quarter the death-rate in the city averaged 15·9 per 1000, whereas the mean rate during the same period did not exceed 10·6 in London and 12·8 in Edinburgh. The deaths of Dublin residents from all causes last week showed a decline of 17 from the number in the previous week, and included 12 which were referred to the principal epidemic diseases, against nine and 15 in the two preceding weeks. These 12 deaths were equal to an annual rate of 1·6 per 1000, the death-rate from the same epidemic diseases last week being equal to 0·9 in London and to 1·9 in Edinburgh. Of the 12 deaths from these epidemic diseases in Dublin last week, five resulted from diarrhoea, four from whooping-cough, and one each from measles, diphtheria, and "fever," but not one either from scarlet fever or small-pox. The fatal cases both of diarrhoea and whooping-cough corresponded with the numbers in the previous week. The 116 deaths at all ages included 25 of infants under one year of age, and 29 of persons aged upwards of 60 years. Five inquest cases and five deaths from violence were registered during the week; and 40, or 34·5 per cent., of the deaths occurred in public institutions. The causes of four, or 3·4 per cent., of the deaths registered in the city last week were not certified either by a registered medical practitioner or by a coroner; in London the causes of all but one of the 933 deaths registered were duly certified, and in Edinburgh all the causes of death were certified.

THE SERVICES.

ROYAL NAVY MEDICAL SERVICE.

IN accordance with the provisions of Her late Majesty's Order in Council of April 1st, 1881, Staff-Surgeon Edward Francis Power has been placed on the retired list (dated July 28th, 1909).

The following appointments are notified:—Fleet-Surgeons: F. J. A. Dalton to the *New Zealand*, on recommissioning; and G. Ley to the *Juno*, on recommissioning. Staff-Surgeons: W. G. Westcott to the *Excellent*, additional, for the *Revenge*; R. H. Mornemont to the *Eclipse*, on recommissioning; L. Lindop to the *New Zealand*; C. R. Sheward to the *Majestic*, on recommissioning; and J. Whelan to the *Adventure*, on recommissioning. Surgeon: S. N. Scott to be surgeon and agent for duty with civilian workmen at Turnchapel and Oreston injured while on duty.

ROYAL ARMY MEDICAL CORPS.

The undermentioned Lieutenants to be Captains (dated July 30th, 1909):—Charles M. Drew, Archibald A. Sutcliffe, Arthur G. Cummins, Hugh E. Gotelee, Archibald S. Littlejohns, William R. Galwey, Frank A. McCammon, George De la Cour, William Egan, Robert G. H. Tate, Alexander Dawson, Frank Forrest, Augustus S. Williams, Victor C. Honeybourne, Clive T. Edmunds, Valentine G. Johnson, Charles R. M. Morris, Richard E. U. Newman, Ernest W. M. Paine, Frederick D. G. Howell, William H. Gillatt, Patrick Sampson, Marcus G. Dill, John B. G. Mulligan, Edward M. O'Neill, Georgie B. Edwards, John W. L. Scott, William C. Smales, Arthur H. Bond, Thomas C. C. Leslie, Donald De C. O'Grady, Lawrence G. Gibson, Philip S. Stewart, and Timothy W. O. Sexton. The undermentioned Lieutenants are confirmed in that rank: Spencer G. Walker, James A. Clark, Harold H. Leeson, William G. Wright, Albert T. J. McCreery, Harry S. Ranken, John A. Manifold, Samuel S. Dykes, Robert C. Priest, Percy S. Tomlinson, Alexander D. Stirling, George P. Taylor, Robert C. Paris, Alfred W. Bevis, Ernest C. Lambkin, Oswald W. McSheehy, Maurice J. Williamson, Charles L. Franklin, Michael White, James J. D. Roche, James R. Hill, Herbert F. Joynt, Alexander S. M. Winder, James R. Yourell, Philip G. M. Elvery, John Beckton, and William B. Rennie.

INDIAN MEDICAL SERVICE.

Major F. D. Browne, has been appointed to the substantive medical charge of the 112th Infantry at Kohat. Captain A. S. M. Peebles has been appointed to the substantive medical charge of the 18th Lancers, vice Captain R. F. Baird. Lieutenant N. J. Simpson has been appointed to officiate in medical charge of the 2nd-9th Gurkha Rifles. Lieutenant J. B. Lapsley has been appointed to the 3rd

Brahmans, and also to hold medical charge of the Cantonment Hospital, Agra.

TERRITORIAL FORCE.

Royal Army Medical Corps.

1st South Western Mounted Brigade Field Ambulance: Major George R. Swinhoe resigns his commission (dated May 13th, 1909).

For attachment to Units other than Medical Units.—Arthur Herbert Norris to be Lieutenant (dated June 22nd, 1909).

THE TERRITORIAL CAMPS.

The *Times* military correspondent, referring to the field operations in the New Forest, says that the physique of the men is excellent. The Salisbury correspondent, in referring to the death of a trooper belonging to the City of London Yeomanry, states that the death was quite independent of camp life. "The sanitation of the camps is perfect, and the cooking of the food could not be better in a restaurant working upon a similar scale." He, however, points out that "an aggravation of heat trouble in many instances was the lack of drinking water. Many of the men had emptied their water-bottles long before the morning's operations were over, and no water was to be found at any distance from the camp." The selection of water-supplies for a camp was discussed in the second instalment of the articles on the Territorial Medical Service which appeared in the last issue of THE LANCET, p. 416, and stress was laid upon "quantity."

THE ROYAL VICTORIAN ORDER.

In connexion with the recent visit of the Emperor and Empress of Russia to this country the King has appointed Staff-Surgeon John Smirnoff and Staff-Surgeon Serge Lentovsky, honorary surgeons to His Imperial Majesty, to be Honorary Members of the Fourth Class of the Royal Victorian Order.

THE RED CROSS SOCIETY.

Sir Frederick Treves, referring at a meeting of the British Red Cross Society at Horsham on August 10th to the memorandum which the War Office was about to issue calling upon the Red Cross Society to take the place it ought to take in connexion with the defence of the country, said that the document would be published in the course of two or three days.

Correspondence.

"Audi alteram partem."

THE NATURE OF ANGINA PECTORIS.

To the Editor of THE LANCET.

SIR,—I trust you will allow me a little space, as I could not be at the Belfast meeting, to express my dissent from the views advocated by Sir Clifford Allbutt referred to in your abstract of his paper at pp. 336-7 of your last number in July.

Sir Clifford Allbutt's positive assertion I do not dispute. I quite agree that stretching of the supra-sigmoid portion of the diseased aorta will account for anginal symptoms in a certain number of cases—which are recognisable by fairly definite symptoms,—but whilst Sir Clifford Allbutt has earned the gratitude of clinicians by having so carefully pointed out this mechanism, he must not expect them to accept without challenge his view that aortic stretching is the only mechanism of anginal suffering. The mechanism of angina consists of one or other of at least three or four combinations, and the modes of death, too, are several. The terms angina major and angina minor adopted by Sir Clifford Allbutt imply degrees of the same thing, and as he seems to regard angina as a disease by itself and not a symptom or a syndrome, the terms appear to me to be only justifiable on the view that it also has only one pathology. In this view I cannot acquiesce.

Clinically, as one meets with cases, I would emphatically maintain that the radiating reflection of the pains to one or both arms, to the throat and shoulder, is by no means peculiar to cases of the graver kind of angina, although it may be more frequent in them. I have seen the most acute anginal suffering, with central agony and reflected pains, in

cases of purely vaso-motor angina, in cases in which there is no discoverable cardio-vascular disease, and in which time has demonstrated the absence of such.

I need scarcely say that I do not regard vaso-motor spasm as contributory to all forms of angina. But what is understood by pseudo-angina cannot be dismissed in the light-hearted manner of the professor, for the vaso-motor phenomena are in many cases of the very essence of the picture. In certain cases of organic heart disease with anginal attacks, any of which may be fatal, the acute anginal attack is started and maintained by the vaso-motor spasm and is relieved by the relief of that spasm. I have recorded in Sir Clifford Allbutt's "Cyclopædia of Medicine" a case of the most severe anginal suffering in aortic regurgitant disease I ever witnessed, in which the mechanism and the relief were obviously of this kind. I have witnessed other cases, not only of aortic regurgitant but of textural heart disease, in which the mechanism of the attack was the same, and I have seen others again—which alone I would regard as cases of pseudo-angina, although I do not like the term—in which there is angina of vaso-motor origin, which may be even severe, but in which the heart—the criterion in prognosis—is sound.

The "pretty fancy" of intermittent claudication, to which Sir Clifford Allbutt playfully alludes, seems to me to be based upon very sound observation and analogy by Burns, Brodie, and Charcot, and to have been supported by some recent very interesting observations by Dr. Parkes Weber on analogous conditions in the legs of excessive smokers. But I have already made this letter too long, and for a full explanation of the views which, from reading and experience, seem to me to be most tenable respecting this grave and interesting malady, I must refer the reader to my revised article in the coming volume of Sir Clifford Allbutt's "Cyclopædia of Medicine."

I am, Sir, yours faithfully,

London, August 9th, 1909.

R. DOUGLAS POWELL.

AN OPERATION FOR THE TOTAL EXCISION OF TONSILS.

To the Editor of THE LANCET.

SIR,—I was about to publish the results of 300 cases of tonsillectomy as practised by me since 1907, when I read the article by Mr. G. E. Waugh in THE LANCET of May 8th, 1909, and I hasten to publish my results and the method of my operation. There is practically very little difference in the technique adopted by Mr. Waugh and myself. Mr. Waugh does not say from what year he has been practising the method he advocates in the article referred to above. As regards the number of tonsillectomies performed by him up to the date of his publication I must admit that he has done three times as many as I have. But considering the population in London and the climatic conditions favourable for throat affections prevailing there, I do not consider that the number of cases operated on by me, mostly in Bangalore with a population of two lakhs or so, compares unfavourably.

The operation hitherto practised in Europe, so far as I am aware, has been the removal of enlarged tonsils by the guillotine. The cases suitable for guillotine are large tonsils causing difficulty in swallowing and breathing. Such cases were placed on the dental chair and under the influence of nitrous oxide gas the tonsils were guillotined within a minute or two. I have also seen such enlarged tonsils guillotined without any general or local anaesthesia, much to the suffering of the unfortunate patients. This was done at the London Hospital out-patient department by a young and energetic clinical assistant who is no longer there. I refrain from mentioning his name, but when his chief asked him if he would do an operation like that on his own son he gave up this practice, at any rate at the hospital.

Of the cases operated on by the guillotine I have seen several in which the whole tonsil was removed satisfactorily without a vestige of its structure being left behind, but the cases in which a part of the tonsil was left behind after this operation had been many. As these cases were mostly out-patients, I had not the opportunity of following their after-history, and therefore I am not in a position to say how far the tonsillectomy with the guillotine method has proved successful.

But since returning to India I have made a close study of my earlier cases operated on by the guillotine method, and to my great disappointment I found that the guillotine was not efficient in the great majority of my cases. In such cases the tonsils, though diseased and septic, giving rise to frequent tonsillitis and pharyngitis and otherwise interfering with the general health of the patients, were not large enough for the application of the guillotine. Besides, the Victoria Hospital, Bangalore, is not provided with a dental chair, and the facility for the administration of nitrous oxide gas is not very great in India. All operations which are not amenable to local anaesthesia or to spinal analgesia have to be performed under chloroform. My earlier cases operated on by the guillotine under chloroform in Colombo and in Bangalore failed to give me any satisfaction. I had to draw the tonsils out with a small pair of vulsellum forceps after adjusting the guillotine and in most cases only a small fragment was thus removed. It appeared to me that the game was not worth the candle. Sometimes the guillotines failed to work, being very blunt, and owing to the want of facility to get them sharpened they had to be sent to London to the manufacturers. This entailed long delay. Under these circumstances it occurred to me that a much simpler operation could be performed without the guillotine and with much better results. Since then I have performed about 300 cases in private as well as at the hospital after the method advocated by Mr. Waugh with slight modification, though I was completely unaware of his method until I read of it in THE LANCET.

The methods I adopt for the removal of tonsils vary with their size and with their association with adenoids or not. In the case of large tonsils in adults I still employ the guillotine under local anaesthesia. The tonsils are swabbed over with a solution of cocaine (10 per cent.) and injected through a hypodermic syringe with a syringe of either cocaine or novocaine with adrenalin at several points. The solution usually employed for injection is novocaine or cocaine grs. 10, adrenalin $\frac{3}{4}$ i, aqua dest. ad $\frac{3}{4}$ i. Within ten minutes the patient is ready and the tonsils are removed with the guillotine almost entire. Sometimes I use the vulsellum forceps to draw the tonsils out of their bed to engage in the grip of the guillotine. Where the tonsils are not much enlarged though diseased, instead of the guillotine I employ a pair of vulsellum forceps and a pair of curved blunt-pointed scissors for their removal; the mouth, of course, is kept open by a gag and the patient is seated on a chair. But in the case of children with diseased and enlarged tonsils who are also invariably subject to adenoids, local anaesthesia is not to be recommended for two reasons. In the first place adenoid growths cannot be successfully anaesthetised by such local measures as swabbing or spraying with solutions such as cocaine or novocaine and adrenalin without much discomfort to the patient, as the growth is situated in the naso-pharynx. Any attempt at such a procedure will lead to much retching and vomiting and to great waste of time when one has several cases to get through. Even if local anaesthesia is complete, the sight of instruments is quite enough in the case of children to produce such a fright as to prevent one from performing the operation. Therefore in the case of children I always employ general anaesthesia and chloroform is the anaesthetic used invariably in India and Ceylon. In operations on the throat and nose the anaesthetic is not pushed to the same extent as required for operations on other parts of the body. Anaesthesia is not necessarily complete. Having partially anaesthetised the patient, the head is allowed to hang well over the edge of the table. The mouth is opened by a gag and the tongue is drawn well forward by a stout silk thread passed through the tip of the tongue. The operator stands behind the head of the patient and draws the tonsil out with a pair of small vulsellum forceps. One disadvantage with the vulsellum is that the diseased tonsillar tissue is likely to give way when pulled out, as it is very friable. A conchotome appears to be preferable, but I have had no experience. I do not use any fine-toothed forceps to mark out the preliminary incision. I think it is quite unnecessary and can be easily left out. Besides, it is not absolutely necessary to define the capsule before the removal of the tonsil. If any pieces are left behind they can be felt by the finger and removed by the scissors or by the punch forceps. Pulling the tonsils by the vulsellum towards the middle