Achylia and Diet

The Swedish investigators find that an unvaried diet—designated by them the "L-diet"—consisting of refined flour, milk, potatoes, and a little butter with little or no meat, fresh fruit, and vegetables is associated with a high incidence of achylia and its accompaniments: mild gastric disorders, mostly in the form of a sense of fullness and oppression in the epigastric region, intestinal disorders mostly in the form of severe constipation and stercoral diarrhoea. While the incidence of achylia among the users of a mixed diet (itself far from perfect) was 13.5 per cent., it was 39.1 per cent. among the users of the "L-diet," amounting to 68 per cent. among the users of the diet in its most unvaried form. It was found that achylia could be produced in human beings by changing the diet from a mixed one to one having the composition given above (the "L-diet"). Further, by substituting a mixed diet for the "L-diet" the achylia usually disappeared. A marked improvement or a restitution of the gastric function occurred in 36 per cent. of achylic cases when given a mixed diet of meat, eggs, fish, fruit, and green vegetables, in spite of the fact that the period of observation was short and that the cases varied as to the degree of functional disturbance: the greater this disturbance the more unfavourable the prognosis. The investigators would therefore appear to have established their point, on statistical, experimental, and therapeutic grounds, that "the composition of the diet is the decisive factor in the frequency of achylia in Norrland."

Anaemia was also found to be associated in a significant way with the habitual use of the "L-diet." The type of anaemia has certain features similar to those in pernicious anaemia. It is not a typical achylic anaemia, nor an anaemia due to deficiency of iron. It has a hyperchromatic element. It is explained partly by the achylia, partly by the iron deficiency of the diet, and partly by B-hypovitaminosis.

Faults of the "L-diet"

As to the faults in the "L-diet" responsible for the production of the gastro-intestinal ill-health, Dr. Martin Odin (who is responsible for that part of the report dealing with diseases and their frequency with special reference to the composition of the diet) considers that this diet "to a great extent relieves the work of the digestive apparatus, owing to the fine disintegration of the food and its deficiency of meat, fruit, and vegetables. Herein perhaps lies the cause of its achylia-promoting effect." Fresh milk often aggravates the gastric discomfort of sufferers from achylia while sour or ropy milk as a rule does not. May it not be that those children in this country who "cannot take milk" are afflicted with achylia? The advisability of giving milk to ill-fed school children without other food accompaniments may well be doubted.

Vitamin B Deficiency

The "L-diet" has other faults, chief among them being a low content of the vitamin B complex and a composition which increases the need for vitamin B. Dr. Odin remarks that "the assumption of a B-hypovitaminosis would explain most of the symptoms," though he refrains from affirming that this is their explanation. For if it be it appears strange to him that his patients should exhibit no signs of beri-beri and little or none of pellagra. His perplexity is evidence of the difficulty of freeing the mind of those adjectival encumbrances—"anti-beri-beri" and "anti-pellagra"—formerly attached to the components of the vitamin B complex. This complex is one of the dietary substances absolutely necessary for physiological well-being, including well-being of the gastro-intestinal tract, and varying degrees of malnutrition due to its insufficiency in the diet are of common occurrence among the sick. Because of the high incidence of gastro-intestinal disease in his experimental animals McCarrison[2] was led to believe that a liberal supply of vitamin B is very important in maintaining the health of the gastro-intestinal tract and that its want is a common cause of gastro-intestinal ailments. Since that time an impressive weight of evidence has accumulated to show that chronic deficiency of vitamin B may be followed by serious damage to the structure of the digestive tract and impairment of its function. Among the most recent results in this connexion are those published by A. Z. Baker, M. D. Wright, and J. C. Drummond.[3] In an experiment planned to demonstrate the types of disorders which arise from subsistence for long periods on diets deficient in vitamin B, they found that the chief effect was the remarkably high incidence of gastro-intestinal ailments. The observations recorded by the Swedish observers provide additional evidence that faulty diet deficient in vitamin B is an important cause of gastro-intestinal disease.

Members of the profession in this country will be grateful to the Royal Medical Board of Sweden for making the results of its pioneer work available to them in English. We commend the report to all those who are interested in social hygiene.

Local News

SCOTLAND

Diphtheria Immunization in Edinburgh

At a meeting of the Public Health Committee of Edinburgh Corporation on September 14 it was decided to appoint an assistant medical officer at a salary of £600 to supervise the administration of a scheme of diphtheria immunization. The medical officer of health, Dr. John Guy, stated that there had been twenty-four deaths from diphtheria in Edinburgh during the first six months of the present year, but that the number of diphtheria cases had been lower during the past three years than previously. Lately, however, there had been evidence that the severer type of diphtheria experienced on the Continent was appearing in Edinburgh, and the twenty-four deaths had occurred among 510 cases. At least two-thirds of all the pre-school children and over half of the school children in the city were susceptible to diphtheria. On an average about 400 children were immunized yearly under the child welfare department's scheme. Further, the school medical department had immunized on an average about 2,800 children and general practitioners approximately 100 children of all ages each year. The child welfare department was unable owing to the size of its clinics to carry out any more immunizations than it was doing at present. It was therefore decided that the medical officer of health should be instructed to make the immunization scheme as effective as possible, and to take up with the British Medical Association the question of obtaining the effective co-operation of general practitioners with the department in the scheme. The scheme would be entirely voluntary,

[2] *British Medical Journal*, 1920, 1, 822.
[3] *J. Soc. chem. Ind.*, June, 1937, p. 191T.

but it had been found that at least 50 per cent. of all parents were quite willing that their children should be subjected to it.

Dundee Maternity Scheme

Under the provisions of the Maternity Services (Scotland) Act, 1937, a scheme drawn up by Dr. W. L. Burgess, medical officer of health for Dundee, to provide a maternity service including midwife, doctor, and, if necessary, obstetrician and anaesthetist, has been approved. The main purpose of the scheme is to make available to women who are to be confined in their own homes the joint care of a medical practitioner and a certified midwife, with the advice or help, if it should be necessary, of an expert obstetrician. All general practitioners in Dundee are to be invited to participate, and all those in special practice as obstetricians to act as specialists. A visiting obstetrician and gynaecologist is to be appointed to Maryfield Hospital at a salary of £450 and a resident maternity services medical officer in the hospital at a salary of £400. It was agreed to send copies of the scheme for comments to the local branch of the Scottish Midwives Association, the directors of Dundee Royal Infirmary, and the Dundee Branch of the British Medical Association.

Chronic Incapacity

In Scotland in recent years it has become clear that chronic incapacity among the insured population is increasing (*Journal*, August 14, p. 350). Cases in which disability has lasted for more than twelve months have reached a new high level. The committee which recently reviewed Scottish Health Services recommended that "to meet the needs of general practice it should be a definite function of the authorities administering the statutory medical services to supplement, where necessary, the existing specialist diagnostic and other facilities." The extent and kind of these requirements is already the subject of an important investigation, and it has been decided to institute a scheme whereby, for all insured persons who have been incapable of work for a consecutive period of three months, clinical and other details will be obtained from which ultimately some quantitative idea of these needs will be forthcoming. The approved society involved will notify the Department in cases in which incapacity has lasted three months. A clinical form will then be sent to the patient's doctor for completion, and this will be returned to the regional medical staff. In a certain proportion of the cases the regional medical officer will desire to examine the patient and discuss his condition with the insurance practitioner. The form suggested, in addition to routine data such as age and occupation, seeks to obtain details of the illness under consideration in respect of history, duration, and present condition, with particular reference to what, if any, diagnostic or therapeutic ancillary methods have been adopted, and whether or not any consultant opinion has been obtained.

ENGLAND AND WALES

Recruitment of Hospital Nurses

Throughout the country considerable difficulty is being experienced in recruiting to the junior grades of female nursing staff, particularly probationer nurses and staff nurses, for duty in hospitals. The London County Council has been considering proposals for alleviating the present shortage. It is borne in mind that any steps taken to deal with the immediate problem should not prejudice whatever may be the appropriate ultimate solution. Proposals have been made for raising the initial salary of staff nurses and for substituting assistant nurses for probationers in the tuberculosis hospitals, except at Heatherwood Hospital. At present, however, some relatively minor steps are to be taken. The salary rates payable to general-trained State-registered staff nurses in the Council's hospitals are £5 a year lower than those paid by nearly all the county and county borough authorities adjoining the London county area. Approximately 350 probationer nurses complete their training twice a year. The wastage rate—that is, the proportion of probationers who do not proceed to the grade of staff nurse, was 38 per cent. during 1936, and it is anticipated that the rate this year will be considerably higher. The number of vacancies in the grade of staff nurses increased from fifty-five in June, 1935, to 306 in June, 1936, and to 454 in June of this year. It is felt that every endeavour should be made to retain in the service as many trained nurses as possible, particularly as it is anticipated that 285 additional staff nurses will be required in the fever hospitals for the biennial outbreak of measles expected during the coming autumn and winter. If the position regarding the recruitment and the retention of trained staff in the L.C.C. hospitals is not improved it will be necessary to continue to employ a large number of institute nurses; the additional cost of employing an institute nurse instead of a staff nurse is approximately £100 a year. It is proposed that for one year probationer nurses who pass their central final examinations this year shall be paid on promotion to the grade of general-trained staff nurse a salary of £75 during their first year of service—that is, an increase of £10 a year. As a corollary to this, staff nurses who passed their final examination last year and are now in receipt of £70 a year are to receive an additional £5. It is also proposed that for the next year staff nurses trained outside the service should be appointed at the rate of £70 a year—that is, an increase of £5 a year—which will bring the Council's rate up to that paid in the counties adjoining London.

Queen Charlotte's Maternity Hospital

The clinical report of Queen Charlotte's Maternity Hospital for 1936 presents formidable sheaves of statistics with little or no comment, but the statistics yield much interesting information. During the year 3,726 patients were treated by Queen Charlotte's—1,216 as out-patients and 2,510 in the wards. The latter are divided into two categories—patients "booked" in the ante-natal department, who numbered 2,266, and patients, numbering 244, sent in on emergency by outside doctors or midwives, and who, in many cases, had received little or no ante-natal supervision. Brief particulars of every case are set out in a series of tables. Out of 158 cases of albuminuria admitted for treatment, one mother died; thirteen babies also died, and nineteen were stillborn. Of thirty cases of cardiac disease three mothers died and there were three stillbirths. Of twelve cases of eclampsia, one mother died, three babies died, and four babies were stillborn. In thirty-three cases of placenta praevia the maternal mortality was *nil* and the foetal mortality over 60 per cent. The results with various methods of delivery can be thus set out:

	No. of Cases	Mothers Died	Babies Died	Still-births
Induction of labour (spontaneous delivery)	204	2	13	28
Induction of labour (forceps delivery)	31	0	1	3
Forceps (labour not induced)	166	3	7	18
Caesarean section	69	3	4	3
Manual removal of placenta	27	1	0	8

Among the 2,266 "booked" cases there were six maternal deaths, and eight such deaths among the 244 emergency cases—a maternal mortality in the first category of 2.64 per 1,000 and in the second of 32.82. The number of cases of premature birth was 160. The lowest weight at

birth of a child who survived was 2 lb. 13 oz., the weight on discharge being 4 lb. 2 oz. Thirty-nine sets of twins were born during the year; seven of the babies died and eight were stillborn. The total number of stillbirths was 137; the stillbirth rate for the "booked" cases was 3.6 per cent. and for the emergency cases 22.1 per cent. In fifty-one cases of trial labour for suspected disproportion one mother died and one baby was stillborn.

Correspondence

Rupture of Extensor Pollicis Tendon

SIR,—In the course of some work on spontaneous rupture of the extensor pollicis longus tendon I have read the letter by Mr. Maurice Lee in your issue of September 29, 1934, page 611. I would warn surgeons against following his advice when he says that should another case present itself he would not hesitate to follow Mr. Andreasen's procedure (*British Medical Journal*, 1934, **2**, 515) of suturing the distal end of the ruptured tendon to the tendon of the extensor of the index finger. I have already published in the *Acta Chirurgica Scandinavica* (1921, **55**, 177) a report, which was referred to in the Epitome to the *British Medical Journal* of January, 1922 (para. 136), of two cases in which I made an interposition from free transplanted tendon between the two portions of extensor pollicis longus tendon. It is always possible to find the proximal portion. I have taken the tendon graft from the tendon of abductor pollicis longus. The result after seventeen years is still excellent. The procedure of fixing the tendon of the extensor pollicis longus in another muscle is not the method of choice.—I am, etc.,

STEN VON STAPELMOHR, M.D.,
Chief Surgeon, Norrköping Hospital.

Norrköping, Sweden, Sept. 9.

Bilateral Lobar Pneumothorax

SIR,—Dr. Crocket's article in the *Journal* of August 7 and the ensuing correspondence in your columns on bilateral artificial pneumothorax treatment prompt me to put in a plea for a trial in this country of the bilateral lobar pneumothorax employed by Dr. Maurer of Davos in the treatment of bilateral pulmonary tuberculosis.

The technique is described in the April issue of the *British Journal of Tuberculosis*. This modification of bilateral artificial pneumothorax is applicable to cases in which the disease is limited, as it often is, to the upper lobes. The principle of the method is, in brief, that after intrapleural injection of hypertonic glucose solution the sound lower lobes are re-expanded and fixed to the chest wall, an air pocket remaining over each of the affected upper lobes. Induction is not always easy and requires skill and patience, but the after-treatment of an established lobar pneumothorax is straightforward.

Three advantages may be claimed for the method. First, the lower lobes and the mediastinum being fixed, a more effective collapse of the diseased upper lobes can be maintained, refills with an end-pressure of zero being given on both sides. Secondly, as a consequence of the gain in functioning alveolar tissue, the anoxaemia, which is frequently present in bilateral pneumothorax, disappears. Thirdly, as the air pockets are small, any of the complications of artificial pneumothorax—effusion, empyema, or perforation—which may arise will be less dangerous and more easily dealt with than when occurring in bilateral artificial pneumothorax.

During the period of induction constant clinical and radiological observation are necessary, and it should only be undertaken in a hospital or sanatorium. Considerable patience is required. The pleural sheets may not adhere at the first attempt and the intrapleural injection of increasing quantities of glucose solution may have to be repeated two or three times. If a refill is given too soon the visceral pleura is peeled off the chest wall. On the other hand, if delayed too long excessive expansion of the diseased lobe and dissemination into the redeveloped lower lobe or lobes is a theoretically possible complication. It has not been seen in practice and the risk appears to be slight. Professor Brauer in the early days of adhesion cutting saw a considerable number of cases in which the pneumothorax was almost completely let out as a result of post-operative emphysema and lack of a timely refill. He states that he never saw an intrapulmonary dissemination from this cause as long as a small air pocket remained over the affected lobe. The other possible complication is the production of a tuberculous effusion with subsequent obliterative pleurisy. I have seen one case in which a tuberculous pleural effusion developed during the induction, probably as a result of irritation of subpleural tubercles. However, the ensuing obliterative pleurisy was easily checked by appropriate treatment. It should perhaps be mentioned here that there is never any tendency to obliterative pleurisy as a sequel of the transient sterile effusion evoked by the hypertonic solution.

When bilateral lobar pneumothorax has been successfully established the after-management of the case is simple and the results more than compensate for the care required during the induction period. I have had an opportunity of observing these cases over a period of several years, and the improvement in the condition of the patient, after a bilateral artificial pneumothorax has been replaced by a bilateral lobar pneumothorax, is very striking.—I am, etc.,

R. J. C. MAXWELL, M.Ch., F.R.C.S.

London, W.C.1, Sept. 16.

Expulsion of Placenta Praevia in Advance of Foetus

SIR,—Being interested in Dr. J. W. Nankivell's Clinical Memorandum on "Expulsion of a Placenta Praevia in Advance of the Foetus" which appeared in the *British Medical Journal* of September 11, I hope you will publish this letter. The condition cannot be so extraordinarily rare as I have had personal contact with two such cases since 1927. In both my cases the entire sac was expelled intact with considerable accompanying antepartum haemorrhage, there being no operative intervention, and in both instances the child lived. I am convinced that many other instances of similar occurrences could be cited but have not been reported in the literature.—I am, etc.,

Dublin, Sept. 13. O'DONEL BROWNE.

Indications for Induction of Abortion

SIR,—May I take advantage of your columns to voice a protest against the attitude held at the moment in some hospitals on the subject of induction of abortion in "suitable cases"? I have had occasion to send two cases to London during the past month, cases in which, in

Obituary

DE BURGH BIRCH, C.B., M.D.,

Emeritus Professor of Physiology, Leeds University

The death took place in a nursing home at Bournemouth on September 18 of Dr. de Burgh Birch, who was professor of physiology in the University of Leeds from 1883 to 1917, and dean of the faculty of medicine for eleven years.

The son of de Burgh Birch, M.D., of the Madras Medical Service, he was born on May 18, 1852, and was educated at Hofwyl, Switzerland, at Manilla Hall, Clifton, and at the Bristol Medical School and General Hospital, proceeding to the University of Edinburgh in 1874 and graduating there as M.B. and C.M. in 1877. Then at the end of three years as assistant to the Professor of Institutes of Medicine he took the M.D., gaining the gold medal, and was elected a Fellow of the Royal Society of Edinburgh. On his retirement from the service of the University of Leeds in 1917, after thirty-four years as a teacher, he was given the title of Emeritus Professor.

Professor Birch was for many years a member of the British Medical Association, which he joined in 1883 on his appointment as the first full-time professor of physiology at Leeds. He was a vice-president of the Section of Pathology and Bacteriology at the Annual Meeting at Leeds in 1889, and vice-president of the Section of Physiology at Bristol in 1895. He had long held a commission as a medical officer in the old Volunteer Force, and for these services was created C.B. in 1909; he also received the Volunteer Officers' Decoration. For two years during the war he was A.D.M.S. to the 62nd (West Riding) Territorial Division.

ANDREW H. WATT, M.B., F.R.C.S.ED.,

Consulting Physician, Johannesburg Hospital

We regret to announce the death on September 3, at Auckland Park, Johannesburg, of Dr. Andrew Watt, who was well known in South Africa as a physician and radiologist and as an authority on silicosis. He gave up consulting practice some years ago to become chief medical officer to the Rand Mutual Assurance Company.

Andrew Hutton Watt, a Scotsman by birth and parentage, was born in 1871, and from the Royal High School went to study medicine at Edinburgh University. He graduated M.B., C.M., with honours, in 1897, and took the F.R.C.S.Ed. in 1899 after holding resident posts at the Royal Infirmary and the Royal Hospital for Sick Children. During the Boer War he served as a civil surgeon, and returned to South Africa after the declaration of peace, gradually building up a high reputation as an expert in the accidents and diseases of the gold-mining population of the Rand. He was for some years physician to the miners' phthisis sanatorium at Springkell, and then settled in Johannesburg as a consulting physician and radiologist. He was the author, with L. G. Irvine, J. P. Johnson, and W. Steuart, of *Silicosis (Miners' Phthisis) on the Witwatersrand*. On retiring from the active medical staff of the Johannesburg Hospital he was elected honorary consulting physician.

Dr. Watt joined the British Medical Association in 1898 as a member of the Johannesburg Division. He was president of the Witwatersrand Branch in 1926–7 and a member of the Federal Council. In 1932 he was appointed a member of the South African Medical Council, through which body his deep knowledge of industrial disease and insurance problems was always at the disposal of the Union Government.

GEORGE H. SIMMONS, M.D.

Dr. Alfred Cox writes:

May I add a few words to your feeling tribute to my old friend? For many years he was, in a way, my opposite number, for though he resigned the secretaryship of the A.M.A. in 1911, as general manager he kept an alert eye on all medical affairs inside and outside the United States. I was introduced to him on one of his visits by my then chief, Whitaker, and a friendship grew up between us which was greatly strengthened by many letters I had from him. He took a great interest in our insurance struggle and favoured me with his views on our tactics—views which were always shrewd. But his chief characteristic was the one on which your obituary notice laid stress—his ability to look at affairs in a detached and dispassionate way. This was very valuable to his friends, for I need hardly say that at the time of the fight none of us was able thus to regard affairs.

In all the crucial periods of the British Medical Association's work during my time I could always depend on his interest and on his advice—spontaneously offered, for he was an assiduous reader of our *Journal*. Though a patriotic American he was proud of his English birth and loved the scenes of his youth, to which he often returned, never without paying a visit to B.M.A. House. His modesty and self-effacement, to which you have justly paid tribute, concealed immense energy and a very sound judgement. He was indeed a "grand old man," for age never dimmed his interest in his life's work.

Dr. JAMES FORSYTH FALCONER, who died suddenly at Hastings on September 12, was born at Elgin in 1875, the son of James Leslie Falconer. He was educated at Elgin Academy and the University of Edinburgh, and took the M.B. and Ch.B. degrees in 1898 and the certificate in medical psychology in the following year. His first appointments were those of house-physician to the Royal Hospital for Sick Children, Edinburgh, house-surgeon to the Glasgow Royal Infirmary, and assistant physician to the Edinburgh Fever Hospital. He was then for some years assistant surgeon and ophthalmic surgeon to the North Ormesby Hospital, Middlesbrough, before settling in Brixham, where he became medical officer of health, Admiralty surgeon, medical officer to the child welfare centres, visiting surgeon to the Seamen's Orphanage, and surgeon to the Brixham Hospital. Dr. Falconer joined the British Medical Association in 1900 and had held office as chairman of the Cleveland Division, Representative at the Annual Meeting in 1919, and a member of the Scrutiny Subcommittee of 1919–20.

Universities and Colleges

UNIVERSITY OF LONDON

A course of three lectures on "Social and Geographical Pathology of Cancer and Tuberculosis" will be given by Dr. Georg Wolff, formerly Director of the Section of Medical Statistics in the Public Health Department of the City of Berlin and Privat-Dozent in the University, at the London School of Hygiene and Tropical Medicine, Keppel Street, W.C., on October 4, 5, and 6, at 5.30 p.m. The chair at the first lecture will be taken by Sir Ernest Graham-Little. Admission to the lectures is free, without ticket.

The Services

Colonel W. E. R. Williams, O.B.E., I.M.S., has been appointed Honorary Surgeon to the Viceroy and Governor-General of India.

COMMISSIONS IN THE R.A.M.C.

The War Office announces that applications are invited from medical men for appointment to commissions in the Royal Army Medical Corps. Candidates will be selected for commissions without competitive examination, and will be required to present themselves in London for interview and physical examination on or about October 21, 1937. They must be registered under the Medical Acts, and normally must not over the age of 28 years.

Successful candidates will in the first instance be given short-service commissions for five years. During the fourth year of this period they will be given the opportunity of applying for a permanent commission. Those not selected will retire on completion of five years' service with a gratuity of £1,000.

Full particulars of the conditions of service and emoluments, also forms of application, may be obtained on application, either by letter or in person, to the Assistant Director-General, Army Medical Services, the War Office, London, S.W.1.

Medical News

The annual dinner of past and present students of University College Hospital will be held in the library of the Medical School, University Street, W.C., on Friday, October 8, at 7 for 7.30 p.m., when the chair will be taken by Dr. W. F. Addey. Applications for tickets, accompanied by remittances (tickets 12s. 6d. each, not including wines), should be made not later than October 7 to the dinner secretary, University College Hospital Medical School, University Street, W.C.

The annual dinner of the University College Hospital Medical Women's Association will be held at the Langham Hotel, Portland Place, on Friday, October 8, at 7.30 for 8 p.m., when the chair will be taken by the president, Dr. Freda Kelly. Members intending to be present should notify Dr. A. L. Winner, 4K, Portman Mansions, Baker Street, W.1, before October 5.

The annual dinner of the Middlesex Hospital Medical School will be held at the Savoy Hotel on Friday, October 1, at 7.30 p.m., with Dr. Douglas McAlpine in the chair.

The annual old students' dinner of St. Thomas's Hospital will be held at the Dorchester Hotel, Park Lane, on Friday, October 8, at 7.15 for 7.45 p.m., with Dr. J. S. Fairbairn in the chair.

The annual dinner of past and present students of St. Mary's Hospital Medical School will be held at Claridge's on Saturday, October 2, at 7.30 p.m., with Mr. V. Zachary Cope in the chair.

A course on recent advances in the knowledge of infectious diseases of children will be held at the University Children's Clinic of the Charité Hôpital, Berlin, under the direction of Professor Bessau, from October 18 to 23. In addition to the ordinary infectious diseases of childhood, rheumatic infection, meningitis, poliomyelitis, encephalitis, pneumonia, tuberculosis, and syphilis will be discussed. The fee is RM. 50. Further information can be obtained from the Berliner Akademie für ärtzliche Fortbildung, Robert Koch-Platz 7, Berlin, N.W.7.

Lord Horder will give an address at the opening session of the Third National Coal Convention, which is to be held at Harrogate on October 6 and 7.

A sessional meeting of the Royal Sanitary Institute will be held in conjunction with the Welsh Branch of the Society of Medical Officers of Health and the North Wales Centre of the Sanitary Inspectors' Association in Llandudno Town Hall on Friday, October 1, at 4 p.m., when there will be discussions on "Tuberculosis in Wales: A Stocktaking," to be opened by Dr. D. A. Powell, and "The Conway Mussel Purification Tanks," to be opened by Dr. R. W. Dodgson. Dr. D. E. Parry Pritchard will read a paper on "Notes on a Recent Outbreak of Bacillary Dysentery."

The French League against Rheumatism will hold its annual meeting in Paris on October 9, when there will be a clinical meeting in the morning at the Hôpital Saint-Antoine and a meeting at the Faculty of Medicine in the afternoon. Further information can be obtained from the Permanence de la Journée du Rhumatisme, 23, Rue du Cherche-Midi, Paris, 6e.

The annual meeting of the French Society of Oto-rhino-laryngology will be held in Paris under the presidency of Professor Brémond of Marseilles from October 18 to 21, when the subjects for discussion will be intracranial surgery of the auditory nerve by Drs. Aubry and Ombrédanne, and acute inflammation of the larynx by Drs. Le Mée, André Bloch, and Bouchet. Further information can be obtained from the general secretary, M. Henri Flurin, 19, Avenue Mac-Mahon, Paris, 17e.

A series of ceremonies and lectures and an exhibition will be held at Prague, Brno, and Bratislava from September 24 to 28 to commemorate the one hundred and fiftieth anniversary of the birth of the celebrated histologist J. E. Purkinje.

On the occasion of the annual Buckston Browne Dinner on November 11 it is proposed to hold an exhibition of works of art by Fellows and Members of the Royal College of Surgeons of England, which will remain open for about three weeks and will be held in one of the Museum Rooms at the College. Any Fellow or Member wishing to exhibit some of his work, either pictorial or sculptural, is asked to communicate with Dr. John Beattie, Royal College of Surgeons, Lincoln's Inn Fields, W.C.2, as soon as possible.

The International Congress of Hepatic Insufficiency was opened formally at Vichy on September 16 by M. Marc Rucart, French Minister of Public Health, who arrived at the spa on September 15 to open a new third-class bathing establishment. Dr. Hamilton Fairley spoke on behalf of the British delegation at the opening session, and Dr. Anthony Bassler was spokesman for the American delegation. At the request of M. Rucart a minute of silence was observed in tribute to the late President Masaryk just before the Czechoslovakian delegate, Professor Josef Pelnar, spoke. Among the other specialists representing their countries on this occasion were: Professor Michele Bufano, director of the Medical Clinic of the Faculty of Medicine of Sassari, Italy; Professor R. Brunel Hawes of the Faculty of Medicine of Singapore; Professor Alfred Mousseau of Montreal; Professor W. H. Craib, Head of the Department of Medicine of Johannesburg; Professor Dimitrije Antitech of the Faculty of Medicine of Belgrade; and Professor Soliman Azmi Pacha of the Cairo Faculty of Medicine.

A Peter Pan children's party in aid of the reconstruction fund of the Hospital for Sick Children, Great Ormond Street, is being given by the Lord Mayor and Lady Mayoress at the Mansion House on Thursday, September 30. Queen Mary and the Princess Royal have consented to attend, and Queen Mary will receive purses.

The Earl of Derby will open the new extensions to Evans's Biological Institute, Runcorn, on the afternoon of Thursday, October 7.

The Mayor of Southwark is opening the new Health Services Department of the borough in Walworth Road to-day, Saturday, September 25, at 3.30 p.m.

The annual Motor Exhibition will be held this year for the first time at Earl's Court, London, from October 14 to 23.