

excited, but I would be glad if you will allow me, with all respect, to criticise Mr. Lane's conclusions and to advance my own more favourable findings.

Mr. Lane states that while he found the results from the use of the substitutes "fairly satisfactory" their "toxic effect is much more intense," and he sounds a note of warning as to their employment. Both of the cases which Mr. Lane cites in support of the intense toxicity theory are capable of a somewhat different construction. Thus in Case 1 a course of intramuscular injections of mercury had to be interrupted owing to the onset of symptoms of mercurialism, and the dermatitis, although it followed an intravenous injection of novarsenobenzol (Billon) administered three weeks after the last mercurial injection, may have been partly or entirely a mercurial dermatitis. I have had under my care three cases of intense general dermatitis due to idiosyncrasy to mercury. Apart from this possibility, the evidence already provided of the patient's tendency to drug intolerance would indicate the need for caution and would suggest a small initial dose.

In Case 2 a second injection of kharsivan was given eight days after the first injection. For either salvarsan or kharsivan this is too short an interval if full doses are employed. Mr. Lane, unfortunately, omits to mention the dosage.

In criticising kharsivan we must not forget that it is comparable only to salvarsan and not to neosalvarsan. Both kharsivan and salvarsan are more toxic and at the same time more efficacious than neosalvarsan. The experience of my assistants and myself with kharsivan, which now covers 180 injections, leads me to conclude that its immediate and remote effects differ in no way from salvarsan. We have found that it is subject to exactly the same limitations and risks, but that it is equally beneficial in promoting the healing of syphilitic lesions. We have not been without our troubles in this series of cases, but we have no reason to blame the drug but only our methods. Two patients were seriously ill. Both of these were pregnant women who received the excessive dose of 0.6 gm. Personally I never use 0.6 gm. either of salvarsan or kharsivan. To do so in pregnant women is to invite complications. Nevertheless, in 43 out of the 180 kharsivan injections doses of 0.6 gm. were used. All of these 43 injections were given to women, and it was only amongst them that any troublesome reactions were experienced. In no case was dermatitis encountered, but more or less gastro-intestinal irritation was evident in 24 cases. Complaint only of headache was made in 4, of feeling sick in 3; vomiting was present in 19 and diarrhoea in 6. A temperature of 100°F. or over was found in 6 instances. There is here, I think, sufficient evidence to warrant the conclusion that a dose of 0.6 gm. is inadvisable, and those of us who have been using this quantity have at last been induced to abandon it. Thrombosis we have not met with since the early days of salvarsan treatment, but when kharsivan is allowed to infiltrate the tissues a cellulitis, as in the case of salvarsan, is to be expected.

That salvarsan is not less toxic than kharsivan in similar dosage is proved by our records, but space will not permit any elaboration on this point. Neosalvarsan in corresponding dosage is much less prone to excite irritation, but how neokharsivan will compare with neosalvarsan I am as yet unable to say, having used only 12 tubes of this preparation. I would like to advise, however, that the

instructions accompanying the vial should be carefully read and rigidly adhered to.

With regard to Mr. Lane's plea for preventive measures calculated to control the spread of venereal diseases at the termination of the war, it is to be hoped that the Army Medical Department will endeavour, for the sake of military efficiency as well as for the public well-being, to supply effective treatment for their venereal cases.

I am, Sir, yours faithfully,
Glasgow. DAVID WATSON, M.B., C.M. Glasg.

THE MENTAL TREATMENT BILL.

To the Editor of THE LANCET.

SIR,—Now that a Bill is being promoted to make it possible for us to treat without certification soldiers and sailors suffering from serious mental disorder due to shock, this is surely an opportunity for extending similar benefits to civilians in special instances. There are many cases of mental disease in which recovery occurs comparatively quickly under systematic residential treatment, and this possibility is evidently admitted by the authorities, the whole point of the new Bill being the avoidance of the stigma of certification. Yet many persons have to be certified for conditions likely to recover within a few months because the law at present does not permit of their being taken into nursing homes or doctors' houses otherwise.

Is there any sound reason why it should not be made possible to treat such cases without certification for a period of six months, provided that certain safeguards are erected? And for this it should be sufficient for the Government to appoint several experienced alienists as special consultants for this purpose, giving them power to issue a permissive certificate to any medical man who has the care of an individual bordering on insanity, yet in whose case there is a reasonable possibility that recovery may occur soon with residential treatment. Such a certificate would be one concerning treatment only, and not affecting the status of the patient as a person of sound mind. Obviously certain conditions should be excluded from the operations of such a Bill under any circumstances, particularly general paralysis, cases of advanced dementia, and all cases exhibiting evident homicidal or suicidal tendencies.

I am, Sir, yours faithfully,
EDWIN L. ASH, M.D. Lond.
Harley-street, W., April 26th, 1915.

THE SCOTOMA OF MIGRAINE.

To the Editor of THE LANCET.

SIR,—With regard to Dr. F. W. Edridge-Green's article on the above subject in your issue of April 24th, though I do not quite follow all his arguments, nor can I produce in myself the phenomena he describes which can be noticed on awaking in the morning and looking at a white ceiling, I feel certain that he is right in attributing the scotoma to disturbance "of the circulation of the eye." I think this is shown very clearly by the following case.

A student of Guy's Hospital some 20 years ago had ocular migraine, which took the form of complete blindness of one eye, and came on very rapidly. I had the opportunity on several occasions of examining the eye when the attack was on. As far as I remember the pupil was always dilated; the ophthalmoscopic appearances were most marked and always the same. The eye could not see

the light from the ophthalmoscope mirror. The retinal veins were so engorged that they looked almost bursting; the arteries—perhaps only by contrast—were thin.

On every occasion I watched the eye whilst the attack lasted, and was always able to say "You are beginning to see again," which meant that the veins were beginning to empty and gaining their natural size, which they succeeded in doing in the course of a few minutes, with complete return of sight. When this gentleman left the hospital he went into practice in a healthy seaside town, where he never had another attack. As far as I remember, but am not certain about it, he suffered from some form of heart trouble.

One of my colleagues at Guy's, long since dead, suffered in exactly the same way. He had conical cornea in one eye, and that eye was very little use to him. His first attack of migraine came on when he was in the street, fortunately not far from home. He went almost suddenly blind in his good eye and had to get someone to take him home. He was naturally very much alarmed, and it was at the beginning of his career. Whilst he was telling his wife that he feared all was over with him his sight began to return and was soon entirely restored. He consulted me about it and I told him it was migraine, and I thought due to something wrong with circulation, that he knew the worst of it and need not trouble himself about it. He had other attacks, but I never had an opportunity of examining his eye during one; at other times the eye was normal except for a low degree of myopic astigmatism. He had cardiac trouble of which he eventually died. I do not know the nature of it.

I am, Sir, yours faithfully,

Brook-street, W., April 25th, 1915.

CHARLES HIGGENS.

OUR LIMBLESS SAILORS AND SOLDIERS.

To the Editor of THE LANCET.

SIR,—A great number of sailors and soldiers serving at the war have already been disabled by loss of limbs, and there will be many more before the war is ended. These men are now being discharged from hospitals and returning to their homes or friends with their wounds recently healed, and without adequate arrangements being made for their future care, comfort, or prospects. The country owes it to these gallant men that proper provision should be made for them, that they should be cared for until they have fully recovered their strength and nerve and learned how to use their new limbs, so as to become capable of taking up employment again in the form best suited to each. This cannot be done in existing hospitals.

A committee has been formed recently with the gracious approval of Her Majesty the Queen, and with the sanction of the Directors-General of the Navy and Army Medical Services, and steps will be taken immediately to establish one or more convalescent auxiliary hospitals (including an officers' branch) where these poor fellows may be concentrated and where they can get fitted and accustomed to their artificial limbs under the best conditions, with the generous advice of several eminent orthopædic surgeons. Application is being made to the Prince of Wales's Fund for a grant. We feel sure that an ever-generous public will also readily respond to our appeal. All communications and donations should be addressed to C. H. Kenderdine, St. Stephen's House, Westminster, S.W. (marked "Auxiliary Hospital").—Yours obediently,

KATHLEEN FALMOUTH,

M. E. GWYNNE HOLFORD.

April 29th, 1915.

Obituary.

SIR THOMAS SMITH CLOUSTON, Kt., M.D. EDIN.,
LL.D. EDIN. & ABERD., F.R.C.P. EDIN.,
CONSULTING PHYSICIAN, FORMERLY MEDICAL SUPERINTENDENT, TO
THE ROYAL ASYLUM, MORRINGSIDE, EDINBURGH.

THE death of Sir Thomas Smith Clouston, which took place suddenly at his residence in Edinburgh on April 19th in his seventy-fourth year, has deprived the profession of one of its leading alienists. For nearly half a century he devoted himself entirely to the study of mental diseases. Born in Orkney, where his father lived, he received his early education at the West End Academy, Aberdeen, and afterwards entered the University of Edinburgh, where he had a brilliant career as a student. He qualified in 1860 as L.R.C.P. Edin. (of which College he became a Fellow in 1873), and in the following year graduated M.D. at the University, where he was the thesis gold medallist, and this, together with the winning of the Fothergill gold medal in 1870, foreshadowed the distinguished future before him. It is noteworthy that two of his fellow graduates were James Bell Pettigrew, the eminent anatomist, and John Anderson, the naturalist.

Immediately after qualifying he was appointed assistant physician under Dr. Skae at the Morning-side Asylum, his two colleagues being the late Sir John Sibbold and Dr. David Yellowlees. This position he held for three years, and in 1863 was appointed superintendent of the Cumberland and Westmorland Asylum at Carlisle. He held this post for ten years, made his mark in it both as observer and administrator, and left to accept the position of physician-superintendent to the Royal Asylum, Edinburgh, where for 35 years he laboured assiduously to render the asylum a model institution for the treatment of mental diseases and a training school for alienist superintendents of other institutions throughout the world. Almost immediately after his appointment he set to work to renovate and reconstruct the institution, and the success of his labours was seen in the opening of Craig House. Some idea of the magnitude of the work of reconstruction may be realised by the fact that during the 35 years of his office the sum of £180,000 had been expended by the directors of the institution which has achieved great financial prosperity during that period.

The lectures on lunacy and cognate subjects which he delivered to the students at the Royal Edinburgh Asylum were marked by a clearness of thought and lucidity of expression which at once placed him in the forefront of teachers in mental diseases, and in 1879, six years after his appointment, he became the first lecturer in mental diseases in the University of Edinburgh. Four years later—namely, in 1883—the first edition of his lectures was published under the title of "Clinical Lectures on Mental Diseases," and the book, which has gone through six editions (the last was published in 1904) has done more perhaps than any other work on the treatment of mental diseases in spreading throughout the world enlightened methods of treatment and wise conceptions of the nature of mental aberration. Among his other notable works are the "Neuroses of Development," published in 1891, the "Hygiene of the Mind," which has seen five editions, and "Unsoundness of Mind," which was published some three years ago.