods that patients in fever hospital wards might repeatedly be infected with different serological types of the haemolytic streptococcus, and many of the so-called complications of scarlet fever particularly were really due to fresh infection occurring in the ward with a strain of haemolytic streptococcus of different serological type from that which was present in the patient's throat on admission. Another form of streptococcal infection was seen in wards devoted to acute rheumatism. Several outbreaks of acute rheumatism following ward epidemics of throat infection with haemolytic streptococcus had occurred at various hospitals. He also insisted upon good spacing and cross-ventilation in recovery wards for post-tonsillectomy cases, for the post-operative complications were not negligible. Finally, he mentioned the minimum space figures of the Ministry of Health for isolation hospitals for infectious disease—namely, 9 feet between beds, 12 feet wall space per bed, and 144 square feet per bed.

Dr. J. C. SPENCE (Newcastle) recalled the work of James Young Simpson, who had insisted that the solution of the problem of ward infection depended upon the building of hospitals with small wards and ample air space. Had Lister's discovery been postponed for a few years Dr. Spence thought that there would have arisen much sooner the kind of hospitals advocated by the previous speaker. Each institution had its own problem. In one home for the mentally defective, with an inmate population of 430, he found that during the last five years there had been six cases of measles, ten of mumps, five of scarlet fever, twenty-one of chicken-pox, and one big outbreak of influenza, in which 199 persons were infected, but no other infectious disease. In another colony, with about the same population, there had been in five years five cases of measles, fourteen of scarlet fever, fourteen of diphtheria, and an outbreak of influenza with 167 cases. In some cottage homes on the outskirts of Newcastle, harbouring 220 children from 3 years upwards, who travelled to the village school each day, there had been in five years one outbreak of whooping-cough, involving sixty children, one case of scarlet fever, and a very few cases of measles and mumps, but no other infectious disease. In a resident school for 120 deaf-and-dumb children, thirty of whom had chronic ear discharge, the amount of contagion or droplet infection proved to be greater among the twenty members of the staff than among the children. In the staff the prevailing illness was septic tonsillitis, whereas among the children the prevailing infection was a skin sepsis. The floor space of the dormitories was adequate, but the children, being deaf-and-dumb, had a habit at night of pushing their beds together so that they might communicate with each other by touch. From these and other institutions he concluded that there was little to criticize in most institutions in the country, such as homes for the mentally defective, residential schools, and orthopaedic institutions. In hospitals it was a little difficult to get figures in the same way, and perhaps a little unfair to rely upon figures. The old days of hospital fever and gangrene had gone, but he thought that there were still surgical wards in which a mild form of hospital septic infection was passed from one case to another. He noticed with what readiness a three days' fever was regarded as due to influenza. He suggested that in the surgical ward these mild three-day or five-day infections were lingering evidences of what sixty-five years ago would have been a virulent hospital fever. During the past four years in Newcastle hospitals

F. T. RANSON AND L. McGOLRICK: LUNG ABSCESS FOLLOWING TONSILLECTOMY

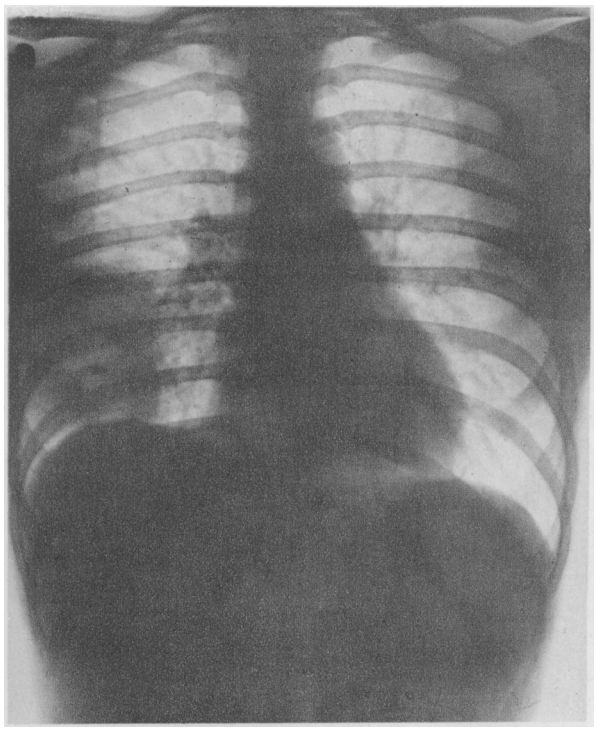


FIG. 1.—Miss M. Showing opacity due to abscess formation at the right base of lung.

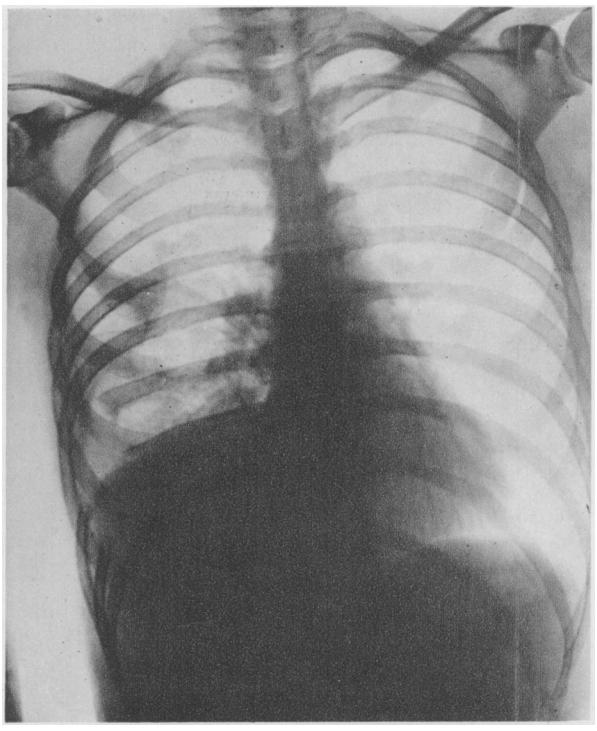
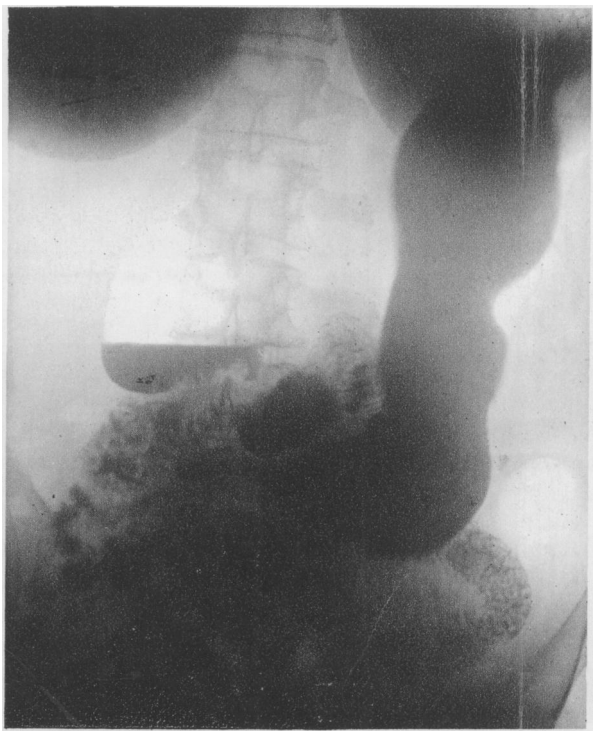


FIG. 2.—The same six weeks later, and more than five weeks after rib resection.

DAVID CROMIE: A DIVERTICULUM OF THE DUODENUM

Ten minutes after full ingestion of meal, showing filled diverticulum against body of third lumbar vertebra and a gas bubble above.

CHARLES E. SALTER: A DIVERTICULUM OF THE DUODENUM



Large diverticulum of junction of 1st and 2nd parts of duodenum, showing large aircap with constant fluid level below: appearance the same after three hours.

failing health, this matter was dropped. It is very pleasing to be able to record that his manuscripts are now in the hands of his son, Richard Bickerton, and the work will soon see the light of day. He was the son of an ophthalmic surgeon, his brother and two sons have followed the same branch of our profession, and his sister married a distinguished ophthalmic surgeon, Dr. Webster Fox of Philadelphia. Mrs. Bickerton predeceased him.

The following extracts from appreciations which appeared in the *Liverpool Daily Post* on the day following Mr. Bickerton's death give some indication of the esteem in which he was held by his colleagues.

Mr. W. E. LIVSEY wrote: By the death of Mr. Bickerton the North of England and North Wales has lost one of the area's most distinguished ophthalmic surgeons. Thousands owe the blessing of sight to his patient care and skill. His training and wide experience were always freely at the service of those attending the institutions with which he was associated. As a teacher he was sound and painstaking, but he was essentially a practical man, and his skill and success as an operator could not be surpassed. His kindness and gentleness to patients, whatever their station, was striking, and there can be few to whom the title of the " gentle doctor " can be more appropriately applied.

Mr. A. MCKIE REID wrote: The passing of Mr. Bickerton must, as does that of any pioneer, sadden many who followed his specialty. He was one of the first to dissociate the practice of ophthalmology from that of other branches of surgery. As an operator he was peerless, and it was sheer joy to watch the faultless technique and smooth rhythm of his work. In addition to a very large clinical practice, he found time to investigate many problems. His confidence inspired the like in his patients, who came and returned from every corner of the world to consult him. He worked and fought strenuously for any cause which he had at heart. His example and inspiration guided the steps of many ophthalmic surgeons in practice to-day, who must always remain grateful for his teaching.

Mr. C. ALSTON HUGHES wrote: A great personality has passed to a rest which he ever denied himself in his working life. If I were asked the most prominent feature of his professional life, I, who sat with Livsey at his feet while ailing devotees passed through his clinic at the Royal Infirmary, would answer with the one word " Success." Success in practice, that elusive quality, seemed inborn. When operating he seemed to know exactly just how far to go. The standard he had set himself was: " If this were my own eye, should I like this operation or treatment carried out? " I do not remember one instance when he flouted this highest ethical and self-imposed rule. I cannot remember anyone who so consistently and pleasantly attained the result we all seek—success in the objective and satisfaction of the patient. The mastery and gentle care of the individual patient, coupled with clinical wisdom and operative dexterity, were the aim and glory of T. H. Bickerton—a kindly genius, a master of the older school.

The following well-known foreign medical men have recently died: Dr. MAURICE HANRIOT, member and treasurer of the Académie de Médecine and Commander of the Legion of Honour, aged 80 ; Dr. TITUS VARAEC, senior physician to the hospital at Lwow, aged 55 ; Dr. KOPCZYNSKI, inspector-general of school hygiene at Warsaw ; Professor RECASENS, dean of the faculty of Madrid, aged 70 ; Dr. JOHN MILTON DODSON, for many years dean of Rush Medical College, Chicago, and more recently director of the Bureau of Health and Public Instruction of the American Medical Association, aged 74 ; Dr. GEORGES JOANNOVIC, professor of pathology and dean of the faculty of medicine at Belgrade, aged 62 ; Dr. OTTO SARWEY, professor at the gynaecological clinic at Rostock, aged 68 ; Dr. CARLOS M. CORTEZO, ex-director general of public health, and ex-president of the Spanish Academy of Medicine, aged 82 ; and Professor SEIDEL, a Marburg stomatologist, aged 47.

Medico-Legal

DEATH AFTER OPERATION

Preoperative Use of Nembutal

An inquest was held at Paddington on November 24th on the death of Winifred McNabb, aged 38, the wife of an officer in the Indian Civil Service, which had occurred in a nursing home in Devonshire Place following an operation.

Mr. R. J. McNeill Love, surgeon, of Harley Street, in reply to Mr. Ingleby Oddie, the coroner, said that Mrs. McNabb had had an operation for appendicitis in India a year previously. She continued to suffer from a vesico-vaginal fistula, for which he advised an operation. This took place on the previous Monday. She had an infected right ovary and extensive signs of old pelvic peritonitis. The operation took two hours, but it was successfully concluded. The patient, however, never recovered consciousness, and died on the Wednesday. She had received on the day before the operation 1½ grains of nembutal, and a further 3 grains on the following morning. He had approved of nembutal being given. The woman was of a highly nervous temperament and requested it herself, as she had found it worked well at her previous operation.

Dr. Herbert Charles, anaesthetist to the Middlesex and Royal Masonic Hospitals, said that he visited and examined the patient the night before the operation, when she particularly requested one of the barbiturates. He said that he would allow her to have nembutal in the smallest dose, provided it was given by the mouth ; he would not administer it intravenously. The amount given was 1½ grains ; it was not uncommon for a single dose of 5 grains to be given, although he himself had never given as much. Next morning, to her disappointment, she was fully awake. He then ordered morphine and atropine hypodermically, and gave two further capsules of nembutal (totalling 3 grains), again by the mouth. This was from half an hour to three-quarters of an hour before the operation. The anaesthetic used for the operation was ethyl chloride with an open mask, followed by light open ether induction. Before she left the operating table her reflexes were returning—the pupils were rolling, the light reflex, the corneal reflex, and the " blowing lid " reflex were all present—and he was satisfied with her condition. Later the nurse said she was coming round and a little excited ; he then administered omnopon, which quieted her for the time being. Next day she did open her eyes once or twice, but she remained unconscious mentally, and from that state she gradually sank, and died on the following morning. The witness added that he had used nembutal on occasion since its introduction, but always by the mouth, and in no instance had the patient failed to recover consciousness. He knew that nembutal was dangerous in septic cases, and he would not knowingly administer it to such a case, but here there were no signs of toxaemia before operation, and the temperature had been normal for over a week.

Mr. Love, recalled, said that after the operation in the early morning the patient remained in a satisfactory condition until the afternoon, when her pulse rose and her condition became somewhat alarming. She had a blood transfusion, and saline and glucose were given during the night. Early the next morning he called in Sir William Willcox, who agreed that her condition was serious, and suggested lumbar puncture and more infusions. She developed pneumonia before death. He had not seen a fatal termination after nembutal before. He knew that nembutal was more dangerous in toxic cases, but here there was no marked toxicity.

Dr. Roche Lynch said that in the cerebro-spinal fluid he found the presence of a member of the barbituric acid group. It was not in sufficient quantity for him to say definitely which it was, but from the evidence there was no doubt that it was nembutal. In the eleven ounces of fluid sent to him there was nearly one-third of a grain—a considerable amount—and in some six or seven ounces of urine about a quarter of a grain. Nembutal, a comparatively new drug, was made up in capsules of 1½ grains, and doses had been given up to three capsules or more. It was considered more toxic when given intravenously than by the mouth, because intravenously its action was so much more rapid. One could not

Cheap Celluloid Toys.—Replying to Mr. Sutcliffe, on November 23rd, Sir JOHN GILMOUR stated that in 1923 the Royal Commission on Fire Brigades and Fire Prevention drew attention to the risks to children by fire from cheap celluloid toys. Since then accidents from celluloid toys had occasionally come to the notice of the Home Office, including one case where there was a fatality. So far as the Home Office was concerned, nothing further could be done without legislation.

Death Certification.—Replying to Mr. Hall Caine on November 27th, Sir HILTON YOUNG said that he was aware of a recent case where a death certificate was issued while the individual concerned was still alive. The question of provision for the medical verification of the fact of death was fully discussed during the passage of the Births and Deaths Registration Act, 1926, and he was not prepared at present to introduce further legislation.

Notes in Brief

The number of men receiving old age pensions under the Widows', Orphans' and Old Age Contributory Pensions Acts, 1925–32, at September 30th, 1933, was 439,341, exclusive of men over 70 in receipt of pensions granted by virtue of those Acts but chargeable to the Old Age Pensions Vote.

The Services

His Majesty has approved the appointment of Colonel A. W. M. Harvey, I.M.S., as honorary surgeon to the King in succession to Brevet Colonel J. McPherson, C.I.E., I.M.S., who has retired.

No. 14 STATIONARY HOSPITAL

The fourteenth dinner of the medical officers of No. 14 Stationary Hospital was held on November 24th, with Colonel Evans, D.S.O., in the chair. The number of those attending was as high as in previous years. Colonel Evans, proposing the toast of "The Hospital," related some intimate details of the circumstances attending its inception, to which others present contributed reminiscences. Messages were read from many unable to attend on this occasion, indicating continued support in the future for a very popular reunion.

Universities and Colleges

UNIVERSITY OF CAMBRIDGE

Among the Graces which passed the Regent House at a congregation held on November 17th was one approving the recommendation contained in the amended report, dated May 20th, 1933, of the Syndicate on the Medical Courses and Examinations of the University, with a substitution amending para. 23 of Section 7, relating to the thesis and examination of candidates for the M.D. degree, which was published in the *University Reporter* of November 7th.

The Faculty Board of Medicine has appointed Dr. G. S. Graham-Smith, Dr. T. S. Hele, Dr. S. Melville, Dr. E. P. Cumberbatch, Professor S. Russ, and Dr. R. J. Reynolds to be members of the Committee for Medical Radiology and Electrology for the year 1934.

UNIVERSITY OF LONDON

A meeting of the Senate was held on November 22nd, when the Vice-Chancellor, Professor L. N. G. Filon, F.R.S., was in the chair.

Dr. R. W. Scarff was appointed to the University Readership in Morbid Anatomy and Histology, tenable at Middlesex Hospital Medical School as from October 1st.

The date of Presentation Day in 1934 has been changed from Wednesday, May 9th, to Thursday, May 10th.

At the celebration of Foundation Day, on November 24th, the degree of Doctor of Science, *honoris causa*, was conferred on Sir Thomas Barlow, Bt., in presenting whom to the Chancellor the Public Orator said: "There are few men living who have had a longer or more intimate connexion with this University, or have shed greater distinction upon her. The most distinguished clinician of his day."

Medical News

On the afternoon of Friday, December 8th, H.R.H. The Prince of Wales, as President of St. Bartholomew's Hospital and a perpetual student of the college, will visit the new Medical College in Charterhouse Square (formerly the Merchant Taylors' School) in order to inspect the site and the buildings.

The Sheffield medical dinner will be held at the Royal Victoria Hotel on Thursday, December 7th at 7.45 p.m., when the guests will be Lord Moynihan, the Vice-Chancellor of the University of Sheffield, Professor J. B. Leathes, F.R.S., and Professor G. A. Clark. The dinner is limited to members of the profession, and tickets (13s. 6d. each) may be obtained from the honorary secretary, Dr. T. E. Gumpert, 331, Fulwood Road, Sheffield.

The annual dinner and dance of the North-West London Medical Society will be held at the Park Lane Hotel on Thursday, December 7th, at 8 p.m. Tickets (12s. 6d. each) can be obtained from either Dr. J. Orrett Musson, 10, Chichele Road, Cricklewood, N.W. (telephone: Gladstone 3232), or Dr. Lionel M. Green, 50, Brook Street, W. (Mayfair 1626).

A meeting of the Fever Hospital Medical Service Group of the Society of Medical Officers of Health is being held in the home of the society to-day, Friday, December 1st, at 4.30 p.m., when Dr. H. S. Banks gives his presidential address on "The Use and Misuse of Antitoxin."

A general meeting of the Medical Officers of Schools Association will be held at 11, Chandos Street, Cavendish Square, W., on Friday, December 8th, at 5 o'clock, when Sir Weldon Dalrymple-Champneys will read a paper on "Undulant Fever." Tea will be served at 4.30 p.m.

The meeting of the Royal Sanitary Institute on December 12th, at 5.15 p.m., at 90, Buckingham Palace Road, S.W., will be devoted to a discussion on practical and scientific problems of the milk supply and their laboratory control, with Professor W. W. Jameson in the chair.

The next meeting of the Society for the Study of Inebriety will be held at 11, Chandos Street, Cavendish Square, W., on Tuesday, January 9th, 1934, at 4 p.m., when Sir William Willcox will open a discussion on "Medico-legal Aspects of Alcohol and Drug Addiction."

The annual congress of the British Institute of Radiology (incorporated with the Röntgen Society) will be held in the Central Hall, Westminster, on December 6th, 7th, and 8th. The official opening by Lord Horder will take place on Wednesday, December 6th, at 2.30 o'clock, and Dr. Stanley Melville will give his presidential address at 5 p.m.

A course of twelve lectures on geology in the service of man will be given by Dr. R. M. Craig at the Imperial College of Science (Royal College of Science, Old Building), Exhibition Road, South Kensington, on Mondays, Wednesdays, and Fridays, at 5.30 p.m., from December 11th to 22nd, and from January 3rd to 15th inclusive. Admission free.

A debate has been arranged by the Fellowship of Medicine for Thursday, December 7th, at 8.30 p.m., in the lecture hall of the Royal Society of Tropical Medicine and Hygiene, 26, Portland Place, W. The motion will be "That operations for the removal of tonsils are too often performed without adequate cause." Sir StClair Thomson will occupy the chair. Mr. Herbert Tilley and Dr. J. Alison Glover will propose the motion, and Dr. Dan McKenzie and Mr. Archer Ryland will oppose it. The debate will then be thrown open for discussion and a vote taken. All members of the medical profession are invited to be present. During 1934, on the second Saturday in each month, a lecture-demonstration will be given at 3 p.m. at the National Temperance Hospital, Hampstead Road, N.W., and on every Tuesday at 2.30 p.m. a lecture-demonstration at 11, Chandos Street, W.

The annual report for 1932 of the Gordon Memorial College, Khartum, states that more attention is now being devoted to the liberal or cultural, as opposed to the purely professional, side of education, and changes in the staff, curriculum, and organization have been made accordingly. This is due to the fact that the number of vacancies on the Government teaching staff is now much less than in previous years, and consequently a wider outlook has to be taken as regards the pupils at this institution. The Syrian members of the staff have now been replaced by Sudanese. The number of boys fell from 534 in 1931 to 470 in the year under review; of these 342 were Arabs. The biology classes are now being conducted at the Kitchener School of Medicine, and the instructional workshops have been amalgamated with those of the Omdurman Technical School. The buildings thus vacated have been equipped for other purposes. A reasonably full course of secondary education is available, and special efforts are now being made to train boys for posts other than those under the Government. In the fourth-year class of the scientific section there were thirteen boys, of whom nine have been admitted to the Kitchener School of Medicine. Physical training forms an important feature of the regular morning programme, taking place at 6.30 a.m., before morning school, and lasting for about twenty-five minutes. The year under review was the twenty-eighth in the annals of the Higher School. Researches conducted by the Wellcome Tropical Research Laboratories included the bionomics and control of insect pests, the preparation of antirabic vaccine, and the investigation of the spinal fluid pressure in syphilis.

On May 27th it was announced that a scheme of research fellowships had been endowed in accordance with a direction in the will of the first Viscount Leverhulme. On August 16th a first list of seventeen fellows was issued. Two further fellowships have now been awarded by the advisory committee and approved by the trustees—namely: Miss E. M. Denby (organizing secretary, Kensington Housing Trust, Ltd.), to study slum clearance and rebuilding at home and abroad; Miss D. A. E. Garrod, M.A.Cantab., B.Sc.Oxon., excavation of Palaeolithic cave sites on Mount Carmel, Palestine. Further information may be obtained from the secretary, Dr. L. Haden Guest, Leverhulme Research Fellowships, Union House, St. Martin's-le-Grand, E.C.1.

According to statistics recently published by the International Labour Office the country with most medical practitioners is England, with 1 doctor to every 822 inhabitants, then come Norway, Italy, and Switzerland, with 1 doctor to every 1,067, 1,218, and 1,231 inhabitants respectively. In Hungary, Esthonia, Germany, Denmark, France, Holland, and Luxembourg the proportion ranges from 1 to 1,290 to 1 to 1,556, Belgium and Sweden have 1 doctor to 2,344 and 2,744 respectively, while in Bulgaria, Poland, and Yugoslavia there is 1 doctor to every 3,059, 3,332, and 3,568 inhabitants respectively.

The Canadian multi-millionaire, Carlo Millar, who died in 1926, left six and a half million lire as a prize for the woman who gave birth to the largest number of children in the six years following his death. At the present time the woman most likely to win the prize is an Italian, who is the mother of twenty-one children (six of them born after the millionaire's death), and is now expecting a twenty-second.

The tercentenary of the birth of Ramazzini, the first writer on industrial hygiene, was recently celebrated at Milan.

Dr. Max Nonne, professor of neurology at Hamburg, has been made an honorary member of the Medical Society of Copenhagen.

Dr. Hulüsi Behdjet has been nominated professor of dermatology at the newly established University of Constantinople.

A museum of medical history has recently been opened at the Ospedale de Santo Spirito in Rome.

Professor Ernst Klummer has succeeded Dr. Albert Jentzer in the chair of surgery at Geneva.

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.**

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QUERIES AND ANSWERS

Treatment of Oedema of Face

Dr. G. M. TORRANCE (Hednesford, Staffs) writes: I should be very grateful for information regarding the treatment of a young woman, aged 21, who has had oedema of the cheeks, especially marked under the eyes, since 1930. The condition is painless, and there is no pricking sensation which one would associate with angioneurotic oedema. The girl appears to be quite healthy in every other way. The condition has been improved by injections of colloidal calcium, with ostelin, and subsequently 15 grains of calcium lactate daily. Improvement is not maintained.

Impacted Third Molars

Mr. A. M. NODINE, M.R.C.S., L.D.S. (London, S.W.19), writes: In the *Journal* (November 18th, p. 953) Dr. T. B. Hewson calls attention to an article in the *New York Medical Journal* of November 8th, 1919, on "Impacted Lower Third Molars." I think he has in mind an article written by me, and has given the wrong name. I put in a great deal of work on this. It was founded on a previous article published in the *New Jersey Dental Journal* in 1915 on "The Pathological Significance of the Impacted Third Molar," and one in the *Journal of the American Dental Association* in 1917 on "The Impacted Third Molar." I am under the impression that references in the *New York Medical Journal* article were so extensive that they had to be omitted owing to their length. In collaboration with L. Monier, M.D., D.S., of Paris, this work is being completed by including other buried, misplaced, and impacted teeth. We have now some records of teeth misplaced in the orbit, nose, brain, etc., and would be very pleased to hear from those who may have records of other misplaced, buried, or impacted teeth, or who would send reprints, or clippings, or references to articles or books calling attention to the same. Any material used we will be pleased to credit to the contributor.

The Sorenson Trial

Dr. GRAHAM GRANT (Central Criminal Court, Old Bailey), in reply to Dr. P. Watson-Williams's inquiry, writes: A full account of the trial can be obtained, on paying their charges, from Walpole and Son, Portugal Street, W.C., the official shorthand writers to the Central Criminal Court. Sorenson was defended by E. F. Peregrine, a member of our profession, who would doubtless give Dr. Watson-Williams any information he desires.

Income Tax

Replacement of Car

"A. D." receives a mileage allowance in respect of his public appointment, but considers that this does not cover replacement of his car. He has just bought an "A" car for £174, having sold his old "R" car for £25. The "R" car cost £194 in 1927, and the inspector of taxes