(Volunteers), to be Surgeon-Lieutenant, with precedence as in the Volunteer Force (dated April 1st, 1908).

Royal Army Medical Corps.

1st South Wales Mounted Brigade Field Ambulance: Captain John Griffiths, from the List of Officers attached to units other than Medical Units, to be Captain (dated August 10th, 1909).

3rd Highland Field Ambulance: Lieutenant Sidney W. Smith resigns his commission (dated June 15th, 1909). Henry James Gorrie to be Lieutenant (dated Sept. 10th, 1909).

2nd West Lancashire Field Ambulance: George Charles Edward Simpson to be Lieutenant (dated Oct. 4th, 1909).

2nd Lowland Field Ambulance: Lieutenant James A. H. Aitken to be Captain (dated Oct. 28th, 1909).

2nd North Midland Field Ambulance: Captain Montague S. W. Gunning resigns his commission (dated Sept. 1st, 1909).

2nd Welsh Field Ambulance: Owen Lewellin Rhys to be Lieutenant (dated Sept. 25th, 1909).

1st Scottish General Hospital: Captain William A. I. Fortescue resigns his commission (dated Oct. 9th, 1909).

Attached to Units other than Medical Units.—Lieutenant Harry Armitage Robinson to be Captain (dated Sept. 28th, 1909).

The transfer of Surgeon-Lieutenant Lloyd Turton Price from the 1st Forfarshire Royal Garrison Artillery (Volunteers), which was announced in the *London Gazette* of Nov. 6th, 1908, is cancelled.

Correspondence.

“Audi alteram partem.”

THE LATE DR. JOHN HERBERT WELLS.

To the Editor of THE LANCET.

SIR,—The death of Dr. John Herbert Wells last month at the early age of 30 years adds another name to the list of those who have lost their lives in the cause of scientific medical research.

After distinguishing himself in original research, Dr. Wells joined the department of therapeutic inoculation at St. Mary's Hospital, where this branch of treatment was advanced materially by his labours. In February, 1908, Dr. Wells undertook pioneer investigation of the treatment of glanders, and in the course of laboratory work which resulted in saving the life of the patient from this, till then, hopeless disease, contracted infection himself, and died after 18 months of suffering on Oct. 16th, 1909, leaving a widow and two small children almost totally unprovided for.

Throughout his long illness Dr. Wells's constant hope was to return to the work in the cause of which he had suffered so severely. He was held in high esteem by the members of his profession, and his thoroughness and personality won him many friends, as the obituary notice in *THE LANCET* of Oct. 23rd abundantly testified. His life was rich with promise and was laid down with manly fortitude as the penalty of his scientific zeal.

A committee has been formed, consisting of the Right Hon. A. J. Balfour, M.P., the Earl of Dalhousie, Lord Justice Fletcher Moulton, Sir Almroth Wright, M.D., F.R.S., Mr. H. A. Harben (late chairman of St. Mary's Hospital), Mr. Julian G. Lousada, Mr. Edmund Arthur Smith (of the Stock Exchange), and Dr. W. H. Willcox; and they now appeal to the public for donations to a fund to be held in trust for Dr. Wells's widow and children.

The committee (on whose behalf we write) feel strongly that in such a case as this, where a man has laid down his life in trying to relieve the sufferings of mankind, it is eminently fitting that some recognition should be made of his work, and they have full confidence that the public will make a ready response to their appeal.

All contributions sent to the Honorary Secretaries and Treasurers of the fund at 16, Old Broad-street, London, E.C., will be gratefully acknowledged.

Yours faithfully,

DALHOUSIE, } Joint Honorary Secretaries
JULIAN G. LOUSADA, } and Treasurers.

16, Old Broad-street, London, E.C., Nov. 11th, 1909.

List of present subscriptions already promised or received:—

	£	s.	d.		£	s.	d.
Sir Edward Tennant ...	100	0	0	THE LANCET Relief Fund ...	25	0	0
Lady Tennant ...	100	0	0	Major Alexander H. Davis ...	21	0	0
Anonymous ...	100	0	0	Mr. Morton Smale ...	20	0	0
Right Hon. A. J. Balfour, M.P. ...	25	0	0	Mr. H. A. Harben ...	20	0	0
The Earl of Dalhousie ...	25	0	0	Mr. Herbert G. Lousada ...	10	10	0
Lord Justice Fletcher Moulton ...	25	0	0	Mr. P. C. Fawcett ...	10	10	0
Hon. Rupert Guinness ...	25	0	0	Mr. Lewis H. Samuel ...	5	5	0
Mr. Max J. Bonn ...	25	0	0	Mr. Philip S. Waley ...	5	5	0
Mr. E. J. Stephens ...	25	0	0	Mr. Edmund A. Smith ...	5	5	0
Dr. W. H. Willcox ...	25	0	0	Miss Margaret Knowles ...	3	3	0
Mr. and Mrs. Julian G. Lousada ...	25	0	0	Miss Natalie Beard ...	3	3	0

* * We are able to announce that the colleagues of the late Dr. J. H. Wells on the staff of the department of therapeutic inoculation at St. Mary's Hospital are making an independent subscription which will be added to the fund later. We shall be happy to receive and acknowledge subscriptions to this fund.—ED. L.

THE STATUS LYMPHATICUS.

To the Editor of THE LANCET.

SIR,—The prominence which has been given in the press during the last three years to the subject of deaths under chloroform has produced in the public mind a feeling of considerable uneasiness, and it is surprising to remember in this connexion how small is the progress we are making towards understanding the lymphatic state. At the risk of an accusation of prematurity, but in the hope of stimulating discussion, or at least some publication of experiences, I venture to submit a few words on the subject, suggesting the line of thought which has been forced upon me by a study of the literature available and by a retrospective examination of my clinical records.

Definition.—Status lymphaticus is a name given to a combination of conditions found post mortem in the bodies of certain young persons who have died suddenly and “unaccountably,” or from “inadequate” causes, of which the inhalation of chloroform vapour is here assumed to be the most important. Evidence has frequently been given that such patients presented during life no disease or peculiarity beyond the presence of “adenoids,” for the cure of which they may have been undergoing operation at the moment of death.

The Vienna School recognised the importance of this condition as a factor in causing danger in anaesthesia many years before the rest of Europe, or America, began to pay attention to it (J. Ewing). The researches tend to show that status lymphaticus cannot be entirely rejected as a pathological entity, although it, as a picture or idea, is open to the criticisms which have demolished the old pathological “diatheses.”

Post-mortem findings.—There have usually been some or all of the following in order of frequency: (1) enlargement of a few, or many, groups of lymphatic glands and of the lymph follicles of the intestinal mucosa; (2) enlargement of the spleen; (3) persistence of the thymus gland in a functional condition; (4) hyperplasia of the red bone marrow; (5) enlargement of the thyroid body; (6) in infants, signs of rickets; (7) in adolescents, hyperplasia of the heart and narrowing of the aorta.

Clinical realities.—Paltauf's theory, supported by Warthin, that the condition is a “lymphotoxæmia,” with compensatory enlargement of the thymus, receives support from a comparison of the three types of patient (now to be described), who may, and not infrequently do, exhibit untoward symptoms when under the influence of chloroform. It is noteworthy that the condition in all three types occurs in young or early mature persons.

1. Young persons, chiefly female, suffering from chronic anaemia and constipation—both points which may be easily overlooked or under-estimated by the anaesthetist in his preliminary examination. When the tissues of a patient are already saturated with one poison, the addition of a very small dose of another may be fatal (and this applies not only to this type of case, but also to the two other types which follow). The danger of giving morphine to a nephritic patient is an example. In cases of pronounced

copric anæmia the tissues are in a low state of vitality and are liable to outright destruction by a very small dose of chloroform. The heart's action is always weak, and often slow and irregular, so that pulse and respiration seem to fail simultaneously when danger appears under chloroform; the fact that artificial respiration applied without delay is usually successful in restoring the patient proves that in these cases the respiratory centre is more deeply poisoned than the heart muscle. Pure chloroform should never, when possibly avoidable, be given to such patients, and the greatest vigilance and care are necessary when administering mixtures.

2. Young persons, more often males, often largely and loosely built, who show on examination: (a) some enlargement of the thyroid and fulness of the episternal notch; (b) a palpable or percussible enlargement of the spleen; (c) *an abnormally slow and inexcitable pulse*, and this in spite of the fact that the patient may be in a miserably anxious and apprehensive state on account of the imminence of the operation. With this there may be, but not constantly, dilatation of the heart. The face is anæmic and rather vacuous, and the pallor may be masked by some degree of cyanosis. These are the cases, in my opinion, to which the name "Status Lymphaticus" should be restricted. The behaviour of these patients under anæsthetics other than chloroform is interesting and suggestive collateral. For instance, nitrous oxide is the most frequently used of all anæsthetics in this country, and the users of this gas can, with little trouble, supply a mass of clinical material of the greatest value. In my experience (15 cases under all anæsthetics) the patient who is only slightly "lymphatic," presenting no signs beyond some lividity of the hands and slight sluggishness of the pulse, requires much more than the normal volume (8 to 12 gallons) of N_2O to "get him over," though, once unconscious, the anæsthesia is sometimes profound and lasting. Such a patient may require as much as 20 gallons of N_2O , especially in warm damp weather. Again, a patient who presents all the signs of lymphatism in a well-marked degree may be totally insusceptible to the narcotising properties of N_2O . He may inhale 30 or 40 gallons without admixture of air for even three minutes and show no result whatever beyond slight dizziness and profuse perspiration. These patients, I believe, always show some abnormality of reaction to nitrous oxide, they *may* show danger signs under chloroform-ether mixtures, and under pure chloroform they almost certainly *will* give trouble. Their reaction to ether does not seem to differ greatly, if at all, from the normal, though Heusler reports a death *after* ether and much loss of blood.

3 *Young parturient women*.—No clinical observation has ever been so mistaken as that which stated that pregnancy conferred immunity from the poisonous effects of chloroform. There are here more factors than one tending to produce too easily an overdose of chloroform vapour (the favourite anæsthetic under these circumstances). There is the diminished "vital capacity" due to encroachment upon the diaphragmatic portion of the thorax, there is the increased carrying capacity of the red blood corpuscles, there is the physical exhaustion produced by prolonged pain and muscular activity, and, hand in hand with this, there is toxæmia from over-metabolism plus foetal metabolism. It is thus not surprising that artificial respiration is fairly commonly called for, and nothing else is necessary, because the heart is stronger than normal, and it is respiration which undoubtedly fails first.

It is only because the subject is one of general interest at the present time that I do not reserve the matter for the collection of further material.

I am, Sir, yours faithfully,

DONALD J. MUNRO, B.S., M.B. Lond.,

Anæsthetist to the Metropolitan Ear, &c., Hospital.

Welbeck-street, W., Nov. 6th, 1909.

LUNG PUNCTURE.

To the Editor of THE LANCET.

SIR,—In the interesting annotation on this subject in your last issue it is stated that "the only conditions which suggest themselves as disadvantages are the possibility of infection of the healthy pleura or of the needle track in septic cases, and the occurrence of hæmorrhage from wounding a vessel or an aneurysm of the pulmonary artery." There is yet another danger to which attention has been called by Dr. George Oliver, Dr. A. E. Russell, and myself, and to which

references will be found in a paper by me in Vol. V. of the Reports of the Society for the Study of Disease in Children, 1905, p. 118. In these cases the patient, who is often in a cachectic condition, immediately after exploratory puncture of the pleura becomes cyanotic and dies. Brouardel has recorded a case in which this occurred when an attempt was made to aspirate a hydatid cyst of the lung. The needle in this case only entered the lung and did not touch the cyst. In a case recorded by Dr. George Carpenter death was due to suffocation by hæmorrhage, but in the others no hæmorrhage was proved to have occurred, and Dr. Russell has suggested that the phenomenon is a reflex inhibition of the cardiac and respiratory centres due to irritation of the afferent fibres of the vagus.

Though rare, this occurrence constitutes a real danger which ought not to be overlooked, especially as the class of case in which exploratory puncture of the lung would be likely to be done is exactly that class in which the percentage of fatal accidents might be expected to be highest.

I am, Sir, yours faithfully,

J. M. FORTESCUE-BRICKDALE, M.A., M.D. Oxon.

Clifton, Bristol, Nov. 9th, 1909.

To the Editor of THE LANCET.

SIR,—I was much interested in reading Dr. Horder's paper on "Lung Puncture, a New Application of Clinical Pathology" in your issue of Nov. 6th. As he stated he could find no reference to such an application of clinical pathology, may I draw his attention to some remarks by Dr. C. J. Macalister on "The Treatment of Chronic Pneumonia by Puncture" and Dr. Blair Bell's comments thereon at a meeting of the Liverpool Medical Institution, reported in the *British Medical Journal*, Nov. 3rd, 1900? In a subsequent issue I wrote to the effect that I had used that treatment in 1887 and 1889, as reported in a paper entitled "A New Method of Bleeding in Some Cases of Pulmonary Congestion," which was published in THE LANCET in 1891.

I am, Sir, yours faithfully,

Cambridge.

J. CHRISTIAN SIMPSON, M.D. Edin.

APPENDICITIS WITH HÆMATURIA.

To the Editor of THE LANCET.

SIR,—Recently I operated on a little boy, aged 3½ years, for acute appendicitis, with a large abscess. Two weeks after the operation he passed large quantities of blood from the bladder. On analysis there was nothing to be seen but blood and oxalate of lime crystals. The hæmorrhage continued off and on for five weeks. The urine now is perfectly normal and has been so for three weeks. Is this possibly a similar case to that recorded by Mr. P. H. V. Hammersley and reported in your annotation of Nov. 6th?

I am, Sir, yours faithfully,

Dorchester, Nov. 6th, 1909.

WM. BURROUGH COSENS.

THE INFLUENCE OF DIET ON THE THYROID GLAND.

To the Editor of THE LANCET.

SIR,—With your permission I should like to comment on a statement in Dr. Chalmers Watson's interesting letter in THE LANCET of last week. He says, "There are conditions—e.g., gout—in which the administration of a diet which contains little protein is of special value this favourable result is in an important degree attained through the influence of that diet on the thyroid gland."

While admitting without question that the form of diet mentioned may produce favourable results, I must confess—with the greatest respect to Dr. Chalmers Watson's admirable researches on the subject—to some scepticism as to the result being due to the influence of the diet on the thyroid gland. If this were so, then a diet consisting entirely, or almost entirely, of protein would, if I understand Dr. Watson rightly, have a converse effect upon the gland and so aggravate the condition, but this is not so. For instance, Dr. Luff has frequently drawn attention to the value of an exclusive meat diet in certain cases of gout, and my own experience has been that the majority of cases may be benefited by this regimen.

Probably Dr. Chalmers Watson may be able to explain the paradox. The only explanation I have to offer as to why a