employed not only affect the professional reputation of my colleagues on the staff of the Battersea Provident Dispensary, and cast a slur upon a system of medical providence which, in the opinion of those best qualified to judge, ought to be extended and encouraged as the best means of checking that abuse of hospitals which, to an increasing degree in recent years, has so seriously curtailed the sphere of work open to the general practitioner.

I am, Sirs, yours faithfully,

LEONARD STRONG McMANUS.

Wandsworth Common, S.W., Dec. 17th, 1906.

* * Dr. McManus has misunderstood us.—ED. L.

THE ADMISSION OF WOMEN TO THE DIPLOMAS OF THE ROYAL COLLEGE OF SURGEONS OF ENGLAND.

To the Editors of THE LANCET.

SIRS,—As a lecturer in the London School of Medicine for Women I wish to thank Dr. A. S. Morton for having so clearly and definitely formulated his objections to the admission of women as Members of the Royal College of Surgeons of England and to reply, so far as I am able, to these objections. Several of them apply rather to the admission of women to the medical profession at all, and sound rather belated now that over 700 are actually on the Register, for after all a time must come when a *fait accompli* has, however reluctantly, to be recognised and accepted.

1 and 2. "Women are not admitted to the Church or to the Bar." It is not quite obvious why non-admission to some of the professions should debar from admission to others and it is only natural that medicine, being a more liberal profession and less bound down by tradition and precedent than the Church and the Bar notoriously are, should be the first to admit women to its ranks. Moreover, there are clearly very strong personal reasons why women have a right, if they so desire, to be attended medically by those of their own sex—reasons which apply far less, if at all, to the other two professions mentioned.

3. "They are not admitted to the Royal College of Physicians of London." I wonder if Dr. Morton were asked to state his objections to the admission of women to the Royal College of Physicians he would say "because they are not admitted to the Royal College of Surgeons," and so reason in a circle *ad infinitum*. Everyone, I suppose, will admit that under existing conditions the two Colleges must act together, and that the approval of one to the admission of women must be subject to that of the other, but as the College of Physicians has not discussed the question for over 11 years, and as the majority of Fellows against the admission of women was then only nine, it is clearly impossible now for anyone to say how a vote would go.

4. "They have been refused admission to the Membership of the Royal College of Surgeons of England already by a unanimous vote of the Members." Unfortunately I am not aware what vote is referred to, but at the meeting of Fellows and Members in 1895, at which the question was fully discussed, the voting was 44 for and 58 against! Moreover, what progress should we make in any department of life were we always to be bound by decisions of bygone years?

5. "The competition from even their own sex is already simply disgraceful in certain parts of London and elsewhere."

6. "There are already far too many portals open to women." I am quite unaware of the "disgraceful competition" to which Dr. Morton refers, but even if it be as severe as he suggests it must in due time be cured by the operation of natural economic laws, for, as in all occupations, if women find they cannot get enough work in the medical profession fewer will enter it. In the long run it is merely a matter of supply and demand. Certainly the opening of the London Colleges to women will not appreciably, if at all, increase the competition. It will only mean that a certain number of women will qualify at those Colleges who would otherwise go to the Scotch or Irish ones, to the Society of Apothecaries, or even to one of the Universities. All that women ask, now that after many years of struggling they have gained an established position in medicine, is that "complete equality of opportunity" which is the ideal nowadays in all departments of life and which is denied them so long as they are excluded by the bodies which grant qualifications to the majority of the medical students in this country. The qualifying bodies have, moreover, a duty to

the public in this matter; there is now a very definite demand for women doctors, not merely from individual women patients, but from a large and increasing number of public bodies in all parts of the country, which find that women can do certain kinds of medical work at least as well as men. Now the qualifying bodies exist essentially for the benefit of the public and it becomes, therefore, their duty to supply properly qualified women as well as men to meet this demand and any body which refuses to do this is really evading its full responsibilities.

7. "If there had been complete unanimity and combination within the ranks of our profession, which there is not, my own belief is that women would never have been allowed to enter the profession of medicine at all, much less that of surgery." I regret that I cannot follow the argument. To state that if medical men had been unanimously opposed to the entrance of women into the profession they would have been unable to enter it is, I imagine, a truism, but how this dream of a non-existent unanimity can be an argument against the admission of women to the examinations of the Royal College of Surgeons I am unable to conceive.

I am, Sirs, yours faithfully,

Cavendish-place, W., Dec. 18th, 1906.

J. WALTER CARR.

THE CLAIM THAT PROF. VON BEHRING HELD HOMŒOPATHIC DOCTRINES.

To the Editors of THE LANCET.

SIRS,—The *Homœopathic World* (published in London), under date Nov. 1st, 1906, publishes what claims to be an extract from Behring's pamphlet, translated from the German, under a headline in capitals: "Professor von Behring acknowledges Homœopathy." From the extract given I make the following extract:—

I am touching here upon a subject anathematised till very recently by medical pedantry; but if I am to present these problems in historical illumination, dogmatic imprecations must not deter me. They must no more deter me now than they did thirteen years ago, when I demonstrated before the Berlin Physiological Society the immunising action of my tetanus antitoxin in INFINITESIMAL DILUTION (capitals mine).

Of the truth or otherwise of this statement I am ignorant. That being so, may I through you ask those wiser than myself whether Professor von Behring did demonstrate before the Berlin Physiological Society 13 years ago "the immunising action of my tetanus antitoxin in infinitesimal dilution"?

I am, Sirs, yours faithfully,

DAVID ANDERSON-BERRY, M.D. Edin., F.R.S. Edin.

St. Leonards-on-Sea, Dec. 14th, 1906.

ON THE VALUE OF EXCISION OF THE OSSICLES AS A CONSERVATIVE OPERATION.

To the Editors of THE LANCET.

SIRS,—Although the radical mastoid operation is now firmly established among the most valuable operations in surgery it is considered by some surgeons to be performed in some instances unnecessarily. No doubt such an assertion is not altogether without foundation, and it is probable that a certain number of suppurating ears that are too hastily submitted to the radical operation might be cured by perseverance with local treatment. There is, however, a certain amount of justification in the extreme measure, for despite the great advances made by otology during the past quarter of a century, the public are by no means fully appreciative of the grave possibilities which may arise from a discharge from the ear. It is therefore sometimes wiser (especially in hospital practice) to perform the radical mastoid operation and so endeavour to free a patient from the danger he carries in his temporal bone, rather than to run the risk of his ceasing attendance before his discharge is completely cured. In speaking thus allusion is only intended to those conscientious surgeons who first endeavour to relieve their patients by recourse to non-operative or to the lesser operative measures, and not to those who fly at once to extremes in simple uncomplicated cases in order to publish long lists of operative statistics of more or less veracity.

There are, of course, numerous cases which, when they first present themselves, are beyond alleviation by simpler methods and which require something more drastic than mere removal of granulations, enlargement of perforations,

&c. It is these cases which furnish the largest number of radical mastoid operations. Many of them, however, could be saved the pain and tedium of the after-treatment attendant upon the complete post aural procedure by timely excision of the ossicles combined with a thorough removal of the outer attic wall. Possibly there is not an extremely large number of such cases, and possibly some of them may ultimately come to require the more serious operation, but they form a very appreciable item in one's practice and consequently claim careful consideration. The satisfaction of one such case is much greater than that proceeding from three successful mastoid operations.

The chief causes which prevent the healing of a suppurating middle ear are deficient drainage and bone disease. The former may be due to accumulations of epithelial and purulent debris or to the presence of granulations. Granulations (putting aside those due to malignant disease) are the result of neglect or caries. It will often be found that in neglected cases of discharge the removal of granulations and the establishment of antiseptics will speedily be successful. When granulations recur after removal and antiseptic treatment caries may be suspected. Caries when occurring in the middle ear generally affects the ossicles, and of these it is the malleus and incus that suffer, the latter more frequently than the former. The reason for this lies in the arrangement of its blood-supply which, owing to the position of the bone slung between its fellows, is dependent upon the muco-periosteum covering it. The most common sites of ossicular caries are the head of the malleus, the body and long (articular) process of the incus. When occurring in the head of the malleus, or that part of the body of the incus which is adjacent to its articulation with the malleus, caries is usually associated with a perforation in Shrapnell's membrane and is often accompanied by caries of the bony outer attic wall. The anatomical arrangement of the attic does not lend itself to efficient drainage in suppuration in that region, and consequently caries is prone to occur there. When the caries occurs in the long process of the incus it is usually accompanied by a perforation in the posterior superior segment of the membrana tensa, and this perforation is frequently occupied by a small granulation which recurs after removal in spite of careful antiseptic local treatment. Such cases often give very satisfactory results on the removal of the membrane and the two large ossicles. The proximity of the head of the malleus and body of the incus to the aditus ad antrum renders the continuance of caries of these bones very liable to lead to implication of the antrum and caries about the tympanic opening of the aditus. Sooner or later, therefore, mastoid trouble will necessitate the radical mastoid operation, a contingency which it is manifestly the duty of the otologist to prevent.

Another aspect of the matter, and a very important one from the point of view of the patient, lies in the preservation of the hearing. Caries of the ossicles of any extent practically means a break in the ossicular chain, the carious bone acting as a foreign body—a broken link. The vibrations of the membrane and ossicles are thus seriously interfered with and considerable impairment of the hearing function ensues. The removal of the damaged vibratory chain, if skilfully performed, results in the freeing of the stapes so that the sound waves strike directly upon it with considerable restoration of the hearing function. This restoration is further augmented if, either at the time of the operation or, better, later, the tendon of the stapedius muscle is severed. The performance of ossiculectomy therefore has a twofold aim; by the removal of the diseased ossicles and the bony outer attic wall drainage is effectively obtained and suppuration arrested, and by the excision of the damaged chain of structures the hearing function is augmented. The operation need not be described in detail here; the essentials must, however, be given. They are—complete removal of the membrane or its remains, removal of both malleus and incus, thorough removal of the outer attic wall and of any small granulations that may be present, and lastly, careful curetting of the sulcus tympanicus in which the membrana tympani is set. The removal of the bony outer attic wall is accomplished either by the burr or by cutting forceps. Although several burrs have been designed for the purpose I know of none that adequately do the work. I prefer, personally, to use the cutting forceps of Krause, which act on the sliding chisel principle. This instrument, properly and carefully used, will remove the whole attic wall efficiently.

The chief difficulty in the operation of ossiculectomy lies

in the hæmorrhage which obstructs the view of the operator. Before the introduction of adrenalin I combated this by packing repeatedly with small pledgets of sterilised wool, but the use of adrenalin (1 in 1000) has greatly facilitated the operation. It is best used by instilling the warm solution into the ear and retaining it for 20 minutes before the operation, and using small wool pledgets soaked in adrenalin from time to time during its performance. It is essential to an efficient operation that the surgeon should be able to see what he is doing as clearly as possible. A considerable experience has convinced me that ossiculectomy is a valuable conservative method, and I believe that if it were more frequently performed and earlier resorted to an appreciable percentage of cases would be saved from the radical operation.—I am, Sirs, yours faithfully,

MACLEOD YEARSLEY, F.R.C.S. Eng.,

Senior Surgeon to the Royal Ear Hospital

Upper Wimpole-street, W., Dec. 14th, 1906.

DELAYED CHLOROFORM POISONING AND ACETONURIA.

To the Editors of THE LANCET.

SIRS,—Dr. Leonard G. Guthrie, in his letter in *THE LANCET* of Dec. 1st on Delayed Chloroform Poisoning, blames a pre-existent fatty condition of the liver as the cause of death and points out several sources whence it may be derived. Amongst these sources he mentions sepsis, without, however, specifying acute or chronic. The fact is well recognised pathologically that prolonged suppuration and chronic tuberculous disease produce more fatty degeneration of the liver than acute suppurative conditions lasting a few days; consequently if Dr. Guthrie's theory be correct we should expect to find cases of delayed chloroform poisoning following the former conditions more frequently than the latter, but this is not the case.

In an article on Post-anæsthetic Acetonuria¹ I pointed out that chloroform could be administered to patients with chronic acetonuria (frequently present in chronic tuberculosis and constantly present in chronic suppuration) with no more danger than to apparently healthy patients, provided renal and alimentary tracts were eliminating actively; also that it was in acute suppurative conditions that chloroform was to be feared—that is to say, in the presence of acute acetonuria. The records of the Sick Children's Hospital, Edinburgh, for the last four years show that 83 per cent. of deaths attributed to the after-effects of chloroform occurred in cases of acute sepsis.

Surgeons attached to children's hospitals where chloroform is the anæsthetic employed must have noticed cases where persistent post-operative vomiting occurred and where the odour of acetone was well marked—in fact, mild cases of delayed chloroform poisoning, which could be arranged in definite series from those exhibiting the mildest symptoms up to those that died. I have shown elsewhere that these cases have a definite relation to delayed acetone excretion and delayed chloroform poisoning, but I am anxious to know whether I am right in gathering from Dr. Guthrie's letter that he agrees with Shenk's observation and that the variability of the after-effects of chloroform depends on the degree of fatty liver present at the time, because it follows that in such a series of delayed chloroform poisoning as I suggest above each patient must be suffering from a fatty liver corresponding directly in degree with the clinical manifestations. A point of greater interest than the fatty liver, and one which does not receive sufficient attention, is the fatty degeneration seen elsewhere in the body. Microscopic examination of the heart, blood-vessels, muscles, and kidneys reveals intense fatty degeneration; especially is this the case in the kidneys, where it is if anything more advanced than in the liver. How is this produced? Is there also a pre-existent fatty condition of the kidney and other organs of the body, or is the renal change wholly due to the action of the anæsthetic? I am in favour of the latter view, but the condition requires further practical and experimental investigation before it can be ascribed to antecedent sepsis or cod-liver oil. The experiments carried out by Stiles and Macdonald proved that chloroform was the direct agent causing the fatty change and there is no reason to suppose that their rabbits suffered from starvation, rickets, or any

¹ Brit. Med. Jour., May 19th, 1906.