flower mass down to its hard base. The growth was very soft, but did not bleed much. She was greatly relieved by this proceeding, the motions again passing with comparative ease. A rapid return is, however, inevitable.

The microscopic appearances of the growths in both the cases narrated were identical, the difference in result being probably due to a more thorough extirpation being possible in the first case.

Various methods of performing the operation of extirpation of the rectum have been practised. The ligature, the cautery, and the *écraseur*, either singly or combined, all have their advocates. From my own experience, however, these various adjuncts appear to be unnecessary. They greatly prolong and complicate an otherwise simple operation. The free and quick use of the knife for all the first part of the operation, reserving the wire *écraseur* for the final separation of the bowel, appears to me to be the best plan of operating. The preliminary posterior incision of Denonvilliers is of the greatest service during the operation, and completely unfolds the parts and gives plenty of room for dealing with hæmorrhage, while it subsequently affords perfect drainage to the wound. No good results from the drawing down of the cut bowel and stitching it to the cutaneous surface; the stitches always give way, and until they do so are a source of danger, by allowing matter to be pent up behind the bowel. I use no dressing nor sutures of any kind whatever; for anything that hinders free discharge is deleterious, owing to the near neighbourhood of the peritoneum and the rapid decomposition that takes place in this part of the body. A frequent gentle and thorough syringing, so as to prevent any accumulation in the wound, is probably the best way of preventing peritonitis.

SURGICAL MEMORANDA.

ANNULAR STRICTURE OF THE INTESTINE.

IN the JOURNAL of May 31st, in the instructive account of annular stricture of the intestine, by Dr. Stephen Mackenzie, I find the following statement: "The fact that full-sized, properly formed fæces are occasionally passed, of course shows that there can be no organic stricture;" and, five pages further on, in the description of a case of colotomy, by Mr. J. Walters, we are told: "In stricture in this region, no positive reliance can be placed on the size of the stools." As both authors are writing about the symptoms of obstruction of the colon, there appears to be a marked discrepancy in their opinions.

In his *Observations on Diseases of the Rectum*, Mr. Curling mentions a case of stricture at the sigmoid flexure, in which the bowel below the stricture had undergone extraordinary dilatation; and it appears possible that, in such a case, we might have fully formed evacuations.

As the other authorities to which I have access direct their observations, in this connection, chiefly to the diagnosis of stricture in the lower part of the rectum, I should like to elicit further light on this subject, as it appears to me to have important bearings.

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VESICAL CALCULUS IN A GIRL.

A YOUNG girl, aged 17, rather deaf, and of weak intellect, had paid two or three visits to the infirmary here, as out-patient. She complained of great pain in micturition, and I treated her for irritable bladder, with considerable relief to her symptoms. Subsequently, her friends sent for me, late at night, to visit her at home, as her pain had returned with increased severity. I now introduced a sound, and at once detected a calculus at the neck of the bladder, which could also be easily felt *per vaginam* and *per rectum*. Giving her a suppository for the night, I promised to return and operate the next day. Dr. Brown, at present acting as *locum tenens* for the house-surgeon, having kindly administered chloroform, I dilated the urethra with the three-bladed dilator; a sponge-tent, previously introduced, having been ejected after half an hour, owing to the involuntary expulsive efforts of the patient. The stone appearing large, a lithotrite was at hand, but this was not required, as the calculus broke up in attempting to grasp it with forceps. On removing the broken pieces, I observed that they consisted of phosphates exclusively, and, on introducing my finger into the bladder, I at once felt something to the touch resembling a piece of wire. On calling Dr. Brown's attention to this, he suggested that it might be a hair-pin, which, on removing it from the bladder, it was seen to be. The pin was very rusty, and, here and there, phosphatic deposits were attached firmly to it. The portions of calculus removed by the forceps alone weighed half an ounce. A good deal has come away since, by the urine, and after washing out the bladder.

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SELECTIONS FROM JOURNALS.

MEDICINE.

A RARE FORM OF DIPHTHERITIC PARALYSIS.—Dr. Dahlerup describes (*Ugeskrift for Läger*, 3rd series, vol. xxvi) the case of a boy aged 12, who, ten or twelve days after recovering from an attack of diphtheritic angina, was seized with difficulty of breathing, which increased to severe dyspnœa at the end of fourteen days. On examination, there was found to be orthopnœa, cyanosis, œdema of the feet, and moderate œdema of the lungs. The heart-beat was somewhat quickened, irregular, and very weak; the area of cardiac dulness was not increased. The heart-sounds were distinct. The pulse was rather feeble. The urine contained a large quantity of albumen. Under the use of digitalis and stimulants, there was slight improvement at the end of a week; the dyspnœa then increased, as did also the œdema of the extremities and lungs; and the patient became collapsed, and died. The temperature at no time of this illness rose above 98.6° Fahr. Dr. Dahlerup believes the case to have been one of progressive diphtheritic paralysis of the heart.

A RARE FUNGOUS GROWTH ON THE HAIR IN THE AXILLÆ.—Dr. Axel Key describes the following case in the *Hygeia* for 1878 (quoted in *Nordiskt Mediciniskt Arkiv*, Band xi). A gentleman had for some time noticed that the hair in his axillæ stuck together, in consequence of being covered with a glutinous substance. The sweat of the axillæ coloured his shirt bright red. His condition in other respects was normal. On examination, Dr. Key found the axillary hairs greatly adherent; and a large part of them were covered with a gelatiniform substance like mildew. This had its seat on the free ends of the hair, where it formed partly isolated or confluent swellings, and partly bands like chains of pearls, or an adhesive mass surrounding the hairs. There were no changes in the skin. Microscopic examination showed that the changes were dependent on a peculiar fungous vegetation, which had a brimstone yellow colour by transmitted light. The development of the vegetation commenced in the form of small, slender, exceedingly delicate scales, which soon formed small round elevations, apparently homogeneous, but containing numerous small glistening spores. The scales seemed partly to lie on the outside of the hair, but for the most part the vegetation penetrated between the outer layer of the epidermis covering the hair. Here and there, the vegetation could be traced to the interior of the hair. No mycelium was found. Dr. Key has not been able to find a similar case recorded in dermatological literature. Buhl alone has described in the *Zeitschrift für rationelle Medicin*, Band iii, a new hair-fungus apparently like that described above; he calls it zoogloœa capillarum. The disorder would, therefore, seem to be very rare.

DEATH CAUSED BY AN ASCARIS LUMBRICOIDES IN THE UPPER AIR-PASSAGES.—Dr. Fürst has published, in the *Wiener Med. Wochenschrift* for 1879, a summary of twenty-four cases of immigration of ascarides into the upper air-passages, from which we quote the following case. A girl, aged 4, had been received into Professor Billroth's hospital for congenital ectopy of the bladder. One evening, she suddenly had an attack of suffocation. Thinking that she must have aspirated some foreign body, the author explored the larynx without any result, and then performed tracheotomy, as she had suddenly ceased to breathe. As no cannula was at hand, a male catheter was introduced into the wound, but met with some obstacle. It was drawn out and then pushed in again, when it went in quite smoothly. Artificial respiration was then resorted to, but the child died. Two hours after death, a female live ascaris, about nine-tenths of an inch long, was seen hanging out of the nostril. It is evident that the catheter had been prevented from penetrating into the trachea by the worm, who probably then changed its position and wandered upwards. The *post mortem* examination revealed a male *Ascaris lumbricoides*, nearly half an inch long, in the jejunum. The author gives the following clinical sketch of the *modus operandi* of the immigration of ascarides into the air-passages. As far as concerns the etiology, vomiting, fever (as a high temperature always quickens considerably the movements of the ascarides), purgatives, abstinence from food—may all be looked upon as favouring the immigration into the larynx. Children are more liable to it than adults. The symptoms are not always the same; sometimes the worm sticks in the glottis, and such cases naturally invariably end fatally within a very short time. At other times, the worm passes the rima glottidis, when the patients die of bronchitis in the course of a few days. The majority of the cases that have hitherto come under observation belong to the first class. The patients become aphonic and asphyctic; occasionally

these symptoms are preceded by hoarseness during a few moments. Then comes a stage of great excitement, anxiety, and profuse sweating, which is followed by loss of consciousness. In cases of the second class, the patients feel much better after the worm has passed through the rima glottidis; but they do not recover their voice, and complain of pain in the anterior part of the throat. The diagnosis is very difficult and uncertain. In young children, the fits of suffocation are often completely masked by convulsions. If laryngitis, croup, diphtheria, spasm and œdema of the glottis, perforation of cold abscesses, or affections of the lungs may be with safety excluded, one is justified in supposing that a foreign body has penetrated into the pharynx or larynx. Then if it can be proved with certainty that no foreign body has been aspirated, and, moreover, if the patients are troubled with ascarides, it may be concluded that the foreign body in the trachea is an ascaris. This supposition will be rendered still more plausible if, after the worm has passed beyond the glottis, the asphyxia decrease and the trachea become painful. If it be not possible to extract the worm, either with the hand or by emetics and expectorants, tracheotomy must be performed. It has been resorted to in three cases out of the twenty-five, but each time with fatal issue. At the necropsy, the worm is generally found in the place where it evidently resided, judging by the symptoms during the patient's life. These places generally bear marks of inflammation, which have been produced either by the mere presence of the foreign body, or by its movements, or else by its peculiar irritating properties. The mucous membrane is red and injected, covered with bloody froth, and in some places eroded. Pneumonia of a circumscribed portion of the lung is sometimes caused by the protracted presence of the worm in one of the bronchi. The inflammatory symptoms are manifested principally in the arytenoid cartilages, as they are much affected by the migrations of the worm from the œsophagus. The usual symptoms of death by asphyxia are also always met with, as well as a certain number of ascarides in the intestines.

SURGERY.

ACUTE PURULENT CATARRH OF THE RIGHT MIDDLE EAR.—The following interesting case is recorded by Dr. Kratz in the *Berlin. Klin. Wochenschrift* for April 21st. The patient, a girl aged 9, had always enjoyed good health till about a week before she was seen by the author. She was then suffering from purulent catarrh of the right middle ear; and, on examination, a small opening of the size of half a lentil could be detected between the incus and the lower portion of the tympanum. The mastoid region was tender to pressure and œdematous; the external meatus was inflamed; the tympanum red, flat, and much swollen. The whole meatus was filled with thick yellow pus. The glands about the ear were swollen; but the parotid was free. The patient had a slight angina and fever. Her power of hearing was much impaired on the right side. When spoken to in a very loud key, she could hear at the distance of about twenty inches; the ticking of a watch only when put close to her ear; but the sound produced by a tuning-fork was distinctly heard over the whole of the head. After the meatus had been well syringed and all the pus removed, the opening in the tympanum could distinctly be seen. On pressing slightly with the finger on the jugular vein of the same side, pus was very rapidly discharged through the opening, the discharge ceasing when pressure was removed. This phenomenon was repeatedly produced, not only on the same day, but several days successively. The origin of it remains unexplained, as, under normal conditions, the jugular vein does not communicate directly with the interior of the tympanum. The possibility of an abscess having formed on the vein and communicating with the tympanum must be excluded, as nothing in the state of the patient proved its existence; and, besides, the circumstance that the pus was only discharged by pressing on the vein would disprove such a supposition. Another explanation of the phenomenon was, that the perforation was either a congenital deficiency or caused by caries. Under such circumstances, pressure on the jugular vein would drive the blood upwards, cause the bulb of the vein to dilate, and thereby cause the pus which had accumulated in the tympanum to be discharged. Similar cases have been observed by several authors—Toynbee, von Tröltsch, Schwartz, etc. The author was of opinion that the aperture was congenital.

DEPRESSION OF THE LEFT FRONTAL PROTUBERANCE.—Dr. Houillot publishes in the *Gazette Médicale de Strasbourg*, No. 1, 1879, the following case of injury to the brain, which was cured by trephining. The patient, a farm-labourer aged 28, had, in a fight, received a blow on the head with a cudgel, which stunned him for about a quarter of an hour. On the next day, he went to his work as usual, and worked for eight days, at the end of which time he fell down suddenly as if he had been shot, but got up again. From this time, he began to suffer from vertigo and somnolence. A careful examination was made, but nothing could be detected except slight paresis of the right arm and tremor. He vomited much during the day. A probe having been introduced into the oblique wound which he had on his forehead, it was found that the frontal bone was fractured and depressed. The patient was taken to the hospital, and it was decided to perform the operation at once. A cruciform incision of one and a half inches was made over the wound, and an opening measuring four-tenths of an inch in depth and one inch across was discovered. The fragments of bone having been removed by means of a hammer and chisel, a purulent collection was found beneath the dura mater. The latter was detached from the brain for a space of nearly two and a half inches, but had remained intact. The pulsations of the brain could be perceived. An antiseptic dressing was applied. There was almost no reaction; the temperature never rose beyond 98.6°; and the cerebral symptoms (cephalalgia, vomiting, slow utterance) disappeared almost immediately. The progress of cicatrisation went on very rapidly; and the patient, who had been wounded on May 4th, was able to return to his work on June 14th.

THE EARTH TREATMENT OF ABDOMINAL TUMOURS. — Dr. Addinell Hewson of Philadelphia has successfully treated by earth-dressing several cases of abdominal tumours, where either ovariotomy has been indicated, or where the case had been considered hopeless. An account of his proceedings may be found in No. 1 of the *Medical Bulletin*, published in Philadelphia. The material he used was pure brick clay of a yellow tint (due to the iron in it), and free from sand or grit. This was dried by a low fire or in the sun, care being taken not to let it be roasted, because in such a case its therapeutical action was destroyed. It was then rolled and sifted, and about a pound and a quarter mixed with sufficient water to constitute a thick paste, was spread all over the affected part. To make it dry quickly he laid a towel over it to absorb the water; the towel was then removed, and in its place a layer of cotton-wadding was smoothly spread on the paste, for the purpose of hastening the drying and of holding the clay when dry in its place. The dressing was then completed by a simple bandage and allowed to remain till it would fall off in from two to five days. He attributes the action of the earth to some chemical property which also had a calming influence on the pain. One of his first patients was a gentleman who was suffering from abscesses and diffuse inflammation of the cellular tissue of the knee, and had made up his mind to have his leg amputated. He recovered the use of his limb and was completely cured. The other patients who derived benefit from his treatment were all women suffering from tumours of the uterus and the broad ligaments; one of them had narrowly escaped ovariotomy, another had for years suffered severe pain during the catamenia, caused by a fibrocystic growth which involved the right ovary. In a third case, the patient had previously undergone ovariotomy, and induced electricity had been applied through the uterus. The tumour grew again after the operation and proved to be in reality a fibrous tumour of the uterus; there were besides several points of hernial protrusion of the bowels, on the spot of the wound, and she had the appearance and size of a woman at full term. The earth-dressing was applied under very unfavourable circumstances, but still proved successful, reducing her in size and preventing the hernial protrusion of the bowels by contracting the cicatrix.

ENTEROTOMY.—At a meeting of the Medical Society in Marburg, held last year, Professor Roser related a case of enterotomy for stricture of the bowel, and made some remarks on the subject. In the case referred to, the sloughing and separation of an invaginated portion of the small intestine was preceded by the formation of a cicatricial stricture; and an attempt was made to relieve the patient by enterotomy and the division of the cicatricial tissue. The patient died of peritonitis. Dr. Roser concluded his communication with the following remarks on enterotomy. 1. After opening the abdomen, the best plan, as a rule, is to introduce the hand as far as the cæcum, and thence trace upwards from the lower end of the small intestine; provided, of course, that there be no reason for believing the stricture to be in the large intestine or in any other special part. 2. When it is necessary to make an incision into and to empty a portion of intestine that is very full, it is safest to draw this portion of bowel forward and to lay the patient on his side, in order to prevent the escape of the contents of the bowel into the abdominal cavity. 3. In these circumstances, the escape of the intestinal contents is at first impetuous and explosive, afterwards intermittent. The first outflow is caused by elastic resiliency; that which follows, by the peristaltic action of the muscles. 4. In order to restrain this secondary escape, it may be of advantage to apply provisional sutures to the opening in the bowel, and to fasten the intestine by the

threads to the wound in the abdominal wall. After this, the sutures may be loosened when necessary, and the contents of the intestine allowed to escape. This is in accordance with Nélaton's teaching, that in many cases only a temporary opening of the bowel is necessary, and not a permanent artificial anus. 5. A temporary opening of the intestine is especially indicated in cases of valvular stricture, where the portion of bowel above the valve is much distended. 6. Among the forms of intestinal stricture demanding enterotomy, that which follows local peritonitis after the successful application of taxis for hernia merits special attention. If, some weeks after the reduction of a strangulated hernia, symptoms of ileus appear, there is reason for suspecting the presence of inflammatory adhesion and contraction. This suspicion was confirmed in a case which had recently occurred, in which enterotomy was performed, too late, on the twenty-third day after symptoms of obstruction appeared.—*Berliner Klinische Wochenschrift*, June 30th.

THERAPEUTICS.

PUERPERAL FEVER TREATED BY BENZOATE OF SODA.—Dr. Lehnebach writes in the *Allgemeine Medicin. Central-Zeitung* that in February last six cases of puerperal fever came under his care. In these cases, artificial interference had been necessary; and all the women were under the care of a very skilful and careful midwife. The source of infection could not be discovered. Three other women, under the charge of another midwife, in whom Dr. Lehnebach was called on to complete delivery by artificial means (one being a difficult forceps-case), were not affected. Of the six cases of puerperal fever, two (a primipara and a pluripara) died in a few days, in spite of the energetic use of quinine and wine. The symptoms were highly febrile, the temperature in the first case exceeding 109° Fahr. He was hence led to try, in the remaining four cases, benzoate of soda, as recommended by Klebs and Letzerich. The result was so remarkable that he believes that, if his experience be confirmed by that of others, benzoate of soda will be as much a specific in puerperal fever as salicylic acid is in acute rheumatism. Of the four patients in question, two were primiparæ and two pluriparæ. In the cases of the primiparæ, he was twice obliged to administer fifteen-grain doses of hydrochlorate of quinine along with the benzoate of soda, as the temperature rose to 105° Fahr. soon after labour. The action of the quinine was much more decisive than in the fatal cases, where he had given half a drachm; the temperature fell from 106° to 100.4° Fahr. Moreover, the quinine, when given with the benzoate, did not produce nausea; whereas in one of the cases it was almost immediately ejected by vomiting when given alone. Except in one case, the temperature did not again rise above 102.75° Fahr. Dr. Lehnebach says also that he has had much success in the treatment of gastric catarrh in children, and of diphtheria, from the use of benzoate of soda—administered in the latter disease both locally and internally.

THERAPEUTIC USES OF BORACIC ACID.—E. Kurz of Florence writes (*Memorabilien*, August 14th) that he has used an ointment of five parts of boracic acid and ten or fifteen of vaseline with much success in several cases of eczema of the face and limbs. One case of eczema squamosum, which had lasted five months, was cured in three weeks. In the case of a child whose whole head was affected with impetigo, the application of boracic acid, affer the removal of the scales, produced a remarkably speedy cure. Two cases of prurigo, which had for a year resisted all other treatment, were cured in one and two months respectively by the application of the boracic acid ointment twice a day. The same treatment was successful in a case of non-syphilitic psoriasis of three years' standing, in which carbolic acid and arsenic had failed. In a case of exfoliative lupus of the nose, the use of boracic acid for a month had no effect; salicylic acid produced slight improvement. In two cases of severe gonorrhœa, injections of a solution of boracic acid (1 in 100 of water) almost completely arrested the discharge; a scanty secretion of mucus, which continued for a time, was cured by the use of subnitrate of bismuth.

THERAPEUTIC USES OF IODOFORM.—E. Kurz (*Memorabilien*, August 15th) says that he has used iodoform ointment with good result in cases of orchitis, strumous swellings, lymphadenitis, lymphangitis, periphlebitis, and exfoliations in the pelvis. In a recent case of indurated chancre, an ointment of one part of iodoform to ten of glycerine ointment produced a cure in a few days; secondary symptoms, however, appeared afterwards. In another case, a large soft chancre with bacony base and ragged edges on the inner part of the prepuce, was cleansed in a few days by the application of a similar ointment once daily; and the sore was completely healed in a fortnight. A patient with spinal myelitis had for several years suffered from prurigo of the arms and thighs, with moist eczema of the legs. Inunctions of the iodoform ointment produced marked improvement of the prurigo in the course of a week; but the eczema became worse. This was relieved, but not quite cured, by the use of boracic acid ointment. A scrofulous boy, with enlarged cervical glands, was treated by iodoform locally and cod-liver oil internally. After some weeks, no trace of the glands could be felt. In a communication to the *Allgemeine Medicinische Central-Zeitung* of September 13th, Dr. Lindemann states that he has found that the balsam of Peru is capable of completely masking the disagreeable odour of iodoform. The addition of two parts of the balsam to one of iodoform is sufficient; but a greater quantity of the former may be used. The best vehicles for ointment are lard, glycerine ointment, and especially vaseline; and for liniment, glycerine, spirit, and collodion. Dr. Lindemann gives the following formulæ. ℞ Iodoformii partem i; balsami Peruviani partes ii; vaselini, *seu* adipis suillæ, *seu* unguenti glycerini, partes viii. Fiat unguentum. ℞ Iodoformii partem i; balsami Peruviani partes iii; spiritûs vini rectificati, *seu* glycerini, *seu* collodii, partes xii. Misce. In making these preparations, the iodoform and balsam should be first rubbed together, and the other ingredients then added. Dr. Lindemann calls attention to the fact that the application of balsam of Peru has been recommended by Dr. Caspari and others in various cutaneous diseases and ulcerative processes.

THE ACTIVE PRINCIPLES OF SQUILL.—E. Merck (*Apoth. Zeitung*, No. 26, 1879) has made some observations on the constituents of the squill, and has separated three principles, which have received the names of scillipicrin, scillitoxin, and sallin. Professor Husemann of Göttingen has examined their physiological effects; and Dr. C. Moeller has written an inaugural dissertation on the subject. Scillipicrin is a white amorphous powder, very soluble in water, and hence well suited for hypodermic injection. It acts powerfully on the heart, retarding its action, and, in toxic doses (1 to 2 centigrammes in the frog) arresting it in diastole. Scillitoxin is an amorphous cinnamon-brown powder, insoluble in water and ether, soluble in alcohol. Its alcoholic solution leaves a long-continued bitter burning taste in the mouth; and the dry powder is very irritating to the nasal mucous membranes. It is easily but not absolutely soluble in aqueous alkaline solutions. When introduced under the skin of frogs in substance or mixed with sugar of milk, it is readily dissolved and absorbed. It has a far more intense toxic action on the heart than scillipicrin, one-eighth of a milligramme being sufficient to cause death in the frog. It arrests the heart's action in systole. Scillin is a clear yellow, crystalline, tasteless powder, sparingly soluble in water, soluble in alcohol and in boiling ether, from which it is again precipitated in the crystalline form on cooling. Its action on the heart is much less than that of the other substances, but it appears to produce *malaise*, vomiting, etc. Which of the two substances, scillipicrin or scillitoxin, is the more valuable diuretic must be ascertained by clinical observation. The remarkable antagonism of their action on the heart indicates that the use of extract of squill, or of scillitin, or of squill in substance, is not the best method of administering the remedy, and that a satisfactory result is only to be expected from the separate use of one of the constituents; scillin, which produces troublesome after-effects, being eliminated.

HYPODERMIC INJECTIONS OF FOWLER'S SOLUTION IN CHOREA.—Dr. L. Péroud, Professor of Diseases of Children to the Faculty of Medicine of Lyons, has employed hypodermic injections of arsenic in chorea since 1875. M. Henri Garin describes in his thesis (*Thèse de Lyon*, No. 14) results obtained in thirty-three cases of chorea in children at the Charité Hospital. In the method followed by M. Péroud, usually four or five drops of pure Fowler's solution are injected into the cellular tissue by means of a Pravaz's syringe. An injection is made every day; sometimes every second or third day. The region preferred for injection is some part where there is loose cellular tissue and few nervous filaments. It is sometimes preferable to inject at the level of muscles most affected. The cases related occurred in female children from the age of 4½ to 14½. Among them were recent, old, and relapsed cases; cases of rheumatic, of paralytic, and of cerebral chorea. M. Garin's reason for preferring subcutaneous injections are these: first, they do not give rise to gastric disturbance; second, the curative effect is generally more rapidly obtained; third, only very small doses, administered every two or three days, are needed. Subcutaneous injections cause little trouble in children; they give rise to no local irritation, although sometimes, when the organism has become saturated, slight indurations occur at the punctures. Sometimes intolerance of arsenic is met with; but this is rare, especially in children, who take it very well. Under the influence of hypodermic arsenical medication, rapid amelioration is the rule. At the same time that the chorea advances to cure, the children become fat, the weight of the body progressively increases, and the amount of solid matters excreted by the kidney diminishes. Under

the influences of arsenical injections, sixteen cases of chorea ended in recovery, after an average of thirty-two days' treatment and about eighteen hypodermic injections. In these sixteen cases, the treatment was purely arsenical. Of thirteen other cases of chorea submitted to injections of arsenic, and also to various other remedies, ten recovered; but a longer time was necessary. These thirteen were, moreover, almost all old or relapsed cases. Hence it may be concluded that arsenic has more chances of cure in recent and simple cases than in old and inveterate cases. This is contrary to the assertions of Aran and Ziemssen.

MIDWIFERY AND DISEASES OF WOMEN.

ELEPHANTIASIS OF THE LABIUM MAJUS.—Drs. Axel Key and M. Asplund describe in the *Svenska läkaresällskapets förhandlingar* (quoted in *Nordiskt Medicinisk Arkiv*, Band xi) a case in which the latter removed from the right labium majus of a girl aged 21 a tumour weighing about ten *kilogrammes* (twenty-two pounds). It had a pedicle nearly six inches in diameter, and reached below the patient's knee when in the recumbent position. Its growth had been very rapid. The patient had also a sort of elephantiasis of the sole of the right foot and considerable swellings on the left leg and thigh. The tumour, which was twenty inches long, was uniformly long and soft, without any hard portions. On section, it was seen to be of uniform structure throughout, with a pale whitish grey colour and watery appearance. On pressure, a large quantity of nearly clear very gelatinous fluid escaped. Microscopic examination showed that the tumour was composed of perfectly developed connective tissue, with small lymph-spaces externally and very large ones internally. This was then a pure case of elephantiasis of the female genital organs; and Key considers the enormous swelling as a very rare specimen of the disease in these parts. It is interesting to observe that it was not alone, but that, as has already been stated, the thigh, leg, and foot were also affected.

OVARIAN PAIN IN PREGNANT WOMEN.—It is well known that, in examining pregnant women and trying to ascertain the position of the fœtus by abdominal palpation, the accoucheur will sometimes hit upon a spot which is so tender that a very slight pressure is apt to produce very severe pain. Dr. Budin's attention having been drawn to the subject, he has studied it carefully, and has come to the following conclusions (*Progrès Médical*, March 1st, 1879). The pain is limited to one particular spot, and has never, with one exception, been known to appear spontaneously, but is always caused by external pressure. On a level with the spot, a small body can be felt moving about under the exploring finger; it is of ovoid form, generally of the size of an olive, and can be moved transversely, though not up and down. If we draw an ideal line from the navel to the anterior superior iliac spine, we find this object either above or under or on the line itself. Dr. Budin thinks it the ovary. In following the back of the fœtus with our finger, we easily provoke the pain and find the ovary. In other cases, it could only be felt rolling under the finger when the uterus was contracted. The contraction having once ceased, it was very difficult to find it again. The left ovary seems to be much more tender to the touch than the right one; the pain is also generally prevalent on the same side. This is probably owing to the position of the fœtus, which lies generally with its back turned to the left and forwards. In two cases, however, where the child's back was turned to the right, the right ovary was painful. It is not yet decided whether this ovarian pain is spontaneously provoked during labour, and whether it can be produced after the ovum is expelled. It is also possible that ovarian pain has been mistaken for a peculiar form of neuralgia which has been called by several authors rheumatism of the uterus, or for the pain which is often caused by the head pressing on the uterine wall. Not one of the women in whom this phenomenon has been noticed was hysterical, so that evidently the pain could only be attributed to the compression of the ovary.

NERVOUS VOMITING IN PREGNANCY CURED BY ELECTRICITY.—Dr. da Venezia relates in the *Giornale Veneto di Scienze Med.* (January 1879) a case of chronic nervous vomiting in pregnancy which was cured by electricity. The patient was a young woman aged 24, in the seventh month of her first pregnancy. She had been suffering for the last two years from frequent attacks of vomiting after food, which had been so frequent during the last month that she had become greatly reduced in strength. The usual therapeutic agents were then employed; but, as no relief was obtained through them, the author resolved to try electricity. A faradic current of moderate strength was used, one of the rheophores being applied to the side of the neck along the course of the vagus nerve, and the other to the epigastrium. After the first sitting, the patient felt better; and after the fourth the vomiting had entirely ceased. The patient had six sittings of five minutes each, and after eighteen days she left the hospital cured and able to retain her food. The author draws attention to this fact, because electricity has not yet been much used in the vomiting in pregnancy, and also because it tends to confirm Professor Semmola's observations concerning its remarkable effects in nervous vomiting. Semmola, however, always uses the constant current.

PATHOLOGY.

ANTHRAX INTESTINALIS.—At a meeting of the German Medical Society in St. Petersburg (*St. Petersb. Med. Wochens.*, No. 27), the following case was reported by Dr. Kade. A girl aged 17, a seamstress, presented the following symptoms when received into the hospital. Her skin was livid; she was very restless and threw herself about; the heart-sounds were very loud; the throat and lower jaw were œdematous; the glands could be felt only with difficulty both here and in the groin; the abdomen was meteoristic and painful; the bladder empty. On being spoken to in a loud voice, she answered slowly and sensibly. There was an excoriated patch on her forehead, and a similar one on the inner condyle of the right femur, where the patient said she had had a pustule before. She had been taken ill three days ago with dysphagia, for which she had taken a dose of castor-oil. On the second and third days, she had felt comparatively well. On entering the hospital, she vomited once, and died three hours later. At the *post mortem* examination, the subcutaneous cellular tissue in the abdominal walls was found to be hæmorrhagically infiltrated; the abdominal cavity contained a serous liquid. The mesenteric and inguinal glands also presented a bloody infiltration. The whole of the intestinal tract was injected. In the duodenum, several semiglobular swellings were found, which became fewer in number in the small intestine, and disappeared in the large intestine. The spleen was soft, little enlarged; the liver was not enlarged, and was soft. Punctiform extravasations were found in the pelvis of one of the kidneys. Several bloody pustules, partly degenerated, were found on the aryepiglottic ligaments. In the apex of the right lung was a fresh infarct of the size of a walnut. The longitudinal sinus of the dura mater was filled with fluid blood. Minute extravasations of blood were on the external lamella of the sinus. The blood itself contained numerous bacteria.

MYCOSIS IN MAN.—Dr. J. Israel has published, in Virchow's *Archiv*, Band lxxiv, a recent observation on this affection. The patient, a woman aged 39, had had, ten months previously, a fall, striking her chest against a bedpost. Three months later, she had pains in her limbs and daily repeated attacks of fever, and entered the hospital in a state of great prostration. Her appearance was suggestive of general septic infection. The whole body was covered with marks and scars of old abscesses as well as with fresh ones; there was a particularly large one on the left side of the thorax opening into a fistula, through which large quantities of fœtid pus were voided. The pus was of a green colour, and covered with small yellow corpuscles of the size of a pin's head or larger, which could easily be taken out with the point of a needle. When examined under the microscope, these corpuscles were found to consist in the centre of a thick mass of fungi, from which long thread-like appendices issued, branching off in every direction. The space between the latter was filled up with pus-corpuscles which had undergone fatty degeneration. There were three different classes of fungi: delicate threads of mycelium, micrococci, and a third form, pear-shaped and brilliant. The same constituents were found in the other abscesses. The woman died three weeks after entering the hospital. The necropsy showed that the large abscess in the thorax communicated with a large cavity filled with pus in the left lung. The liver, spleen, intestines, and kidneys, were covered with purulent foci varying in size from a lentil to an apple, and containing the same species of fungi. In the kidneys, the convoluted tubes were found in several places to contain embola formed of fungi, though there was as yet no suppuration in their vicinity. There could be no doubt as to the abscesses having been caused directly by the parasites, although it was impossible in this case to find the primary source of infection. The author, however, has offered the following hypothesis. He had noticed before that, in cases of caries of the teeth which had given rise to abscesses in the gums, the pus of the abscesses contained fungi which bore a close resemblance to those which he discovered in this case of pyæmia or septicæmia; this led him to suppose that the patient in question had a carious tooth, whence the fungi might have been aspirated into the lungs, and by some chance into a pneumonic focus which had been caused by the fall, and ultimately have been carried through the system through the medium of the circulation.

INTERNATIONAL CONGRESS OF MEDICAL SCIENCE, AMSTERDAM.

THE Sixth International Congress of Medical Science was held in Amsterdam during the week from September 7th to September 13th.

Bright's Disease.—The following note was presented to Section I—that of Medicine—at the discussion on Bright's disease, by Professor Semmola of Naples. It comprised a *résumé* of the communication made by Dr. Semmola to the International Medical Congress at Brussels, on different kinds of albuminuria, which was reported in the *Gaz. Méd. de Paris*, 1875; also a *résumé* of further researches made by Professor Semmola, and communicated to the present International Congress of Amsterdam. He said:

1. My first researches were conducted as far back as 1850. I think that I was the first to show the classic influence of alimentation and diet on the quantity of urine which is secreted in Bright's disease. (See Jaccoud's work, *Manual of Internal Pathology*, Paris, 1873, vol. ii, p. 685.)

2. This influence of diet on the increase or decrease of albumen in the urine, according to the greater or less amount of nitrogenous elements in the food, was the starting-point of all my researches. It led me to conclude that it is absolutely necessary to direct our attention not only to the renal lesions, but also to general nutritive disturbances in which the albuminoid bodies are either not at all, or only imperfectly, assimilated and consumed.

3. This idea, which I have always endeavoured to develop concerning the etiology of Bright's disease, has, to my mind, been confirmed by another classical fact which has hitherto remained completely misunderstood. I mean the considerable and progressive decrease in the quantity of urea which is formed in the organism from the first stages of chronic Bright's disease. (See note at the end.)

4. I have always insisted on this classical and fundamental point, and have repeatedly made communications on the subject to the Académie de Médecine of Paris and to that of Naples. I especially insisted on this point in Paris (1867) and in Brussels (1875), and have convinced myself by the study of three hundred clinical cases that the decrease of the urea from the first stages of Bright's disease is owing to a defective oxidation of the albuminoid matter.

I find that in all books authors speak of the defective excretion of urea; but I have never yet been able to discover anything about the defective formation, which I am sure is a principal and fundamental fact: a characteristic phenomenon of Bright's disease.

It is caused by the total or partial absence of the cutaneous functions. In consequence of this suppression of the respiratory functions of the skin, two chemical disturbances arise, which are closely united from a biological point of view—viz., the alteration and inassimilability of the albuminoid substances, and defective combustion, *i.e.*, a decrease in the formation of urea. I leave it to experimental physiology to elucidate the part which the cutaneous functions play in the assimilation and combustion of albuminoid matter. I shall merely restrict myself to pointing out the intimate connection between the two which has been revealed by the pathological condition; and I foresee that it will lead to the solution of a problem which is of great importance both for physiology and pathology. As I have said before, this is a capital and fundamental fact, that can be repeated experimentally by varnishing to a certain extent the skin of a dog. It proves that the real chronic Bright's disease is a general affection, a defect in nutrition, in which the changes that take place in the kidneys (beginning with hyperæmia and ending with cirrhosis and atrophy) do not constitute the primary cause of the principal symptoms of the disease. Physiology fails to explain by what mechanism a morbid process, which has been confined to the kidneys from its very beginning—that is to say, at an epoch when they still fulfil their duty as purifying apparatus—could have had any effect on the production of urea, and thus act on the whole system. I beg my honourable colleagues to direct their attention to this point of renal pathology. It is a most important point, that has hitherto remained unobserved, because it can only be studied in the first stages of the disease, which only in rare cases come under notice in hospitals and clinics.

In all other cases of albuminuria that are not instances of true Bright's albuminuria, this decrease in the production of urea which runs parallel with the increase of albumen is not found. Consequently, it is of the highest importance to distinguish carefully between these different kinds of albuminuria so as to avoid a mistake that is often made and is dangerous, both clinically and therapeutically. The cause, the mechanism, the evolution, in short the *cachet* of the general chemical process of nutrition, combined with the decrease in the production of urea, and last but not least, the pathological alterations which take place in both kidneys, form a harmonious *tout ensemble*, which is always the same and constitutes the true type of Bright's disease properly so called.

6. The decrease in the production of urea which takes place in other cases of albuminuria is not in any way connected with albuminous filtration. It may exist in some cases, but varies very much according to the particular disease that has produced the albuminuria, and at the same time created disturbances in the general process of nutrition (heart-disease, etc.). Here, however, the decrease in the production of urea is not connected with the phenomenon of albuminuria; its progress takes place in an entirely different way, and it is not till the last stage of those various affections, *i.e.*, when the kidneys have become thoroughly diseased (amyloid degeneration, etc.), that a very considerable decrease takes place in the secretion of urea in the urine for want of filtration. It results from the aforesaid, that this decrease is a mechanical effect which gives rise to the accumulation of urea in the blood with all its fatal consequences.

7. In Bright's disease, properly so called, there are two causes for the decrease of urea in the urine. In the first stage of the disease, the decrease is caused by incomplete combustion, a defective nutrition, combined with changes in the albuminoid, which is gradually developed, owing to the suppression of the cutaneous functions. Later on, that is to say, when the affection of the kidneys has reached a further stage, a second decrease of the urea takes place in the urine owing to defective secretion.

8. The tendency to exaggerate the anatomical point of view of the affection has led to neglect of the chemical and more universal aspect of it, thereby producing a conclusion which is perfectly paradoxical so far as regards scientific pathology, *i.e.*, "clinical unity" and "anatomical plurality" (large white kidney, amyloid degeneration, etc.). It is impossible to perceive in what way a general alteration, which shows itself with the same symptoms and consequently must spring from the same causes, can bring forth different anatomical results. The final difference in the lesion shows that there has been a difference in the nature of the preceding morbid processes. By combining all the conditions under which the symptoms constituting the clinical aspect can exist, the successive evolution of the process, and the constant relation between it and its special causes, we shall succeed in reconstructing the edifice of true Bright's disease, and in distinguishing it as a peculiar pathological species which differs from other species of albuminuria.

9. The passage of albumen into the urine may take place through the three physiological factors that preside over the renal functions; viz., *a.* chemical constitution of the blood; *b.* degree of pressure; *c.* condition of the histological elements of the filtering apparatus.

10. Consequently, there are three classes of albuminuria, viz.: *a.* dyscrasic albuminuria (caused by excess of presence of the albuminoid constituents of the blood or by alterations occurring in them); *b.* mechanical albuminuria; *c.* Albuminuria produced by irritation, *i.e.*, by some local histological cause existing in the kidney. This species is caused by the irritating effect of all the agents that penetrate into the kidney, either from without or that are formed in the organism.

These three classes of albuminuria are closely related to different anatomical conditions of the kidney. If each one of these three conditions have been only transitory, the anatomical structure of the kidney may remain in its normal condition and no albuminous filtration will take place (as in series *a*). In other cases, it may be modified by a transitory morbid process, and then regain its previous normal condition. Finally, if the pathological condition that has given rise to albuminuria be persistent, the anatomical structure of the kidney undergoes a gradual change, and causes a particular defined lesion which differs according to the cause, and is in relation with each of the three factors which have modified the renal function so as to determine the filtration of the albumen. This will be more clearly shown in the diagram which follows:

If we look at the clinical history of Bright's disease properly so called, with a view to classifying it among one of the preceding groups, we find that it cannot be placed exclusively under either of these heads. It is a mixed albuminuria, *i.e.*, its complicated etiological mechanism contains all the other three mechanisms of the other classes of albuminuria, and it forms a pathological specialty that has nothing whatever to do with the other classes of this affection. Analysed in this way, Bright's disease reveals a constant evolution and a harmonious relation between the nature of the cause, the etiological mechanism, the chemical and anatomical alterations, and the clinical form. The *modus operandi* is as follows: *a.* The gradual effect of moist cold on the skin. The gradual action of moist cold is the only cause of true Bright's disease. Other causes produce albuminuria and lesions that differ from the true type. *b.* The respiratory functions of the skin decrease gradually, till they

cease completely. Their absence gives rise to the following disturbances, which appear at the same time, and are closely connected with each other: 1. Cutaneous ischæmia; 2. Accumulation in the blood of matter which ought to have been excreted by the skin; 3. Alteration of the albuminoid bodies, so that those which originate from the peptones are not assimilated; 4. Decrease in the combustion of the albuminoid bodies, and consequently in the production of urea.

Diagram of Classes of Albuminuria.

Variety of Albuminuria.	Causes.	Condition of Kidney.	Urea in the Blood and in the Urine.
a. Chemical conditions of the blood. Dyscrasic albuminuria.	Presence in the blood of an excess of albumen, owing to the diet.	Normal kidney.	The maximum of urea, sulphates, & phosphates contained in the urine varies according to the individual.
	An excess of the albuminoid constituents of the blood, owing to defective combustion.	Irritative hyperæmia, which is more or less intense according to the organ or apparatus whose functions are affected: the cutaneous surface, lung-disease, etc.	Progressive decrease of the urea in the urine, though it is not accumulated in the blood. Want of production.
	A change in the chemical constitution of the albuminoid bodies which circulate in the blood. This change renders them incapable of being assimilated, etc. (cachexia).	Fatty degeneration. Amyloid degeneration.	*Idem* owing to the gravity of the case which causes cachexia.
b. Degree of pressure of the current of the blood. Mechanical albuminuria.	Various neuropathic affections having a direct or indirect effect on the vaso-motor system.	More or less transitory renal stasis.	Amount of urea almost normal, within the limits of physiological oscillations.
	Pregnancy: in short, every kind of pressure exercised on the inferior vena cava or the renal veins.	*Idem*, but occasionally the stasis becomes permanent, owing to the general conditions of the organism, or to organic causes that produce the lesion.	Amount of urea not depending on the pregnancy or the organic causes that produce pressure.
	Cardiac diseases that have not yet reached the stage of compensation.	Persistent stasis, cyanosed kidney, cardiac kidney.	Amount of urea decreases in proportion as the affection of the heart increases.
c. Histological alterations take place in the kidneys. Irritative albuminuria.	All the irritative processes in the kidneys, from their first stage up to complete nephritis.	All the anatomical consequences of inflammation beginning at the first stage, and the degeneration of the different kinds of epithelium up to renal sclerosis and atrophy.	Amount of urea is normal or slightly increased, owing to the fever (acute stage).
	The albuminous filtration is more or less considerable in proportion to the *rôle* and effect that the inflamed elements may have in the mechanism of the urinary filtration.		Decrease in the production of urea, though there is no increase in the blood, owing to general disturbances in the combustion.
		This depends on the special histological seat of the inflammation and its particular course.	Decrease in the production of urea owing to defective filtration, and consequently accumulation in the blood.

If it were possible to arrest for a moment the harmonic solidarity of all the organs and apparatus, the kidneys might be excluded, as it were, for a certain time, during which first period they would be in no way connected with the true pathology of Bright's disease. But a similar abstraction can only be conceived in order to show that the anatomical lesions of the kidney are only a secondary process, and do not constitute the initial lesion of Bright's disease.

The four aforesaid causes produce the following effects upon the kidneys:

1. Renal hyperæmia. (Increase of pressure.)

2. Irritating effect of the said hyperæmia, owing to the accumulation in the blood of substances that ought to have been excreted by the skin, and its dyscrasic condition in consequence. (Inflammatory effects.)

3. Elimination of the albumen through the kidneys (the depuratory organs *par excellence*), because, the constitution of the albumen being altered, owing to paralysis of the respiratory functions of the skin, it has become an useless substance, and may almost be regarded as a foreign body in the organism.

4. The progressive decrease of the urea in the urine is the result of the decrease in its production.

Thus we have a twofold series of effects, that are closely connected with and complement each other, *i.e.*: 1. The general nutritive lesions, with all their characteristic consequences; 2. The anatomical development of the inflammatory process of both kidneys, from the first stage to the last. These two series of disturbances constitute Bright's disease, or Bright's albuminuria.

The differences which exist in the clinical form of other albuminurias, and the combination of various final anatomical lesions existing in the same kidneys, depend entirely on special etiological causes (alcoholism, gout, syphilis, etc.), which modify the general condition of the individual, and consequently add to the renal lesions that are peculiar to the inflammatory chronic process other elements that vary according to either the nature of the alteration, or to their seat being more or less confined to one or the other of the different histological elements which constitute the kidneys. It follows that true Bright's disease has nothing to do either anatomically or clinically with any of the other species of albuminuria, whatever may be their origin. I also believe that it is not at all true, though affirmed by several authors, that Bright's disease may be caused by alcoholism, gout, etc. Whether considered from a scientific or a practical point of view, this appears false; because it is a well known clinical fact that there is such a thing as albuminuria caused by gout, alcohol, etc. And each one of these affections corresponds to general nutritive alterations, which differ not only according to their etiology, but also are represented anatomically by considerable alterations in the kidneys, which in some cases are due to nephritis. These alterations, however, vary very much, so far as regards the affected spots; sometimes they are restricted to one kidney alone (embolic nephritis, pyelitis, stone, syphilis, etc.). If both kidneys be affected, we always find that there exists a secondary disease, in which predominates an inflammatory condition either of the elements of the parenchyma or of the connective tissue, and which is either due to the irritating effect of a foreign body that passes through the kidneys (alcohol, resinous matter, cantharides, etc.), or to the presence of a deposit of urea that irritates and inflames the neighbouring tissues. In cases of degeneration (fatty, amyloid, etc.), the kidneys are as much affected as many other organs (liver, spleen, etc.); and it would be absurd to regard these cases as belonging to Bright's disease. I repeat it again and again, I am justified by my researches in concluding that true Bright's disease is a constant clinical type, a pathological specialty the characteristics of which *intra vitam* are albuminuria, absence of urea, cachexia, and a peculiar anasarca. The anatomical changes consist in an inflammatory process of both kidneys, which progresses very slowly, and extends gradually over the whole of the organ. These changes, however, are not quite the same for all the elements of the kidneys, but differ according to the physiological part that each element plays in the discharge of the renal function. All the exclusively histological localisations that have been held up as special forms of Bright's disease do not exist in nature in an isolated condition. They may only predominate in some elements that are more affected than others. That this renal affection is always a bilateral one I have already mentioned. I believe that this constant bilaterality constitutes, from an anatomical point of view, the peculiar characteristic or the final control of true Bright's disease, thereby adding a new proof to what I have said, viz., that there exists a profound universal deterioration of the system, which precedes the outbreak of the disease, and must necessarily act on both kidneys at the same time, though with characteristic slowness.

According to my opinion, this constant renal alteration ought alone to be called "Bright's kidney", for the following reasons, viz.: It is caused by the effect of moist cold; the dyscrasia following it is of a particular nature; and finally it develops gradually from a simply hyperæmic state till it becomes atrophic. It may occasionally reveal somewhat different symptoms; but this only takes place when another cause (alcoholism, gout, etc.) is superadded to the action of moist cold. Thus we have a series of complicated effects, both in the clinical form *intra vitam*, and in the nature of the alterations which are found in the kidneys and other organs after death.

I shall have the honour of communicating in a few words the results that I have obtained in the treatment of Bright's disease, by taking the said doctrine as my starting-point. I shall submit them to the judgment of my illustrious colleagues, and thank them beforehand for their kindness.

POSTSCRIPT.—It is true, that several authors acknowledge that there is a more or less considerable decrease in the production of urea from the onset of the disease; but they ascribe it to the anæmic condition of the patient. Now, this decrease in the secretion of urea dates from the

first time that albumen appeared in the urine, that is, from an epoch when it is impossible to admit that an anæmic condition has been induced by the want of albumen in the blood.

I repeat it, and it is a most important fact, the decrease in the combustion of the albuminoid bodies is caused by an alteration which takes place in them after the suppression of the cutaneous respiration. The decrease of urea and elimination of albumen are two facts which are closely connected with each other from the first moment of the affection.

Beri-Beri.—M. VAN LUNT read a paper on beri-beri. After having given an exhaustive historical sketch of the affection, the author proceeded to speak of its geographical distribution. Beri-beri is met with principally in the tropics, but also in China and Japan up to the fortieth degree of north latitude, on the eastern coast of Australia and southwards of the Cape of Good Hope to the thirty-sixth degree of south latitude. The characteristic of this disease, which is regarded by the Germans as merely a variation of the affection commonly called pernicious progressive anæmia, is an impoverishment of the blood, together with all the symptoms of serous anæmia; *e.g.*, increasing prostration, shortness of breath, pains and formication in the lower extremities, the latter being rather stiff; and motor paralysis. At the same time, the said members grow anæsthetic, the anæsthesia spreading gradually over the whole of the cutaneous region, and coinciding with muscular hyperæsthesia. The patient has anasarca, and effusions take place in the serous cavities. The temperature is rather low than otherwise (97.8°). The affection is an essentially chronic one; sometimes there is an apparent amelioration of the symptoms, but the patient never recovers. Death generally comes on in the midst of nervous complications (coma, convulsions), or from exhaustion following vomiting. On examining the blood under the microscope, the number of the red corpuscles is seen to be greatly diminished; they also seem to have lost their tendency of forming rolls. The blood contains a large number of microcytes, and of granulated brilliant bodies. The solid principles of the blood (albumen, fibrin, fat, salts) are greatly decreased in proportion. In short, the blood has become hydræmic. All those who have carefully studied this affection in the countries where it occurs most frequently attribute it to the want of proper food, from which the inhabitants of the said countries almost constantly suffer. To this may be added other causes, such as overwork, pregnancy and lactation in the female sex, dampness of the climate, etc. The treatment, according to the author, consists in the administration of diuretics, tonics, analeptics, and principally in a strengthening diet. The affection might perhaps be prevented if the nations that are now decimated by beri-beri were protected from famine by prophylactic measures.

On Stammering.—M. CHERVIN of Paris read a paper on stammering. This disturbance of speech is generally ascribed to a spasm of the muscular apparatus that aids in the articulation of sounds. This theory, which is essentially false, has led surgeons to perform many unfortunate and useless operations (section of the tongue or of certain of its muscles, of the hyoglossus; extirpation of the tonsils, the uvula, etc.). M. Chervin thinks that stammering is caused simply by a disturbance in the co-ordination of the movements that are necessary to emit an articulated sound. This explains how it is that this disturbance of speech is frequently of an intermittent type; and why, under the influence of a methodical treatment, which is in reality only a series of gymnastic exercises, that are practised by the apparatus which helps to form articulate sounds, it is possible to cure this affection in a very short time. The author has gathered from statistics that, from 1850 to 1869, 13,215 young men in France were exempted from serving in the army because of stammering. Great discretion must, however, be exercised in delivering certificates on the subject, as stammering is very easily counterfeited. In general, fright and emotion play a great part in the etiology of the affection. It occurs more frequently in the male sex than in the female, which the author attributes to the fact that young girls are less exposed to violent emotions. The treatment lasts about three weeks. During the first week, the patient has to go through methodical exercises of reading and recitation for a certain number of hours daily; for the remainder of the time, he must be perfectly silent and isolated from his friends. In the second week, he is allowed to speak to his attendants or friends, but must speak very slowly, and pronounce each syllable distinctly. In the third week, the patient may converse freely, but must still speak very slowly.

On the Indications and Counterindications for Operations in Individuals suffering from Constitutional Diseases. — At the fourth general meeting of the Congress, Professor Verneuil spoke at length on the pathological importance of this question. His communication may be shortly summarised as follows. 1. Surgical operations are not formally counterindicated in individuals who are affected with constitutional diseases. They may be performed under such circumstances, are often useful, and in some cases even very necessary. 2. Their prognosis is much more serious than in healthy individuals. It is less certain, and more difficult to make; for we have no clue whatever as to the favourable or deleterious effect that the traumatic lesion may have on the general health of the patient; neither can we judge in what way the disease will affect the local process of healing. 3. The prognosis varies according to the different constitutional diseases, and for each of them considered individually. It varies also according to the degree of the alterations that have taken place in the different parts of the body. 4. The danger attached to the diathesis is not great as long as it is still confined within the boundaries of dyscrasia. It increases considerably with the manifestation of chemical and histological lesions. It becomes alarming when the principal viscera—such as the liver, kidneys, spleen, heart, lungs—are extensively affected by sclerosis, steatosis, amyloid degeneration, phlogosis; or when they present pathological products that belong specially to certain diathetic conditions—*e. g.*, tubercles, gummata, carcinomata, and various neoplasms. 5. We are not justified in depriving diathetic individuals of the benefit of surgical intervention, even in cases where it might be dangerous. It must be the aim of the practitioner to render the prognosis less serious, and to assure the success of the operation. He will succeed in doing this if he be very careful about choosing the most favourable moment for the operation, adopting the best method for performing it, and applying the most efficient dressing. He will also do well in putting the patient under a hygienic, dietetic, pharmaceutic treatment—in a word, under a medical treatment which is adapted to the constitutional disease. 6. The practitioner must be thoroughly well acquainted with the etiology, pathology, development, the end, and the medical treatment of constitutional diseases, in order to make sure of the indications or counterindications for the operation. In this way, he will be better able to judge whether he had better perform the operation or not, and to calculate with more or less precision what the chances may be. A knowledge of these conditions, which perhaps all surgeons do not possess to a sufficient degree, would tend rather to prevent surgical operations than to encourage them, and would inspire the operator with a higher degree of confidence in the efforts of nature supported by a comparatively mild therapeutic treatment. 7. A conscientious examination of the immediate or future effect of operations performed on individuals under some constitutional diathesis will tend to destroy many of our illusions respecting the power of surgical art. It is sad to say, though we must say the truth, that complete and lasting favourable results are very rare. No doubt, there may be many successful operations; but the therapeutic results may be far from successful. A manifestation of the diathesis or some intercurrent affection may be suppressed; but frequently the constitutional disease increases in force and rapidity. Many patients suffering from cancer and scrofula would live longer if they had remained under medical treatment, instead of passing through the hands of surgeons. 8. It is only just to add that, although the aforesaid operations are more frequently attended by palliative than by curative results, nevertheless they are sometimes extremely useful. In extreme cases, they may prolong life, render it less hard to bear, and give the patient at least a gleam of hope. In less serious cases, and where the constitutional disease may be successfully treated, the operation has a good effect upon the treatment, by allowing the medical man to gain time, suppressing an immediate cause of danger, and giving the therapeutic treatment greater scope.

M. Verneuil's address was much applauded, and he received a hearty vote of thanks from the meeting.

Extract from the Remarks of Professor Sayre of New York on the Treatment of "Spondylitis", and of "Scoliosis", by Partial Suspension to improve the position of the Body, and the application of Plaster-of-Paris Bandage to retain it: and his Conclusions. — Dr. SAYRE said: I am very much obliged for the invitation to make a *practical demonstration* of the plan of treatment adopted by me for some years past for Pott's disease, and also for lateral curvature of the spine. By this means, a more clear and definite understanding of the plan can be conveyed than it is possible to impart in any other manner with the same accuracy and attention to minuteness of detail which is so essential to success. It is neglect of these details in the preparation of the materials, used in the elastic shirt employed, and in the proper application of the gypsum bandage, that has caused the failure of the treatment in the hands of some.

I am quite confident that there is no case of spondylitis, or of scoliosis, that is in condition to be treated by any mechanical means which cannot be more successfully treated by this method than by any other yet devised. At the same time, it can be done with perfect freedom from pain or discomfort, and without any of those excoriations so common in the use of all other mechanical appliances. If any of these accidents should occur in the treatment of a case, it will be due not to the plan which I have suggested, but to the imperfect manner in which that

plan has been executed. I have known of cases in which the surgeon or physician had become convinced of the correctness of the plan of treatment, and then transferred the patient to the instrument-maker for its application; and of course, in the majority of cases, this transference to incompetent hands, would produce a failure, and thus bring the treatment into discredit.

I suppose that, in cases of cataract, hernia, ovariotomy, stone, aneurism, trephining, or any other surgical operation, if the same rule were to be adopted, it would be attended with similar results. Certainly no surgeon would expect his instrument-maker to perform any of these operations for him. Neither has he the right thus to expose the life of his patient to danger, or to impose upon the instrument-maker the delicate duty of the application of a bandage, which requires as much, if not more, skill than is necessary for the performance of any of the operations above referred to.

The first requisite is an elastic woollen shirt, knitted and without seams, similar to a stocking, with tapes at the top to tie over the shoulders, instead of sleeves, as the shirt can then be pulled tightly down, and secured by a safety pin between the limbs; and thus, by its elasticity, be made to fit accurately all the inequalities of the trunk. Previous to its being thus secured, a pad of cotton, folded in a napkin, should be placed under the shirt, over the region of the stomach; and in females it should also cover the mammæ. After the plaster has "set", this pad is to be removed, and thus allow room for the stomach to expand after meals, and also to prevent any undue pressure on the mammary glands. The bandages should be made of coarsely woven muslin, called "crinoline", so that the plaster can be rubbed into its meshes. They should be from three to four inches wide, and about three to four yards long. The gypsum should be pure, and freshly ground, and perfectly dry; it should be rubbed into the meshes of the cloth, and then rolled, but not too tightly. As thus prepared, the bandages can be kept in an air-tight vessel, ready for use at any moment. If the climate be very wet, it is as well to subject them to the heat of an oven for a few minutes before using, to evaporate any moisture the plaster may have absorbed.

When about to apply the dressing, the surgeon takes a single roll of the bandage, and drops it into a vessel of cold water, which should be deep enough to completely immerse it in the vertical position, and, as soon as the gas has all escaped, it is ready for use. As he removes it from the water, he squeezes out the surplus water, and drops into the basin another roll—end up—and, by the time the first one is applied, the next will be ready for use. This is to be continued until as many are applied as each particular case may require.

In cases of spondylitis, the patient is to be carefully extended by the head and axillary straps, until he is perfectly comfortable, and never beyond that point.*

I have learned that some surgeons administer an anæsthetic during suspension. I think this practice extremely dangerous, and should most strongly condemn it.

As soon as the patient has been extended until he is perfectly comfortable, apply the wetted roller-bandage smoothly over the skin-fitting shirt, not drawing it tightly, but simply unrolling it around the body, while an assistant follows with his hand and fingers, and presses it into all the inequalities and irregularities of the body, thus obtaining an accurate mould of the trunk in the improved position which extension has given to it; and, by keeping the patient in this position for a few minutes until the plaster has "set", he will then be retained exactly in the same position so long as the plaster remains unbroken.

After the plaster has "set", the pad which has been placed over the stomach and mammæ is to be removed. Slight pressure should be made over the lower part of the abdomen in the crista ilii before the plaster has hardened, so as to mould it to the form, and remove the undue pressure on the spinous processes and the crest of the ilium. As soon as the plaster has "set", the patient (unless paralysed) can go out of doors and take the ordinary exercise so necessary for health, and, if an adult, can resume some active employment by which he can earn his support.

The advantages claimed for this plan of treatment are:

1. Its applicability in all cases where any mechanical treatment can be applied, and by any physician in the country without the aid of an instrument-maker.

2. That, being accurately adjusted to all parts of the body when in its improved position, it gives more uniformity of support than can be done by any other means, and without making any undue pressure at any prominent point, and thus avoids all danger from sloughing and excoriations.

3. By absolutely immobilising the spine, and removing undue pressure from the inflamed portion of the vertebræ, it affords greater facilities for ankylosis than can be given by any movable apparatus.

4. The patients thus treated are capable of daily exercise in the open air, so necessary for health, and also of earning their support by manual labour.

5. By applying this treatment in the early stages of the disease before deformity has occurred, the patients will be cured (when curable) without any deformity.

Dr. Sayre then applied the treatment to a boy aged six years, who had a very bad angular deformity in the middle dorsal region from Pott's disease of two years' standing. He was unable to sit up or stand without support, and suffered intense pain on the slightest movement of the body. He had worn a "Taylor's spinal supporter" constantly for two years. When first applied, as stated by Professor Tilanus and Dr. Zegers, the deformity was scarcely perceptible; and although the instrument had been constantly applied and most carefully adjusted, yet the deformity had very materially increased, and the disease was still progressing. The boy was carefully suspended by the neck and axillæ until he expressed himself as feeling comfortable; and the change in his face was certainly most marked, being changed from a pinched expression of agony to a smile of real pleasure. Dr. C. H. H. Sayre, the son of Dr. Sayre, while the boy was thus suspended, then applied the bandages, his father rubbing each layer firmly together and carefully pressing them into all the inequalities of the body. A small pad was placed on either side of the projecting spinous processes to protect them from undue pressure. The head-support or "jury mast" was also added to take off the weight of the head, as suggested by Dr. S. W. Gross of Philadelphia. When the plaster had "set" and the head-swing had been properly adjusted, the little fellow ran around the Hospital without supporting his hands upon his knees as formerly, or resting on any article of furniture.

[Amsterdam, September 15th.—I saw the boy running in the ward to-day, and he says he has been free from pain since the jacket was applied.]

Dr. Sayre then applied the treatment in the case of a young girl with a very severe lateral curvature after she had suspended herself by the pulley and head-swing, as suggested by Dr. Lee of Philadelphia. When she came into the lecture-room, she was wearing a complicated spinal brace with lateral supports and springs worked by screw and lever, the object being to force the body straight. Before this instrument was removed, she was placed against the wall and her height accurately measured by Dr. Zegers. The instrument was then removed, and the same measurement taken. She had increased in height without any extension being applied very nearly three-quarters of an inch; thus proving conclusively that the instrument was not only of no use whatever, but absolutely injurious. The instrument was a very good imitation of Mr. Brodhurst's of London, and manufactured by Busch of Amsterdam. There was an extensive chafe on the projecting angles of the ribs, as also under the axillæ and from the shoulder-straps over the clavicles, showing that the instrument had been applied with as much force as the patient could endure, and yet she was much more erect when it was removed than she was when it was on. The knitted shirt was then put on, the mammary and stomach pads applied, and the shirt having been previously secured between the thighs, was then drawn up very firmly to make it entirely smooth; and secured by tying the tape over the shoulders. The patient then partially suspended herself by slowly climbing up a rope, which ran over a pulley and was attached to a collar under her chin and occiput. As she thus climbed up the rope, with her arms extended to their full length, until the heels were slightly elevated from the floor, a marked change took place in the curvature of her spine, which was very perceptible to everyone in the room. While she was thus suspended, Dr. C. H. Sayre applied the plaster-bandage, his father carefully rubbing in each layer and making gentle pressure into each intercostal space; and in a few minutes she was completely encased from axillæ to pelvis in the plastic cuirass. So soon as the plaster had become hard, she was placed against the wall where she had been previously measured, Mr. Lister of London and Dr. Zegers of Amsterdam again made an accurate measurement of her present position, and it was found that she had increased more than an inch and a quarter in height, and was nearly two-and-a-half inches taller than she was with the spinal brace upon her. After adjusting her dress, she seemed perfectly comfortable, could take deep full inspirations, and was certainly very greatly improved in her appearance.

The success in these two demonstrations was complete, and the superiority of the plan of treatment very frankly admitted by every member of the Congress present.

Professor Marey's Pedomètre.—M. Marey read a communication on experiments he has been making on walking, by means of a special

* The apparatus and mode of application are fully described in *Sayre on Spinal Curvature.* Smith, Elder, and Co., 15, Waterloo Place. London: 1877.

pedomètre, which registers the steps. This contrivance consists in a rubber-tube, which connects a rubber-ball placed in the sole of the shoe with the instrument itself that is suspended over the shoulders like a field-glass. In this way, he has been enabled to study the differences between walking on a level ground and walking up hill, for the step changes according to the declivity of the soil. Thus, in walking up hill, the step is longer by a fifth than in walking on level ground. This, however, applies only to the going up, as, on the contrary, the step is shorter in going down. The shape of the shoes has also great influence on the gait; the best shoes are those that are almost without heels, and where the sole is a trifle longer than the foot. Thus, the physiological experiments have only confirmed what had been foreseen by practised walkers, and revealed by the pathological phenomena which occur in individuals who use bad shoes, especially those of the kind called Louis XV. By means of the same instrument, M. Marey is able to register the movement of a carriage, and, in short, the "frequency" of any phenomenon which takes place during several hours. He obtains graphically a curve, which varies in length, and consists of a series of lines. The elevation of the curve is in direct proportion to the number of times the phenomenon has been repeated within a given time. He has also studied respiration during sleep, and has found that it remained the same during the first hours of sleep and became less deep only towards morning. The respiratory movements grow superficial towards 5 A.M. Finally, M. Marey presented, in the name of M. d'Arsonval, one of the most distinguished young French physiologists, the report of a highly-interesting discovery. M. d'Arsonval has succeeded in discovering a proceeding by means of which it is possible to calculate closely the amount of caloric thrown off in a given time. The method used hitherto was very imperfect, and consisted in placing the animal in an apparatus which was surrounded by ice, the water that was obtained from the melting of the ice being subsequently collected. This was a highly imperfect proceeding, and the conditions in which the animal was placed were very bad. M. d'Arsonval has constructed an apparatus, with a mean temperature of 30° C. (86° F.). Whenever a change takes place in this temperature, water flows in and the original temperature is re-established. The air which the animal breathes is of the same temperature, and it may be kept for hours in this apparatus. By means of this method, it will be possible to make numerous experiments respecting the temperature of the body under the influence of food, hunger, fever, putrid infection, etc.; and not only the sum total of heat that has been produced, but also the different phases through which it has passed. M. d'Arsonval has discovered that there exist very interesting differences between the heat produced by different animals. Thus, *e.g.*, the rabbit throws off one degree of caloric in twenty minutes, but the guinea-pig throws off more, which shows clearly that the bulk of the animal is not a sufficient indication for calculating the heat produced by living beings. These experiments are made with wonderful precision, and, owing to the graphic method, they may be carried on for a considerable length of time. All the mistakes that arise from the imperfections of our senses are eliminated, as the results are inscribed automatically.

On the Transfer of Sensibility.—A paper was read by Professor Eulenburg of Griefswald, called "Researches on the Transfer of Sensibility". The question asked was: Do the agents which modify to a certain point (either by increasing or lessening it) the sensibility of the cutaneous region of either half of the body, produce consecutively the same disturbance in a corresponding spot of the opposite half of the body? The author then proceeded to give an account of the agents which have appeared to him the most capable of modifying the sensibility of the skin. The following were the proceedings employed to increase the local sensibility: cutaneous faradisation (along the dorsal part of the right forearm till a circumscribed redness was produced); or mustard poultices prepared especially for this purpose by Aebler and Rumpf. The latter agent seems to be less reliable and to act less rapidly. For the purpose of diminishing the local sensibility, the author has used Richardson's method, which consists in irrigating the part with pure ether or "compound fluid", by means of a pulveriser. The effects of the proceeding were heightened by combining it with Zesamendi's modification (a superficial incision of the epidermis after irrigating the spot for about two minutes). In a very short time, a circumscribed ischæmia is produced, with loss of sensibility. M. Eulenburg has measured in all his experiments: *a.* the perception of space (*Raumsinn*) of the skin, by means of Sieveking's æsthesiometer; *b.* the faradic sensibility, by testing the minimum of sensibility with volta-faradic currents, according to Munk and Leyden's method. The following are the results obtained from the experiments made on ten persons (medical students). 1. The faradic stimulation of the skin produces an increase in the sense of space and in the electric sensibility of the stimulated part; simultaneously a decrease takes place in both these classes of cutaneous sensibility in the corresponding part of the body. These alterations migrate from one part to the other; in some cases, there is even a period of oscillations following the initial decrease in the corresponding part, during which the faradic sensibility seems to be increased. The normal condition is restored in both parts almost simultaneously. 2. Local hyperæsthesia (decrease in the "perception of space", and in the faradic sensibility) that is caused by the ether spray is constantly accompanied by a considerable increase of sensibility in the symmetric spot. The oscillations are absent in most of the cases, but the decrease is much more sharply defined than the increase in the opposed region. These experiences prove that transfer is a physiological fact which is simply exaggerated in pathological cases. Perhaps the cutaneous sensibility belongs to the bilateral symmetrical functions (similar to the secretion of sweat). The application of certain metals, or the approach of a magnet, would suffice to produce centripetal effects (functional alterations) in the regulating centres of this symmetric action.

Report of the Last General Meeting.

On the Functions of the Metric System in Medicine.—On international uniformity in medicine, (*a*) in private and in hospital practice, (*b*) as a general basis of medicine, (*c*) and of universal medical statistics, Professor SEGUIN spoke as follows:

When the Congress of Geneva separated, there still existed a considerable gap in the mode of communication between medical men. The metric system having since then been accepted by the American Medical Association, and a metric commission having been appointed by the British Medical Association, a constant current of observation and experimentation will soon be established. We hope that the time is coming when nobody will say what Professor Charcot was obliged to confess in Cork last month: "Gentlemen, it is not your national language that prevents me from becoming familiar with your works, it is your gothic weights and measures." And this obstacle has been removed in the interval between two sessions of the Congress by the power of disciplined minds. For what still remains to be done, unity in medicine will take as its starting-point the *mètre*. This will help us to understand the various names that are used to design quantities in other sciences—algebra, chemistry, natural philosophy, etc.—and without which a congress like ours cannot be said to be international. I will go further, and say more; even among nations who use the *mètre*, the physicians are far from having always applied it to its legitimate purposes—*e.g.*, there are only a very few who use it in making a diagnosis, and fewer even in making the prognosis of the disease, notwithstanding that we are beginning to expect the physician, both in hospital and private practice, to give us a mathematical account of the vital quantities that have been entrusted to him, and of the therapeutic quantities he has opposed to the pathological quantities in order to restore the equilibrium of life. New instruments seem to be invented almost as soon as they are needed, as Professor Marey has shown us; and, with their help, medicine has been enabled to give a mathematical account of its operations, and of the operations of the principal functions. Instruments such as these were dreamt of by Bouillard, Louis, Andral, and Bowditch, and the other founders of the numeric method of observation, and now we possess them. This is but a confirmation of the fact that important discoveries are foreshadowed, as it were, by dreams. Owing to these discoveries, less scope has been left to conjectures in our art, and we are more able to calculate with some certitude the probability of certain events. But it is not enough merely to possess those beautiful instruments, and to know how to handle them. We must use them according to an uniform plan, and register their results with mathematical exactitude. If we do not bear this in mind, every new analytic or graphic process that is discovered will only add new materials to the existing chaos. One thing alone can save us from such a misfortune; and that thing is the adoption of a general method, which, in our opinion, is the metric method of observation. The general adoption would be greatly furthered if the paper used for recording the observations were metrically ruled, so as to enable practitioners to make the same reductions or allowances without possessing an exceptional talent for drawing. Another important point is to render more perfect, by rendering them more precise, the records of observations that exist already, and some of which I herewith lay before you. They are very imperfect, I know; and will only cease to be so when you shall have corrected them according to the results of experience. It is clear that, with the aid of these notes, we shall be able to calculate our diagnostic and therapeutic operations with as much certainty as the banker calculates the balance between his debit and credit. If we leave on one side our personal practice, and pass on at once to the highest interests of our profession, we see at once in what way these instruments and methods will aid us in advancing medical doctrines and general medicine. This will be more clear when we have compared the individual observations that have been made on the uni-

form basis of the *mètre* and with identical methods, in order to discover the facts from which laws are derived. Must I add, that at the same time, and with the same notes, it will be possible to follow the effects of drugs on disease, and the reaction of the latter on the normal properties of drugs. Finally, the simple collection of these individual observations will furnish the materials for statistical tables that will not only refer to the death-rate, but be for the first time "medical". They will present to us a sort of diagram of the progress of health and disease in the human species. There remains much to say on the importance of adopting a general method in medicine, or rather medical mathematics; but, for fear of becoming too prolix, I pass at once to the conclusions of this work. 1. The metric system must be the basis of international medical unity. 2. The scales and degrees of the instruments must be metric, or at least uniform. 3. The records of observation, both in private and hospital practice, and the tables of medical statistics, must be prepared on an uniform plan, so as to give harmonious results. 4. The members of the Congress are requested to record their own cases as much as possible by graphic and numeric methods; to propagate the use of these methods among their colleagues; and to communicate to the members of the Commission any criticisms or improvements that may have been suggested to them by experience. The Commission will give an account of them in its next report. 5. We adopt the conclusions offered by Professor Gille in the name of the Pharmaceutical Section of this Commission. 6. We unite our petitions to those of the pharmaceutists, requesting you to adopt the conclusions of this twofold work which has been bequeathed to the present Congress by the Congress at Geneva. 7. Finally, we beg that you will help to fill the vacant places in this Commission that are due to the absence of many of its members, and especially to the regretted death of Dr. Wilkinson, ex-President of the British Medical Association, and the irreparable loss of Professor Gubler, who was more than our colleague, for he was our strength and our head.

M. GILLE having read his report on the same subject, the Commission Internationale du Système Métrique was reappointed and reconstructed as follows: Dr. Dechambre and Professor Marey, Paris; Guye, Amsterdam; Warlomont and Gille, Brussels; Sayre and Seguin, America; Ernest Hart, England.

TODMORDEN.—This is a somewhat meagre report for a district with a population of more than 23,000. The death-rate is given as 21.4 per 1,000, against 22.3 in 1877. The 496 deaths included 107 under one year of age, or 131 per 1,000 births. The mortality returns compare favourably with those for 1877, except as regards the deaths from five to twenty years. None of the zymotic diseases were especially fatal, but diarrhœa caused 16 deaths. There seems to be room for improvement in the scavenging and drainage, and the imperfect polluted water-supply deserves particular attention.

LIVERPOOL.—In this large municipality of over half a million persons, there were 20,612 births and 15,584 deaths registered in 1878. Both the birth and death rates were higher than in 1877; the death-toll amounting to 29.3 per 1,000, against 29.0 in the previous year. The rate of the parish itself was equal to 34.9 and that of the out-townships to 23.7 per 1,000. The increased mortality of the year was owing to the prevalence of measles and scarlatina, the former causing 444 and the latter 947 deaths; and to the great extremes of temperature in the summer and winter quarters. The hot weather in June, July, and August caused a large increase in the number of deaths from diarrhœa; and the winter frosts had a very serious effect upon the health of the aged, 337 more deaths from pulmonary disease being registered than in the corresponding weeks of 1877. The deaths of infants below the fifth year of age amounted to 7,408, and thus comprised 47.5 per cent. of the total deaths, the average percentage being 47.9. Zymotic diseases occasioned 3,698 deaths, and accounted for 23.7 per cent. of the total mortality, and 2.3 per cent. less than the average for the preceding ten years. "Typhus and infantile remittent fever", under which misleading title Dr. Taylor includes all continued fevers, caused 375 deaths, 122 of which were typhoid and 155 typhus cases. Diarrhœa was fatal in 979 and whooping-cough in 422 instances. Tubercular diseases occasioned 2,078 deaths, or 3.9 per 1,000 of the estimated population. Dr. Taylor's tables are, as usual, very full and interesting; and the details given of sanitary work show the magnitude of the operations essential for the supervision of a large town. Thus 52,000 visits were paid to the 1,100 lodging-houses in the town; 2,092 privies were converted into water-closets; 4,428 cases of infectious disease were reported; 7,107 visits were paid to houses for disinfection purposes; 35,052 articles were sent to the disinfecting apparatus; 190,000 pounds of veal, 100,000 of pork, 240,000 of fish, besides other viands, were seized and destroyed; and over 70,000 nuisances were dealt with.

The British Medical Journal.

SATURDAY, SEPTEMBER 27TH, 1879.

THE DOCTOR IN THE KITCHEN.

THE public mind is not yet sufficiently awakened to the importance of a thorough and active campaign against the waste of food which characterises the habitual dietary of rich and poor in Great Britain; but, from the extended welcome given to the few words which we wrote on the subject last week, it is apparent that the prospect of a winter of much scarcity has predisposed many to the earnest consideration of this question as one of much public moment. A good doctor, it has often been said, must be a good cook; and it is reported of a cynical physician of great repute that, being seen to issue from the kitchen of a large institution which he was visiting, he said, on being interrogated; "I always go to salute the cook; the cooks are the doctors' best friends; if they were not so bad, we should have but few patients. I owe half my income to bad cooks." This light witticism—"spoken ironical", as Artemus Ward would have it—conveys a serious meaning which we all recognise. A bad cook is wasteful of material, of money, of fuel, and of health; and, with a few exceptions, English cooks are all bad cooks, in one sense or other; unskilful in execution, or extravagant in selection, and destitute of sound and economical traditions. Neglecting for the moment the cooking of the rich—who are usually content with a diet as monotonous as it is heavy and excessive in nitrogenous elements—we may turn to those who most interest us, as the types upon whose model the poorer classes follow at a humble distance. If we look to the *cuisine* of the lower middle classes, and of the modest household of the curate, the clerk, and the skilled artisan, we see that, as a rule, the art of cooking begins and ends with roasting, boiling, or grilling a limited number of joints of meat and a limited repertory of vegetables. The smaller the household and the income, the less the range of choice, and the smaller the ingenuity in rendering common things digestible and palatable. The staple dinner of the hearty and well paid artisan is a rump-steak, or a cut of the best part of mutton or beef; and, when there remains cold meat or cold vegetables, or cold fish, the art of dealing with them, however simply, is little studied either by housewife or cook. In a French household, the little piece of stewed meat is preceded by a pleasantly flavoured soup, made with the bones and the parings of the meat, and some of the remnants of yesterday's dinner, with perhaps crusts of bread and some vegetables added; the meat itself is served with stewed beans, or carrots and onions, or potatoes. If the joint of one day be a piece of beef, next day the cold meat appears, perhaps cut in slices, with oil and vinegar, or with a mustard sauce. The cold potatoes and cold stewed beans or cauliflower of the previous day make an excellent salad next day, with perhaps a tomato added, cut in slices. The maccaroni and cheese left over from a previous meal reappears at the next, reheated with other sliced cold vegetable, celery or salsify, or whatever else, and covered with a little browned scraped cheese.

The commonest fish, such as ray—which diet poor and rich alike neglect—is served habitually with a little "brown butter"; and neither workman nor epicure need despise the nourishing and toothsome dish. Cold boiled fish reappears either "à l'huile", or with a sauce of oil and mustard beaten together into a cream, and is at least as welcome as on

beings and in animals. Thus, if a frog be poisoned with salicylic acid, tetanic phenomena often occur. Under those conditions, it was necessary to find out whether the drug affects the muscles directly, or whether it acts on the central nervous system. By alternately interrupting and restoring the communication between the leg of a frog and the central nervous system, it has been ascertained that the action of salicylate of soda concentrates itself mainly on the latter. The rapid cessation of the muscular contractility is also due to a direct action of the drug on the nervous system, and not to the intermediate agency of the muscular fibre. M. Livon quoted here the case of a woman whom he had attended, and who had convulsions after taking two *grammes* of salicylate of soda.

M. CHALOT of Montpellier contributed a paper on Injections of Chlorhydrate of Pilocarpine after the Operation for Cataract by Extraction, and in some other Cases. After having observed that injections of this kind have not given any satisfactory results in uni- or bi-lateral hydrarthrosis, in simple hydrocele, or after amputations, the author proceeded to give the history of the use of pilocarpine in affections of the eye, and related several cases that had come under his notice in the service of M. Courty. In one case, where extraction of the cataract had been performed after von Gräfe's method, he injected chlorhydrate of pilocarpine; but, another treatment having been carried on at the same time, he was unable to arrive at a definite conclusion on the subject. In another analogous case, the patient became unconscious, and exhibited phenomena of intoxication after the fourth or fifth injection; that was the only result that had been obtained in this case. The same took place in four or five more cases of affections of the eyes that were treated in the same way. Patients, as a rule, do not tolerate these injections easily, and often object to them. They are frequently followed by symptoms of excitement, and in some cases of intoxication. There seem to exist no relations between the physiological and therapeutical effects of the drug, and no good results have ever been obtained.

M. L. H. PETIT read, in the name of M. QUINQUAD, a paper on the Relations between Disease and Hæmatic Lesions. This highly interesting paper, which bristles with numbers, and is based on many hundred analyses of blood may be summarised as follows. Every disease must give rise to a hæmatic lesion, as the blood is a mirror in which the slightest disturbances of the organisms are reflected. To every morbid affection corresponds a certain chemical alteration of the blood. This is why the chemistry of the blood forms such an important point of medical diagnosis.

M. MARQUIS of Hyères read a paper on Intestinal Gravel. After having summarised the interesting works of M. Laboulbène on the subject, he proceeded to give a case of intestinal lithiasis that had come under his notice. The patient was a very anæmic woman, who constantly passed in her stools small granular oblong brownish bodies, which were evidently formed in the intestines, but were neither biliary nor renal calculi. There was simultaneously a considerable hypersecretion of the intestinal mucus. It seemed as if the gravel were produced in greater quantities the more anæmic the patient became.

M. SÉGUIN of New York spoke at length on the necessity of adopting the metric system in America and Great Britain.

M. BROCA, jun., read, in the name of M. de VARIGNY, a paper on Cerebral Atrophies in Patients who had undergone Amputation. It appears that cerebral atrophy does not occur constantly in such cases. It is often very difficult to diagnose when it exists. He did not think that it could be of much importance in the study of localisations. The facts that are actually known do not seem either to strengthen or to weaken Ferrier's theories on the subject.

THE LOCAL GOVERNMENT BOARD REPORT.

THERE is but little of purely medical interest in the recent report of the Local Government Board, which differs from its predecessor of last year in being a plain record of work done, without any self gratulation on its accomplishment.

During the year 1878, the Board approved the appointments of the medical officers of health for forty-seven more districts, making a total of 1,206 appointments confirmed since the passing of the Public Health Act of 1872. The returns showing the state as regards vaccination of the children born in 1876 must, on the whole, be considered satisfactory. Of the entire number of births in 1876, only 4.3 per cent. remain unaccounted for, as against 5.1, 4.8, 4.8, and 4.7 per cent. respectively in the four preceding years. The returns show a marked difference in the amount of vaccination in different parts of the kingdom. The metropolis is still conspicuous as furnishing the largest proportion of cases which escape vaccination; but a substantial improvement is exhibited in these returns as compared with those for the previous year. The several Unions show, however, widely diverging results, the amount of default being in some districts very great. The whole of this question is now under inquiry by Dr. Stevens, one of the Board's most experienced inspectors, and it is to be hoped that something may be done in the direction of greater efficiency of the metropolitan vaccination staff before another epidemic of small-pox comes upon us. The divisions of the kingdom that are numerically the best vaccinated are the eastern and south-western, in both of which, 97 per cent of the entire number of children are duly disposed of in the vaccination register; and there are about a dozen individual counties in which the proportion rises to about 98 per cent. of the births. Of all the counties in England and Wales, there are only nine in which the proportion of cases unaccounted for reaches or exceeds 5 per cent. of the registered births.

During the year, the public vaccination of 276 unions, comprising 1,396 districts, was inquired into by the Board's medical staff. To the vaccinators in 760 of these districts, grants of money were made to the extent of £11,994, the grants varying from seven shillings to £271. Under the stimulus of these awards, and the close supervision over the work of public vaccination now exercised, the vaccination is reported as now reaching, in most cases, a very high standard. No less than 9,590 applications for lymph were received by the national vaccine establishment during the year, and 14,954 charged points and 22,096 tubes of lymph were distributed.

Besides about twenty-one local inspections into matters connected with the provision of hospitals for infectious diseases, and a number of by-law inquiries, twelve inquiries were made by the Board's medical department into particular outbreaks of infectious disease, or the repeated occurrence of such disease. One of these—in the Dewsbury registration district—was of exceptional length; and two others—the Kilburn diphtheria epidemic and the violet-powder poisoning cases at Loughton—were of quite unusual interest. Dr. Bollard continued during the year his valuable inquiry into effluvium nuisances, a further instalment of which, concerning substances of mineral origin, is promised us in the forthcoming report of the medical officer. In speaking of the reports of local medical officers of health, more than 1,400 of which are annually received by them, the Board record an advance in the quality of the reports received, and an increasing appreciation on the part of the officers of the necessity for systematic sanitary work, not merely dependent on the actual presence of infectious disease.

This is a matter on which we have often had occasion to comment. No medical officer of health can be said to be fulfilling his functions—functions which are essentially preventive—unless he supervises his district systematically, irrespective of the presence or absence of infectious disease. It should be his highest aim to secure the removal of unwholesome conditions before they have become associated with the outbreak of disease; and it is only by the regular survey of the district that he can do this with satisfaction to himself or to his authority.

ASSOCIATION INTELLIGENCE.

COMMITTEE OF COUNCIL: NOTICE OF MEETING.

A MEETING of the Committee of Council will be held at the offices of the Association, 161A, Strand, London, on Wednesday, the 15th day of October next, at 2 o'clock in the afternoon.

FRANCIS FOWKE, *General Secretary.*

161A, Strand, London, September 15th, 1879.

SOUTH-EASTERN BRANCH: EAST SURREY DISTRICT.

THE next meeting of this district will be held at the White Hart Hotel, Reigate, on October 9th, 1879, at 4 P.M.: F. B. HALLOWES, Esq., in the Chair.

The following papers are promised.

1. Dr. D. W. Chas. Hood: On Croup and Diphtheria.
2. Mr. Hallowes: A Clinical Report upon an Outbreak of Enteric Fever at Redhill in the early part of 1879.
3. Dr. John Walters: The Treatment of *Post Partum* Hæmorrhage by Injections of Hot Water.

The dinner will take place at 6 P.M. Tickets, 6s. a head, exclusive of wine.

JOHN H. GALTON, M.D.Lond., *Honorary Secretary.*

Woodside, Anerley Road, S.E., September 15th, 1879.

SHROPSHIRE AND MID-WALES BRANCH.

THE annual meeting of this Branch will be held at the Salop Infirmary, Shrewsbury, on Tuesday, September 30th, at 3 o'clock in the afternoon; JAMES BRATTON, Esq., F.R.C.S., President, in the Chair.

The annual dinner will take place at the Lion Hotel, at 5 o'clock P.M. the same day.

Members intending to read papers, or bring forward subjects for discussion, are requested to communicate with

HENRY NELSON EDWARDS, *Honorary Secretary.*

Moreton House, Shrewsbury, September 15th, 1879.

EAST YORK AND NORTH LINCOLN BRANCH.

A CONJOINT meeting with the Yorkshire Branch will be held at York, on Wednesday, October 8th.

Gentlemen who intend to read papers are requested to inform the Secretary of the titles before the 27th instant.

E. P. HARDEY, *Honorary Secretary.*

35, Regent Terrace, Anlaby Road, Hull, Sept. 18th, 1879.

WEST SURREY DISTRICT.

THE next meeting of this district will be held at Guildford, on Friday, October 24th, 1879.

Gentlemen desirous of reading papers or cases are requested to communicate at once with the Secretary.

A. ARTHUR NAPPER, *Honorary Secretary.*

Broad Oak, Cranleigh, September 22nd, 1879.

SOUTH-EASTERN BRANCH: WEST KENT DISTRICT.

THE first evening meeting of this district was held at 197, Parrock Street, Gravesend, the residence of J. C. Armstrong, Esq.; the chair being taken by JOHN ARMSTRONG, M.D.

An exhaustive and well-written paper on Fractures was read by Mr. JESSETT of Erith, who enlarged at considerable length on their pathology, varieties, and treatment.

Dr. J. BRAXTON HICKS kindly gave the history of a most interesting case of Extra-uterine Fœtation; and afterwards showed tracings of the abdominal and fœtal movements.

A cordial vote of thanks to the Chairman for presiding, and to J. C. Armstrong, Esq., for his hospitality, closed a very pleasant evening.

BORDER COUNTIES BRANCH: ANNUAL MEETING.

THE annual meeting of the Border Counties Branch was held at the County Hotel, Carlisle, July 25th, 1879. In the absence of the President owing to illness, Dr. TIFFEN took the chair at one o'clock. The following other members were present: Drs. Barnes, Lockie, Campbell, Brown, Murphy, Elliott, Maclaren (Carlisle), I'Anson, Horan (Whitehaven), Dick (Harrington), Burt (Kendal), Arras (Wetheral), Smith (Dumfries), Taylor (Penrith), Rigg (Burgh-by-Sands), and Erskine Stuart (Dunse).

New Member.—John A. Erskine Stuart, L.R.C.S.E. (Dunse), was elected a member of the Branch.

Report of Council.—Dr. MACLAREN then read the report of Council as follows:—

"The Council have the pleasure of submitting their eleventh annual report to the members of the Border Counties Branch.

"*Number of Members.*—At the commencement of the year, there were ninety-nine members on the list; during the year, eight new members have been elected, three have resigned, two have left the district, and one has died, so that the present number is one hundred and one.

"*Meetings.*—During the year, meetings have been held at Dumfries, Whitehaven, and Melrose. At these, ten papers have been read to the Society on subjects of general or original interest; the attendance of members has on the whole been good, and the discussions have been ample. At Dumfries, at the invitation of the local members, those who attended the meeting were driven to Carlaverock Castle, and the attractions of the spring meeting were increased by an inspection of Abbotsford and Melrose Abbey.

"*Spring Meeting.*—The Council recommends the Branch to fix the spring meeting at Gilsland, for the purpose of making it a conjoint one with the Northern Counties Branch.

"*Death of the President-elect.*—The Council has to regret the loss of one of its members, Dr. Reeves, who was chosen President-elect at the last annual meeting. He was a member of the Branch from its formation, contributed many interesting papers, and took a lively interest in all its proceedings. He will be long remembered by the members not less for his ability than for his geniality and candid honesty.

"*Financial Statement.*—The balance in hand at the end of 1877 was £4 8s. 8d. The receipts from eighty-nine subscriptions and twelve arrears are £12 12s. 6d. The disbursements amount to £14 os. 1d., leaving a balance of £3 os. 7d.

(Signed) "JAMES GILCHRIST, *President.*
"RODERICK MACLAREN, *Hon. Sec.*"

It was moved by Dr. BARNES, seconded by Dr. LOCKIE, and unanimously agreed to, that the report of the Council be adopted.

Dr. BURT moved, and Dr. I'ANSON seconded, a vote of thanks to the office-bearers of the past year, which was carried unanimously.

Meetings.—It was resolved that only one meeting in addition to the annual meeting be held during the ensuing year, and that this meeting take place either at Gilsland or Hexham, as may be arranged for the purpose of meeting the North of England Branch.

Office-bearers.—The following office-bearers were then chosen. *President-elect:* Dr. Campbell. *Honorary Secretary and Treasurer:* Dr. Kendall Burt. *Honorary Secretary for Scottish Section:* Dr. Smith. *Council:* Drs. Rigg, McBean, Dick, Tiffen, I'Anson, Symons, Barnes, Hoggan, Grierson. *Representative on the Parliamentary Bills Committee:* Dr. Taylor.

The retiring President (Dr. Gilchrist) was elected a permanent Vice-President of the Branch.

Dr. Tiffen then vacated the chair, and introduced the President for the year, Dr. MACLAREN, who delivered his inaugural address "On the Progress of Surgery during the Past Twenty Years".

On the motion of Dr. I'ANSON, seconded by Dr. DICK, the thanks of the meeting were given to Dr. Maclaren for his address; and he was requested to publish it.

Papers.—The following papers were then read.

A Case of Poisoning by Soda Salicylate. By J. KENDALL BURT, M.B. and C.M. (Kendal).—This was the case of a lady who had taken sixty grains in six hours (twenty grains every three hours). The symptoms were as follows. First, attacks of unconsciousness for the first fifteen minutes; each attack lasting three minutes. Second, after attacks of delirium for three hours, each attack being about twenty minutes in duration; perfectly lucid intervals of a few minutes each. A pulse of 120, very feeble. Temperature reduced from 102° to 99°.

Sulphur as a Topical Application in Diphtheria. By JOHN A. ERSKINE STUART, L.R.C.S.E. (Dunse).—Sulphur precipitatum (milk of sulphur) used as a topical application has been very useful in my practice in seven cases of diphtheria, either blown on through a quill, or stirred up with water and swabbed on. It causes almost immediately after application blackening of the membrane and detachment of it. To show its rapidity of action, six of these cases only required an average of 2.6 visits. In opposition to the views of Dr. Oertel in his Report on the Epidemic of Diphtheria in the Royal Household of Darmstadt, and of Dr. Braithwaite of Leeds in his last *Retrospect* (January to June 1879), and the Reporter in the *Medical Record* of June 15th (the two latter criticising my first notice of the subject in the *Practitioner* of April 1879), I am of opinion that the action of sulphur in this disease is a specific action, not a mere "scouring powder" (Dr. Oertel), nor that its action is principally by friction. I use no friction. I have found the application of carbolic acid, sulphurous acid, and solution of muriate of iron in equal parts a pretty sure remedy locally applied, but deleterious from making fresh abrasions a fitting field for the growth of new membranes. The use of strong caustics is to be strongly deprecated. The sulphur treatment is easily used, and is not at all disagreeable to the patient.

Operation for a Case of Strangulated Inguinal Hernia. By WILLIAM BROWN, M.R.C.S. and L.R.C.P.E. (Carlisle).—The patient was a male aged 60, and had been the subject of a hernia for the last ten years. The hernia became strangulated while the patient was walking, about five o'clock on the afternoon of Thursday, July 17th. Symptoms of strangulation soon followed; and when I was called in at eight o'clock in the evening they were urgent. On examination, a large scrotal hernia was present in the right groin, measuring twelve inches in length from the external ring to its most dependent part. The tumour was exceedingly tense, absolutely dull on percussion, with an indistinct feeling of fluctuation and impenetrable to transmitted light. Taxis was tried without success. When thoroughly under the influence of ether, taxis was again fairly tried without avail. The operation was then proceeded with in the usual way, and the sac arrived at by the division of two coverings upon the fingers. When the sac was opened, several inches of somewhat congested bowel came into view. When the stric-

ture was freed, the bowel began to descend rapidly, but this anticipated difficulty was overcome by raising the pelvis to a height and returning the gut in successive portions. Wire sutures were used for the skin-wound. All the symptoms of strangulation vanished with the operation, and his pulse and temperature have been normal since the operation. The skin-wound has healed by first intention. This case shows the importance of an early operation. In this case, antiseptics were totally neglected; and, though the hygienic conditions of the man's habitation were anything but satisfactory, the case has so far done remarkably well.

Dinner.—The members and their friends afterwards dined together; Dr. Maclaren in the chair, and Dr. Campbell in the vice-chair.

HOSPITAL AND DISPENSARY MANAGEMENT.

A PAIR OF DISPENSARIES.

A HANDBILL has lately been freely distributed, both in the east and west end thoroughfares, which states that an "united surgery and dispensary (self-supporting) for the treatment of all diseases" has been opened by "Dr. Hursley, Physician and Surgeon", at 72, City Road, Finsbury Square, and also at 2, Oxendon Street, Piccadilly. Dr. Hursley is extremely liberal of his time, for he attends at his dispensaries from nine in the morning till ten at night; and his charge is only one shilling a week during illness. In fact, this is only another example of the "shilling dispensaries" upon which we have often expressed our opinion. They have sprung out of the provident movement; but they have neither the advantages nor the safeguards which belong to the provident system. They simply offer the poor medical attendance and medicine on very easy terms, which are not calculated to raise the working classes or to uphold the dignity of the profession.

OBITUARY.

PYE HENRY CHAVASSE, F.R.C.S., BIRMINGHAM.

WE record with regret the death, on the 21st inst., of Mr. Pye Henry Chavasse, a prominent member of the profession in Birmingham. The deceased was born at Cirencester in 1810, and at an early age selected the medical profession for his career in life, and became a pupil of his cousin, Mr. Thomas Chavasse, who then carried on an extensive practice in the Old Square, Birmingham. Having completed his pupilage, Mr. Chavasse entered as a student at University College, London; and in 1833, was admitted a member of the College of Surgeons and a Licentiate of Apothecaries' Hall, and shortly afterwards commenced to practise in Birmingham, directing his attention more particularly to the diseases of women and children. The active duties of his profession were vigorously pursued up to five years ago, when failing health compelled retirement into private life. In 1852, the deceased was elected a Fellow of the Royal College of Surgeons. Although not connected with any of the hospitals, Mr. Chavasse took great interest in the welfare of the various medical institutions of the town in which he lived, and was a regular attendant at the meetings of the Birmingham Branch of the Association and kindred societies, and held, at one time, the office of President of the Queen's College Medico-Chirurgical Society. His name, however, is more generally associated with various popular medical works, dealing with maternal cares and duties, numerous editions of which have been published, and whose usefulness is furthermore exemplified by their translation into nearly every European language and also into several of the languages of Asia.

For some time the exact nature of the disease under which the deceased laboured was somewhat obscure, but latterly the symptoms pointed towards cerebro-spinal sclerosis, and a *post mortem* examination revealed the existence of that lesion.

Of a frank and genial disposition, Mr. Pye Chavasse was always a firm friend to his professional brethren, and those who were his patients held him in the highest esteem.

ANDREW MUNGLE, M.D.

WE regret to announce the death of this most promising student of the Edinburgh University, at the early age of 20, on September 13th, of typhoid fever, at the Sunderland Infirmary, where he had been doing duty during the absence of the house-surgeon. He was born on September 26th, 1858, was educated at the Edinburgh Academy, and received his medical training at the university of that city. During his college life, which he commenced in 1873, at the age of 15, he distinguished himself highly in nearly all the classes he attended, both in Arts and Medicine, carrying off several medals and other rewards. Being too young to graduate, he spent nearly a year at the Dumfries Infirmary as assistant house-surgeon. After passing his final examination with distinction at Edinburgh about two months since, he acted as *locum tenens* at Ayton, Berwickshire, and lastly at the Infirmary at Sunderland, where he died after an illness of eleven days. He was much admired by his fellow-students for his hard and earnest work and his kind and amiable character, and by them his loss will be deeply felt. Although he was only a month at the Sunderland Infirmary, so highly was he esteemed by the medical staff and the committee, that the whole of the staff and many of the members of the committee followed his remains to the station on their removal to Edinburgh.

MILITARY AND NAVAL MEDICAL SERVICES.

THE ARMY MEDICAL WARRANT.

SIR,—So the new warrant, I hear, has foundered on the rock of finance. Its promoters could not expect any other fate to be in store for it. It was a preposterous and absurd attempt to extract public money for a small but chosen band of men at the expense of the many.

I am, sir, not above receiving as much money as a generous public likes to bestow, but, if asked whether or not my services would be overpaid by such a scheme, my answer would be unhesitatingly in the affirmative.

Medical officers as a body have never asked for more pay; they have asked for fair play and justice; and a very little tact in consolidating the various warrants would have sufficed all parties, and averted the present *fiasco*.

It is to be hoped that the Secretary of State for War will now write a new warrant in one line. "The warrant of 1858 will take precedence of all later and immediate issues; excepting the new designations." The rank of deputy surgeon-general is useless and unnecessary; it will cease to exist, and be replaced by that of brigade-surgeon. It is to be understood that the possessor of this latter title is to give evidence of his professional knowledge and ability, whilst, at the same time, he has the ability to execute administrative work whenever called on to do so. He is not to be an administrative officer, but a purely executive officer with administrative ability.—I am, sir, your obedient servant, OLD WARRANT.

August 22nd, 1879.

ARMY MEDICAL DEPARTMENT IN INDIA.

SIR,—I wish to draw the attention of surgeons who may be thinking of entering the service, to certain facts which I think cannot be sufficiently grasped at by outsiders. Owing to the comparatively small number who have entered the service during the last few years, and promotion going on all the same, the number of surgeons-major to surgeons has now assumed the proportion of about three to one. All duties having anything of an irksome nature are delegated to surgeons, and the amount of such duties has vastly increased in proportion to the diminution of surgeons, a certain number being promoted whose turn has come round, while a sufficient number do not enter the service to fill up the gaps.

Whenever a move takes place (now a pretty constant thing), the surgeon-major remains quietly in his place, and the surgeon has to go. This is more especially the case in India, where, from October 1st to March 15th, or occasionally a little later, troops are marching or travelling by rail all over the country, in all cases a surgeon being sent to accompany them; and often he has to make one march after another for months together, of course being quite unsettled all the time. This marching ceases during the summer months; but at this time cholera is most frequent, and if the station that he happens to be at escapes, very likely he is sent off to some other place where the epidemic has broken out. As a rule, very short notice is given to him before making any of these moves (this may be unavoidable in cholera time); but the hardest part of all is, that, on coming into a new district, he comes under the orders of a new principal medical officer, who may, and frequently does, cancel any previous orders the surgeon has received as to returning to his former station immediately on completion of the duty he has been ordered away for. I could quote several instances in which a surgeon has got short notice of a move, has hurried away with a small stock of necessaries, and then has been detained by the new principal medical officer, who states he has no one to take his place. This state of things effectually prevents a surgeon from making himself comfortable in any station. The fewer belongings he possesses, the better, as he must leave the most of them after him when suddenly ordered off, and then he will have either to part with them at a sacrifice, or undergo the expense of having them sent after him. The pay that the surgeon gets in India is 317 rupees per month; no advance on what was given in the old days of assistant-surgeons. This pay does not amount to £1 per month more than his home pay and allowances, whilst everyone else serving Government gets an increase of pay for serving in India, amounting very often to nearly double the amount of his home pay. There is no possible way open to the surgeon of the Army Medical Department of adding to his 317 rupees per month. Lock hospitals (though intended for the protection of British—not Indian—troops), jails, staff appointments, etc., are chiefly held by officers in the Indian Medical Department; but in cases where they are held by officers in the Army Medical Department, surgeons-major apply for and get them, thus adding to their already comfortable incomes. There is, therefore, no chance of any of these appointments being held by surgeons. All senior officers appear to comfort themselves with the reflection that they had to rough it when they were young, but now, at their time of life, they go in for ease. This reflection, however, is no comfort to a man, the tenure of whose appointment is limited to ten years.

On consideration of the above facts, I think few men can be shown who have wasted their lives more than the surgeon, Army Medical Department, who is compelled to waste five years of his life in India, with scarcely any comfort to himself, owing to the uncertainty of his movements; risking his health all the while, and getting inadequate remuneration, with no prospect of adding to it. These matters exist, and are not remedied, in spite of the fact that it is surgeons, and not surgeons-major, who are so urgently required in the department at present. —I am, sir, faithfully yours, PETERKIN.

MEDICAL NEWS.

APOTHECARIES' HALL.—The following gentleman passed his examination in the science and practice of medicine, and received a certificate to practise, on Thursday, September 18th, 1879.

Torbitt, Charles, Oldbury, Worcestershire

The following gentlemen also on the same day passed their primary professional examination.

Munyard, Thomas G., Westminster Hospital
Prentice, Zachariah, Guy's Hospital

At the Preliminary Examination in Arts, held at the Hall of the Society, on the 19th and 20th of September 1879, the following passed, and received certificates of proficiency in general education. In the First Class, in order of merit:

1. H. Armstrong and L. Pickering. 3. J. H. Menzies. 4. A. W. Clark, S. Herbert, G. R. Hulbert, and Florence J. Jebb. 8. F. Bromhead, H. G. Haines, R. T. Westbrook, T. D. White, and W. S. R. Woodforde. 13. H. A. Desvœux, C. S. Robinson, and H. H. Tomkins.

In the Second Class, in alphabetical order:

G. G. Adams, T. E. Adams, R. H. J. Allen, S. G. Allen, A. B. Avarne, W. G. Axford, G. L. Baker, R. H. Bates, C. E. Bean, W. H. Bell, C. N. Bensley, A. Blakiston, J. F. Boissiere, J. A. Bradbury, E. M. Brown, C. S. Browning, L. W. Burton, H. D. Buss, A. K. A. Cæsar, J. C. Cater, P. E. Cleaver, J. W. Cockerill, J. W. Cook, E. R. M. C. R. Cousins, J. J. G. Crang, Mary Crawley, T. W. Crook, J. O. D'Aquiar, J. W. Dawes, C. Dolman, J. O. Downes, J. B. Drew, F. D. L. Eusor, A. P. Feddon, H. Fitton, S. H. Fox, E. S. Fry, G. F. Gilbert, J. Good, O. B. Granville, H. W. Haydon, H. H. Hewitt, C. E. Humphryes, C. R. Huxley, A. E. Huxtable, F. J. Jaynes, Mary A. Kenealy, H. R. Kenwood, C. J. Kirkpatrick, W. E. Lowe, Mary McGeorge, J. H. McRice, J. T. R. Maddox, R. Mills, C. E. Morris, Margaret Morice, A. G. Momber, J. J. Parsons, A. M. Page, D. E. Phillips, T. Pitman, H. Potter, A. J. Richards, W. B. K. Richards, W. S. Richmond, L. Roberts, A. M. Ross, P. C. H. Ryan, F. O. Smith, Augusta Stolte, R. Swyer, W. E. Swyer, W. S. Tebb, A. H. Tenison, M. Thompson, J. Thorpe, A. F. Tidswell, Jas. H. Walker, G. J. Walklett, D. H. R. Walwyn, H. E. Watts, and T. Young.

MEDICAL VACANCIES.

Particulars of those marked with an asterisk will be found in the advertisement columns.

THE following vacancies are announced:—

ARDEE UNION—Medical Officer of the Workhouse, at an annual salary of £85, and £15 as Consulting Sanitary Officer. Election on the 30th instant.

ARDWICK AND ANCOATS DISPENSARY AND HOSPITAL, Manchester—Junior House-Surgeon. Salary, £100 to £120, with apartments and attendance. Duties commence January 1st, 1880.

*BELGRAVE HOSPITAL FOR CHILDREN, Pimlico—Resident House-Surgeons. Board and lodging. No salary. Applications to the Honorary Secretary at the Hospital on or before October 4th.

BELFAST ROYAL HOSPITAL—General Superintendent. Salary, £200 per annum, with rations and residence in the house. Applications on or before September 27th.

*BIRMINGHAM GENERAL HOSPITAL—Assistant Physician. Salary, £100 per annum. Applications on or before September 29th.

*BRIGHTON AND HOVE LYING-IN INSTITUTION—House-Surgeon. Salary, £120 per annum, with furnished apartments, coals, gas, and attendance. Applications on or before October 2nd.

*BROMPTON HOSPITAL FOR CONSUMPTION—Resident Medical Officer. Salary, £200 per annum, with board and residence. Applications on or before October 8th.

FAREHAM UNION—Medical Officer for the district of Titchfield. Salary, £100 per annum, and usual extra medical fees. Applications before September 30th.

*GENERAL LYING-IN HOSPITAL, York Road. Lambeth—House-Physician. Applications on or before October 15th.

HARTLEPOOL FRIENDLY SOCIETIES' MEDICAL INSTITUTION—Two Resident Medical Officers. Salary, £150 per annum, a proportion of accouchement fees, free residence, coal, and gas; rates and taxes (except income-tax) paid by institution. Applications not later than October 7th.

*LEICESTER INFIRMARY AND FEVER HOUSE—Honorary Physician. Applications on or before October 4th.

*NORTH SHIELDS AND TYNEMOUTH DISPENSARY—House-Surgeon and Dispenser. Salary, £120 per annum, furnished house, gas, coals, etc. Applications must be forwarded by October 1st.

QUEEN'S COLLEGE, Galway—Professorship of Practice of Medicine. Candidates to forward testimonials to the Under Secretary, Dublin Castle, on or before the 29th instant.

RADCLIFFE INFIRMARY, Oxford—House-Surgeon. Salary, £105 per annum, with board, lodging, and washing. Double qualification and registration as a medical practitioner requisite. Application on printed form, to be obtained of Secretary, to be returned, with testimonials, on or before October 4th.

*ST. MARYLEBONE GENERAL DISPENSARY—Honorary Physician. Election on October 1st.

*TIVERTON INFIRMARY AND DISPENSARY—House-Surgeon and Dispenser. Salary, £100 per annum, with furnished apartments, coals, gas, and attendance.

WEST-END HOSPITAL FOR DISEASES OF THE NERVOUS SYSTEM, PARALYSIS, AND EPILEPSY, 93, Welbeck Street—Assistant-Physician.

*WEST SUSSEX, EAST HANTS, and CHICHESTER INFIRMARY—House-Surgeon and Secretary. Salary, £100 per annum.

MEDICAL APPOINTMENTS.

Names marked with an asterisk are those of Members of the Association.

CAMERON, James, M.D., appointed Medical Officer of Health and Public Analyst for the Parish of Hendon, Middlesex.

GWYNN, Edmund, M.D., appointed Medical Officer of Health for Hampstead, *vice* C. F. Lord, Esq., resigned.

BIRTHS, MARRIAGES, AND DEATHS.

The charge for inserting announcements of Births, Marriages, and Deaths, is 3s. 6d., which should be forwarded in stamps with the announcements.

MARRIAGES.

BRUNTON—STOPFORD.—On September 20th, at St. Peter's Church, Dublin, by the Venerable C. P. Reichel, D.D., Archdeacon of Meath, assisted by the Rev. J. F. Bickerdike, *Thomas Lauder Brunton, M.D., F.R.S., London, to Louisa Jane, youngest daughter of the late Venerable Edward Adderley Stopford, LL.D., Archdeacon of Meath.

DEATH.

*CHAVASSE, Pye Henry, F.R.C.S., at Hagley Mont, Edgbaston, Birmingham, on September 21st.

PRELIMINARY EXAMINATIONS AT THE ROYAL COLLEGE OF SURGEONS OF ENGLAND.—At the recent Examination in Arts, etc., for the diplomas of Fellow and Member of the Royal College of Surgeons, 431 candidates underwent that ordeal—viz., 294 for the Membership, and 137 for the Fellowship.

APPOINTMENT UNDER THE ADMIRALTY AND WAR OFFICE.—The Lords Commissioners of the Admiralty have appointed Mr. Z. C. Bryan Surgeon and Agent for the Care of Sick and Wounded Seamen and Marines at Little Hampton; and the War Office authorities have appointed the same gentleman to take medical charge of the troops, *vice* Dr. Candy, deceased.

PUBLIC HEALTH.—During last week, 3,145 deaths were registered in London and twenty-two other large towns of the United Kingdom. The mortality from all causes was at the average rate of 19 deaths annually in every 1,000 persons living. The annual death-rate was 14 per 1,000 in Edinburgh, 17 in Glasgow, and 24 in Dublin; whilst in the twenty English towns the death-rates were as follow: Portsmouth 11, Norwich 12, Brighton 15, Wolverhampton 15, Nottingham 16, Bradford 16, Plymouth 16, Birmingham 17, Bristol 17, Hull 17, Sheffield 18, Oldham 19, Leeds 20, London 20, Manchester 20, Sunderland 20, Leicester 21, Salford 23, Newcastle-upon-Tyne 25, and the highest rate (26) in Liverpool. The annual death-rate from the seven principal zymotic diseases averaged 3.7 per 1,000 in the twenty towns, and ranged from 0.0 and 1.4 in Wolverhampton and Oldham, to 4.8 in Manchester, 4.9 in Leeds, and 6.3 in Liverpool. In London, the deaths exceeded the average by 30. The annual death-rate from all causes rose to 19.7. The 1,366 deaths included 1 from smallpox, 27 from measles, 60 from scarlet fever, 16 from diphtheria, 36 from whooping-cough, 21 from different forms of fever, and 92 from diarrhœa; thus, to these diseases 253 deaths were referred, being 24 below the average, and equal to an annual rate of 3.6 per 1,000. Different forms of violence caused 46 deaths; 39 were the result of negligence or accident, including 14 from fractures and contusions, 6 from burns and scalds, 2 from drowning, 1 of a child aged two years from sucking lucifer matches, and 9 of infants under one year of age from suffocation. Seven more cases of suicide were registered. At Greenwich, the mean temperature of the air was 57.6°, and 0.5° above the average. The general direction of the wind was north-easterly, and the horizontal movement of the air averaged 6.1 miles per hour, which was 5.4 below the average. Rain fell on three days of the week, to the aggregate amount of 0.29 of an inch. The duration of registered bright sunshine in the week was equal to 22 per cent. of its possible duration.

COUNTERFEIT EGGS.—The *Allgemeine Medicinische Central Zeitung* quotes the following from the *Neue Preussische Zeitung*:—It is well known that in America everything is counterfeited; the wooden hams and nutmegs sent from the New England States are well remembered. Eggs are now also counterfeited; and this manufactory is carried out on a large scale. On one side of a large room the reporter saw several large copper vessels, filled with a thick glutinous yellow mass, which a man was constantly stirring. This was the yellow of the egg—the yolk. On the opposite side were similar vessels, in which the white was fabricated. The egg-shells were made of a white substance resembling plaster-of-Paris, by means of a blow-pipe, just as soap-bubbles are blown. After being dried in an oven, the egg-shells were filled: first with artificial albumen; then with some of the artificial yolk; and lastly with a little of the artificial albumen. The small opening at the end of the egg was closed with white cement: and the greatest achievement of modern civilisation, the artificial egg, was ready. In appearance it resembled a natural egg; but, whether cooked or raw, it was indigestible and injurious to health.

OPERATION DAYS AT THE HOSPITALS.

MONDAY.....Metropolitan Free, 2 P.M.—St. Mark's, 2 P.M.—Royal London Ophthalmic, 11 A.M.—Royal Westminster Ophthalmic, 1.30 P.M.—Royal Orthopædic, 2 P.M.

TUESDAY.....Guy's, 1.30 P.M.—Westminster, 2 P.M.—Royal London Ophthalmic, 11 A.M.—Royal Westminster Ophthalmic, 1.30 P.M.—West London, 3 P.M.—National Orthopædic, 2 P.M.—St. Mark's, 2 P.M.—Cancer Hospital, Brompton, 3 P.M.

WEDNESDAY..St. Bartholomew's, 1.30 P.M.—St. Mary's, 1.30 P.M.—Middlesex, 1 P.M.—University College, 2 P.M.—King's College, 1.30 P.M.—London, 2 P.M.— Royal London Ophthalmic, 11 A.M.—Great Northern, 2 P.M.—Samaritan Free Hospital for Women and Children, 2.30 P.M.—Royal Westminster Ophthalmic, 1.30 P.M.—St. Thomas's, 1.30 P.M.—St. Peter's, 2 P.M.

THURSDAY....St. George's, 1 P.M.—Central London Ophthalmic, 1 P.M.—Charing Cross, 2 P.M.—Royal London Ophthalmic, 11 P.M.—Hospital for Diseases of the Throat, 2 P.M.—Royal Westminster Ophthalmic, 1.30 P.M.—Hospital for Women, 2 P.M.—London, 2 P.M.

FRIDAY.....Royal Westminster Ophthalmic, 1.30 P.M.— Royal London Ophthalmic, 11 A.M.—Central London Ophthalmic, 2 P.M.—Royal South London Ophthalmic, 2 P.M.—Guy's, 1.30 P.M.—St. Thomas's (Ophthalmic Department), 2 P.M.—East London Hospital for Children, 2 P.M.

SATURDAY....St. Bartholomew's, 1.30 P.M.—King's College, 1 P.M.—Royal London Ophthalmic, 11 A.M.—Royal Westminster Ophthalmic, 1.30 P.M.—St. Thomas's, 1.30 P.M.—Royal Free, 9 A.M. and 2 P.M.—London, 2 P.M.

HOURS OF ATTENDANCE AT THE LONDON HOSPITALS.

CHARING CROSS.—Medical and Surgical, daily, 1; Obstetric, Tu. F., 1.30; Skin, M. Th.; Dental, M. W. F., 9.30.

GUY'S.—Medical and Surgical, daily, exc. Tu., 1.30; Obstetric, M. W. F., 1.30; Eye, M. Th., 1.30; Tu. F., 12.30; Ear, Tu. F., 12.30; Skin, Tu., 12.30; Dental, Tu. Th. F., 12.

KING'S COLLEGE.—Medical, daily, 2; Surgical, daily, 1.30; Obstetric, Tu. Th. S., 2; o.p., M. W. F., 12.30; Eye, M. Th. S., 1; Ear, Th., 2; Skin, Th.; Throat, Th., 3; Dental, Tu. F., 10.

LONDON.—Medical, daily exc. S., 2; Surgical, daily, 1.30 and 2; Obstetric, M. Th., 1.30; o.p., W. S., 1.30; Eye, W. S., 9; Ear, S., 9.30; Skin, W. 9; Dental, Tu, 9.

MIDDLESEX.—Medical and Surgical, daily, 1; Obstetric, Tu. F., 1.30; o.p., W. S., 1.30: Eye, W. S., 8.30; Ear and Throat, Tu., 9; Skin, F., 4; Dental, daily, 9.

ST. BARTHOLOMEW'S.—Medical and Surgical, daily, 1.30; Obstetric, M. Th. S., 2; o.p., W. S., 9; Eye, Tu. W. Th. S., 2; Ear, M., 2.30; Skin, F., 1.30: Larynx, W., 11.30; Orthopædic, F., 12.30; Dental, F., 9.

ST. GEORGE'S.—Medical and Surgical, M. Tu. F. S., 1; Obstetric, Tu. S., 1; o.p., Th., 2; Eye, W. S., 2; Ear, Tu., 2; Skin, Th., 1; Throat, M., 2; Orthopædic, W., 2; Dental, Tu. S., 9; Th., 1.

ST. MARY'S.—Medical and Surgical, daily, 1.15; Obstetric, Tu. F., 9.30; o.p., Tu. F., 1.30; Eye, M. Th., 1.30; Ear, W. S., 2; Skin, Th., 1.30; Throat, W. S., 12.30; Dental, W. S., 9.30.

ST. THOMAS'S.—Medical and Surgical, daily, except Sat., 2; Obstetric, M. Th., 2; o.p., W. F., 12.30; Eye, M. Th., 2; o.p., daily except Sat., 1.30; Ear, Tu., 12.30; Skin, Th., 12.30; Throat, Tu., 12.30; Children, S., 12.30; Dental, Tu. F., 10.

UNIVERSITY COLLEGE.—Medical and Surgical, daily, 1 to 2; Obstetric, M. Tu. Th. F., 1.30; Eye, M. W. F., 2; Ear, S., 1.30; Skin, Tu., 1.30; S., 9; Throat, Th., 2.30; Dental, W., 10.3.

WESTMINSTER.—Medical and Surgical, daily, 1.30; Obstetric, Tu. F., 3; Eye, M. Th., 2.30; Ear, Tu. F., 9; Skin, Th., 1; Dental, W. S., 9.15.

MEETINGS OF SOCIETIES DURING THE NEXT WEEK.

WEDNESDAY.—Obstetrical Society of London, 8 P.M. Cases:—Cholera in the New-born, by Dr. Lucas. Papers:—Mr. Alban Doran, "Deficient Development of the Uterus, Atresia of the Os Externum, Atrophy of the Ovaries"; Dr. Chambers, "Case of Congenital Inguino-Ovarian Hernia (double)—Operation"; Report of Subcommittee on the Specimens removed.

LETTERS, NOTES, AND ANSWERS TO CORRESPONDENTS.

COMMUNICATIONS respecting editorial matters should be addressed to the Editor, 161, Strand, W.C., London; those concerning business matters, non-delivery of the JOURNAL, etc., should be addressed to the General Manager, at the Office, 161, Strand, W.C., London.

AUTHORS desiring reprints of their articles published in the BRITISH MEDICAL JOURNAL, are requested to communicate beforehand with the General Secretary and Manager, 161, Strand, W.C.

CORRESPONDENTS not answered, are requested to look to the Notices to Correspondents of the following week.

PUBLIC HEALTH DEPARTMENT.—We shall be much obliged to Medical Officers of Health if they will, on forwarding their Annual and other Reports, favour us with *Duplicate Copies*.

CORRESPONDENTS who wish notice to be taken of their communications, should authenticate them with their names—of course not necessarily for publication.

WE CANNOT UNDERTAKE TO RETURN MANUSCRIPTS NOT USED.

DR. A. RANSOME (Manchester).—It will be published at the earliest opportunity.

CORRESPONDENTS are particularly requested by the Editor to observe that communications relating to advertisements, changes of address, and other business matters, should be addressed to Mr. FRANCIS FOWKE, General Secretary and Manager, at the Journal Office, 161, Strand, London, and not to the Editor.

FOREIGN DEGREES.

SIR,—In answer to my letter to you of last week, I have received numerous letters from gentlemen holding foreign degrees, and also from other gentlemen. It is quite impossible for me to discuss this question *privately* with all these gentlemen *simultaneously*, and I have, therefore, requested those of them to whom I have not as yet been able to reply, to address me through the columns of the BRITISH MEDICAL JOURNAL, when, if they write in their own names and attach to them the description of their qualifications, it will give me great pleasure to reply to them; but anonymous communications I must decline to notice.—I am, sir, your obedient servant,

130, Stockwell Road, S.W., September 24th, 1879. R. H. S. CARPENTER.

SIR,—Seeing Mr. Carpenter's letter on this subject in the BRITISH MEDICAL JOURNAL of last week, I wrote to him privately, and received from him in reply an intimation that he would prefer that all correspondence should be publicly conducted. I therefore venture to trouble you with this.

In his letter, Mr. Carpenter mentions the case of A. B., who, having only the L.S.A. diploma, was admitted to examination, and received the degree of M.D. from the University of Brussels. In my letter to Mr. Carpenter, already referred to, I asked him to give me the name of A. B.; or, if he did not feel at liberty to do that, at all events to furnish me with the year of his graduating. As Mr. Carpenter has not thought proper to do either, I am necessarily writing to some extent in the dark with respect to this particular case.

Now, sir, the authorities at Brussels admit that formerly men with only one qualification did occasionally gain admission to the examination, which they furthermore confess was not always as stringent as it now is: but, sir, bygones must be bygones, and whatever was the case formerly, the Regulations of the University of Brussels for the examination of candidates without residence distinctly state that a double qualification is now a *sine quâ non*. If by any means a singly qualified candidate have gained admission to the degree, it will be a fact as interesting to us as to Mr. Carpenter himself. With regard to the examination itself, no discussion can be of any use. Those who have *not* been present at an examination can hardly be expected to know very much about it; and those who *have* (and it is entirely open to the public throughout) know that it is a good one—a thorough test of a man's theoretical as well as of his practical knowledge. I would suggest to those numerous gentlemen who write about the examination, without in reality knowing anything about it, to take a trip to Brussels (or as these gentlemen, with singular unanimity, almost invariably term it, "run over to the Continent") and see and hear what is required of candidates. The next examination will commence on Tuesday, October 7th.

I think the whole subject should be looked at fairly, and that it should be remembered that many of our British examinations now are very different from what they used to be, and that a great many gentlemen who obtained their diplomas some years ago, did so on much easier terms than are exacted of candidates of the present day.—I am, sir, your obedient servant,

F. ERNEST POCOCK, M.D.Brux.

20, Golborne Road, Westbourne Park, September 24th, 1879.

SIR,—As a foreign graduate, I request you will allow me space to reply to Mr. R. H. S. Carpenter's letter on foreign degrees in the BRITISH MEDICAL JOURNAL of September 20th. The case of (1) A. B., I think, is one very commonly met with in this country. There is nothing surprising in meeting with a man now and then who is sufficiently well educated to pass a good medical examination, but who is in other branches of knowledge badly educated. It must be remembered that the University of Brussels admits registered British practitioners to examination for the M.D. without testing their extra medical knowledge, presuming that, if registered in this country, they are well educated in other branches. This man appears to have been registered here before passing at Brussels, according to Mr. Carpenter's statement. I am acquainted with three British graduates who can only just manage to speak the Queen's English. With regard to case No. 2 (C. D.), I confess I am unable to account for such a state of things. One thing I am convinced cannot be—that is, I am quite sure such a man has never presented himself for examination and passed at either Giessen or Jena. To obtain either of those degrees, a man must undergo an examination upon all medical subjects before the whole Faculty of Medicine, which C. D. could not have done, if, as Mr. Carpenter says, he never had one hour's medical education. There needs further explanation of this case. It is possible that this fellow, who appears to be unfit for a learned profession, bought his degree from the widow or representative of some deceased medical man, and then assumed his name. Such things have been frequently done before. This second case seems almost too absurd for serious consideration. We must not in this country imagine that the authorities of all other universities, save our own, are asleep or indifferent to their responsibilities and interests. Foreign universities are conducted upon just as good principles as (some think better than) our own; though, perhaps, people in this country, with their insular prejudices so deeply rooted, cannot understand it.

In conclusion, I think many will agree with me that Mr. R. H. S. Carpenter, in his zeal, has brought bad evidence to support his cause. Both cases are isolated ones; the first corresponding exactly with many British graduates, the second representing a state of things too absurd for intelligent men to believe it can exist exactly as related by your correspondent.—I am, sir, yours, etc.

H. J. HARDWICKE, M.D.Giessen, M.R.C.P., F.R.C.S.Ed.

Sheffield, September 1879.

SIR,—If Mr. R. H. S. Carpenter will obtain from Giessen a copy of rules and regulations for the degree of M.D., he will, I think, after perusal thereof, change his opinion as to the course of study necessary for graduation. Had C. D., being well-to-do, obtained his diploma by personation? Had he possessed himself of some other man's diploma? Relatives of deceased practitioners show a tendency to preserve rather than to destroy documents of the kind.—I am, etc.,

Hastings, Sept. 20th, 1879. J. BEADNELL GILL, M.D.

SIR,—Mr. Carpenter is somewhat sweeping in his denunciation of foreign degrees. In looking over the names of those gentlemen possessing foreign degrees practising in this country, one is rather impressed than otherwise by the good professional position and known social standing which the possessors of the said degrees occupy. One remembers the kind of examination candidates in former years were submitted to for the degree in some of our northern universities, and doubtless abroad at the same period degrees were conferred upon conditions even more favourable. Half a

century ago, the fashion led men of eminence to seek a continental degree; the custom is not unlikely to become revived, in case the obstacles to graduation in England be not removed.—I am, sir, your obedient servant,

September 20th, 1879. COSMOPOLITAN.

A SUFFERER.—It is contrary to our custom for us to comply with such a request. A Sufferer should consult some practitioner of repute in his own neighbourhood, who, if he considered further advice necessary, would doubtless intimate to our correspondent the names of several consultants, the opinion of any one of whom might then be obtained.

PEPSINE WINE AS A REMEDY FOR THE SICKNESS OF PREGNANCY.

SIR,—Dr. William Fraser, in an article on "Sickness during Pregnancy", recommends the use of pepsine wine very strongly. I have used this preparation in a manner similar to what he has, but have been disappointed with my results. Probably the pepsine wine I used was not of a good quality. I would esteem it a great favour if Dr. Fraser would furnish in detail instructions how to make it, so that it could be relied upon. The preparation of the wine does not appear, so far as I know, in the *Pharmacopœia*.—I am, yours respectfully, A MEMBER.

INFANTILE DIARRHŒA.

SIR,—I beg to apologise for a mistake which has inadvertently crept into the latter part of my letter to you on the subject of "infantile diarrhœa" appearing in the JOURNAL of September 20th, the mistake being due to an omission on my part in copying rather hastily from my rough original. The last paragraph should properly read thus: "Mr. Budd states that, according to his own observations, diarrhœa hardly ever takes place amongst those infants that are fed on condensed milk; and this, too, I myself have noticed, and have also heard the same statement made with regard to 'Mellin's' (?) extract: and I consider that the small quantity of malt-extract contained in the latter, as well as the sugar of milk—to which is assigned by Mr. Budd, with regard to condensed milk, the prevention of its turning sour—renders it so efficacious as a prophylactic, as it is thus so nearly approximated in its constituents to the infant's natural food." *In vitium ducit culpæ fuga* (Horace), so that if you will give this letter an early insertion in your paper you will much oblige, sir, your obedient servant, WM. A. G. LAING, L.S.A.

69, Lemon Street, Truro, September 21st, 1879.

SCARBOROUGH.—Mr. Alfred Haviland, Medical Officer of Health, Northampton, proposes the planting of the whole of the North Undercliff with pine-trees from one end to the other. The effect of pine-trees, when massed together, on the atmosphere is, he considers, most beneficial to those suffering from delicate lungs (consumptives). The trees would further add to the beauty of the northern cliffs, whilst robbing the winds of much of their harshness.

SIGNATURE OF VACCINATION CERTIFICATES BY UNQUALIFIED PERSONS.

SIR,—I should like to know your opinion, as well as that of your readers, on the conduct of a medical practitioner who allows an unqualified assistant to sign his (the medical man's) name to vaccination certificates on infants whom he has never seen. The matter, I venture to think, is of very great interest to the medical profession: as, if the law allow an unqualified assistant to sign the name of his principal to certificates of this and the like nature, most medical men will employ unqualified assistants rather than qualified; the former class being undoubtedly cheaper, and one which a certain class of medical men treat with a disrespect which a qualified man would not put up with. Enclosed is my card and address, but not for publication.—I am, etc., COUNTRY SURGEON.

*** It is decidedly wrong for a medical practitioner to certify cases of vaccination performed by an unqualified assistant when he has never seen the cases.

MEDICAL CERTIFICATE OF THE CAUSE OF DEATH.

SIR,—By Section 20 of the Births and Deaths Registration Act, 1874 (37 and 38 Vic., c. 88), it is enacted that: "In the case of the death of any person who has been attended during his last illness by a registered medical practitioner, that practitioner shall sign and give, etc. . . . a certificate stating to the best of his knowledge and belief the cause of death, etc." And under Section 39 of the same Act, every person who refuses or fails, without reasonable excuse, to give or send any certificate in accordance with the provisions of the Act, is liable to a penalty not exceeding forty shillings. I maintain that I have a reasonable excuse for not giving or sending any certificate of the cause of death of any person or persons attended in their last illness by me, either as a registered medical practitioner or union medical officer, unless I am paid for giving or sending the same.

An expression of your valuable opinion, as well as that of the members of the profession generally, on the subject will oblige. I enclose my card, and am, sir, yours truly. SINE TIMORE.

*** We fear that a court of law would not admit non-payment of a fee as a "reasonable excuse", provision for such payment not being made in the Registration Act.

M. P.—Dr. Blandford's *Insanity and its Treatment* (published by Simpkins, Marshall, and Co.) is a handy and practical work. Bucknill and Tuke's *Manual of Psychological Medicine* (published by J. and A. Churchill) is a standard book of reference.

ZULU.—The best work on Cottage Hospitals is *The Cottage Hospital: its Origin, Progress, and Management.* By Henry C. Burdett. It is published by J. and A. Churchill, New Burlington Street, London.

THE ALCOHOL QUESTION.

SIR,—In the JOURNAL of July 5th, 1879, under the heading "Treatment of Disease without Alcohol", you publish some statistics of Dr. Webster of St. George's. I should like to know how he arrives at his percentage of death-rate, or on what data he framed his comparison with the other hospitals enumerated. For instance, he states his mortality has been 12¼ per cent. on an average number of 559 patients. Now, the deaths at St. George's during the year have been 313 (BRITISH MEDICAL JOURNAL, August 1879). The total number of patients admitted from Lady-Day 1878 to Lady-Day 1879 has been 2142. Taking number of admissions and average number of patients, I cannot reconcile his percentage with my calculations. In the interest of the alcohol question, I write for information as to how he worked out his figures.—Yours faithfully, ENQUIRER.

BICYCLES IN COUNTRY PRACTICE.

SIR,—I would feel greatly obliged by any of your readers giving his experience of the use of a bicycle or tricycle in country practice. I am told that many country practitioners now make use of them in their rounds.—I am, etc.,

September 17th, 1879. COUNTRY PRACTITIONER.

NOTICE TO ADVERTISERS. — Advertisements for insertion in the BRITISH MEDICAL JOURNAL should be forwarded direct to the Publishing Office, 161A, Strand, London, addressed to Mr. FOWKE, not later than *Thursday*, Twelve o'clock.

CASE OF FŒTAL MONSTROSITY.

SIR,—Not long ago I attended a woman in her fourth confinement. After a some what tedious labour, she was delivered of a male child, presenting a most striking deformity. The cranial bones were imperfectly developed, the top of the head being one pulpy mass. The child was entirely destitute of eyes, the left eyebrow only being visible about an inch external to the socket. What represented the nose was simply the bony framework, on each side of which were two distinct fissures, extending through the upper lip, resembling an enlarged form of double harelip, accompanied by a double cleft-palate. Its cheeks were hanging down like dog's ears, giving the child a most hideous appearance. I could with ease discern the epiglottis. Singular to remark, the external ears were perfectly formed. The second and third phalanges of the fingers on the right hand were absent, there being no fingers on the left. The trunk and lower limbs were well developed, and apparently well nourished.

In conversation with the mother some days afterwards, I ascertained that some months previously her eldest boy had been amusing himself with some dynamite caps, which exploded, injuring the little fellow severely about the face and hands. Attracted by the boy's shrieks, she rushed to the spot where he was, and the sudden shock to her nervous system, at seeing him in such a disfigured condition, completely upset her, and it was a long time before she recovered from the effects of it. This occurring about the eighth week of the woman's pregnancy, made me think that there must have been some connection between the effects of the accident and the monstrosity.—Yours faithfully, GEO. LOWE, L.R.C.P.

Middleton-in-Teesdale, September 2nd, 1879.

DR. W. WILBERFORCE SMITH.—The matter is scarcely of sufficient public interest to warrant us in assigning to the memorandum in question the position sought for it. If desired, it can appear next week in this part of the JOURNAL.

ENQUIRER.—The evidence of Dr. Sharpey, Sir Wm. Gull, Dr. McKendrick, Dr. Rutherford, and others, contained in the Blue Book issued by the Select Committee on Experiments on Animals, will supply material for meeting the habitual misstatements of anti-vivisectionists. The opening address of Dr. Pye-Smith, delivered in the department of Anatomy and Physiology at the recent meeting of the British Association at Sheffield, and published at page 349 of the BRITISH MEDICAL JOURNAL for August 30th, 1879, might also be consulted.

WE are indebted to correspondents for the following periodicals, containing news, reports, and other matters of medical interest:—The Western Morning News; The Glasgow Herald; The Manchester Guardian; The Yorkshire Post; The Leeds Mercury; The Cork Constitution; The Coventry Herald: The British Guiana Royal Gazette; The Ceylon Observer; The Wigan Observer; The Peterborough and Huntingdonshire Standard; The Sussex Daily News; The Liverpool Mercury; The Banffshire Journal; The Newport and Market Drayton Advertiser; The North Wales Guardian; etc.

*** We shall be greatly obliged if correspondents forwarding newspapers will kindly mark the passages to which it is desired to direct attention.

COMMUNICATIONS, LETTERS, etc., have been received from:—

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Manual of Practical Anatomy. By J. Cossar-Ewart, M.D., F.R.C.S.E., F.R.S.E. With Outline Plates. London: Smith, Elder, and Co. 1879.

A Demonstration in Antiseptic Surgery. By Joseph Lister, F.R.S., LL.D. Dublin: John Falconer. 1879.