George Albert Bott to be Surgeon-Lieutenant (dated Oct. 30th, 1905).

ROYAL ARMY MEDICAL CORPS (VOLUNTEERS).

Eastern Command: Woolwich Companies: Captain E. T. Inkson, V.C., R.A.M.C., to be Adjutant, vice Major T. P. Jones, R.A.M.C., whose tenure of that appointment has expired (dated Oct. 24th, 1905).

THE SOUTH AFRICAN MEDAL FOR CIVIL SURGEONS.

Medals or clasps for the undermentioned gentlemen who served as civil surgeons in South Africa, and whose addresses are unknown, await issue at the War Office. Applications for these should be made to the Secretary, War Office, 63, Victoria-street, London, S.W.

Albertyn, J.
Aldred, A.
Alexander, K. B.
Allport, P.
Bayley, P.
Bishop, W. O.
Booth, R. R.
Calder, W. J.
Clark, M.
Clarke, G.
Clarke, W.
Crean, G. G.
Dunlop, C. D.
Elmes, H.
Fehrson, J. McCall.
Fenton, J.
Froud, W.
Fryer, R. C.
Galbraith, H. T.
Gillanders, I. L. G.
Gilbert, R. G.
Gillespie, J.
Goule, H.
Hangen, T. M.
Hart-Jackson, W.
Harvey, H.
Harwarden, G. F.
Hibberden, G. A.
Horne, H. R.
Hudson, W.
Hunter, C. W.
Hunter, F. A.
Johnston, T.
Jones, G. B.
Kerr-Bell, T. J. H.
Klein, M.

Langdon, D. C.
Leslie, G. W.
Loeser, H. A.
Lundie, G. F.
Mentell, H. T.
Mate, W. F.
McDougall, A. H.
Milne, J. E.
Nangle, J.
Nixon, E. A.
O'Connor, C. E.
Ogle, A.
O'Farrell, F. J.
Parkinson, W. G.
Peters, C. A.
Phillips, N. C.
Ralston, F. C.
Riordan, H.
Robertson, W. R.
Rowland, F.
Short, W. R.
Simon, W.
Simon, E.
Smith, W. H.
Somerville, W.
Stephen, L. N. G.
Stow, F. E.
Thomas, F. C. M.
Thomas, H. S.
Tucker, J. A.
Twigg, E.
Visser, J.
Warren, T.
Wellford, F.
Wilkinson, R. H.
Woodhouse, W. B.

ENTERIC FEVER IN THE ARMY.

Without going further into this subject we may say that Dr. H. E. Leigh Canney read a paper on Oct. 8th, at the Royal United Service Institution, on "The Toleration of Enteric Fever by the Army." Major-General Sir Thomas Fraser presided. In the course of the lecture Dr. Canney said the lack of progress towards sanitary organisation in the Army since 1901 was to be deplored. In the recent war the Japanese had given a demonstration of striking success by carrying out in its main essentials the plan which he had advocated. The Japanese have no doubt enjoyed a singular immunity in Manchuria and it would be interesting to know if the officers of their medical service attribute the freedom from enteric fever chiefly to the sterilisation of water. Lieutenant-Colonel Climo took part in the discussion which followed. He considered that a sanitary service should be trained by the Royal Army Medical Corps and should be a branch of the Army Medical Service.

INOCULATION AGAINST ENTERIC FEVER IN THE ARMY.

It has been decided that whilst it is most desirable that troops should be inoculated against enteric fever before embarkation for foreign service, such inoculation may, under the present system, be safely carried out on board ship, provided that the first "vaccination" be done at least 14 days, and the second at least four days, before the vessel is due at the port of disembarkation.

VOLUNTEER MEDICAL TEST.

The *Standard* of Nov. 13th states that the War Office have called for a return of all recruits of volunteer corps who have been medically examined since July 11th. In addition they ask for recommendations from general officers commanding as to a reduction of the capitation grant in corps where volunteers are returned as efficient but otherwise medically unfit. From the results of the medical inspections already made it would appear that the "unfits," at the most, only number about 6 per cent. and the majority of these are either "under chest measurement" or "bad teeth," and a less number "disordered action of the heart."

NEW BARRACK BUILDINGS.

The *Broad Arrow* states that projects for the new barrack buildings at various centres in the United Kingdom are well

in hand, yet although the new barracks at Tidworth are nearing completion, and ere long there will be a complete infantry brigade and a cavalry regiment quartered there, neither church nor hospital is yet to be seen in the whole of those splendid buildings.

Lieutenant-Colonel H. H. R. Charles, I.M.S., has presented to the Royal College of Surgeons of England a large collection of skulls, skeletons, and other specimens, representative of many of the castes and tribes of India and other parts of Asia.

Correspondence.

"Audi alteram partem."

THE OPERATION FOR CLEFT PALATE.

To the Editors of THE LANCET.

SIRS,—The writer of the leading article on Some Considerations on the Operation for Cleft Palate in THE LANCET of Nov. 4th sums up those considerations in favour of the flap operation performed at an early age. But he still has some misgivings as to the general advisability of that method of treatment on account of "the danger of sepsis, the sloughing of the flaps, and the impairment of the general health of the child." He adds further, "that at a very early age the tissues are more lacerable than later," and also "that older children are more easily kept quiet after the operation."

As I have recently had the opportunity of observing the progress of events in more than 300 cases upon which the flap operation has been performed irrespectively of age, the conclusions to be drawn from even such small data may be of some guidance. The frequency of the occurrence of sepsis and the sloughing of the flaps is proportional to the length of time that has elapsed prior to the operation since the teeth have erupted. In other words, the longer the time since the teeth have been cut the greater is the liability to the presence of dental caries, with the consequent fouling of the oral cavity, and therefore the liability to sepsis and sloughing after an operation is greatly increased. Nor does the careful preparation of such a mouth before operation yield results sufficiently encouraging to make it a field of operation in any way preferable to, or even as desirable as, one in which the teeth have not yet come through the gums. With regard to the general health of the child, the experience of these few cases has shown that it tends to improve markedly after the operation and that those disorders of malnutrition so frequently associated with this type of deformity completely disappear when the defect in the palate has been remedied so that the mother can feed the child properly. This is of the utmost importance and is an urgent reason for the performance of the early operation, since every year a certain number of infants die who are unable to obtain operative treatment soon enough. Priority of admission to hospital is accorded to those in whom wasting has already begun, since experience has shown that the closure of the cleft in the palate is one of the surest ways of arresting the wasting process. Careful instruction of the parent about diet is of little avail until the operation has been done. If the tissues are "more lacerable," as is stated, then the vigour of the operator must be proportionately diminished, and this is not difficult.

Lastly, the consensus of opinion amongst the sisters of the wards in which these cases have been is that a child of a few months old is far more tractable and more easily nursed after an operation such as this than one of a few years old. The brunt of the after-treatment of these cases falls upon the sisters and therefore their evidence on this point is of great value.

I am, Sirs, yours faithfully,

GEORGE E. WAUGH,

late Resident Medical Superintendent, Hospital for Sick Children, Great Ormond-street, W.C.

THE MEDICAL MAN, THE CORONER, AND THE PATHOLOGIST.

To the Editors of THE LANCET.

SIRS,—The case alluded to in your annotation in THE LANCET of Nov. 11th, p. 1420, is so important to the profession and to the public that I trust you

will allow me space to notice a point not alluded to by the coroner, the pathologist, and yourselves. The words of Subsection 2 of Section 20 of the Births and Deaths Registration Act, 1874, are: "In 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 to some person required by this Act to give information concerning the death a certificate stating to the best of his knowledge and belief the cause of death," &c. Again, on the inside of the cover of the book of forms of certificates furnished by the Registrar-General is the following notice: "N.B.—No medical practitioner is justified in giving a certificate unless he was personally in attendance upon the deceased during the last illness."

Does the attendance of the medical man upon the deceased John Waple come within the meaning of the subsection of the Act and the Registrar-General's note? As a surgeon of 40 years' practical experience, I maintain that it does not, and to imply that it does is a gross abuse of language. What are the facts? The medical man was called and saw the deceased *in articulo mortis* as verified by the fact that death occurred 20 minutes later. He was thus debarred from giving a certificate and ought not to have been asked to do so. As neither he nor any other medical man was called to see the deceased till shortly before his death the question arises whether the son was to blame. This was clearly a matter for the coroner to decide. An inquest was not forced by the medical man, who acted in strict accordance with the law, the words I have quoted showing not only what a medical practitioner ought to do when he has attended a person during his last illness but what he must not do if he has not. It was the culpably loose giving of death certificates which led to the appointment of the Select Committee of the House of Commons of which Sir Walter Foster was chairman. That committee condemned most strongly the loose manner in which deaths were certified and registered. It also recommended that every death should be certified by a registered medical practitioner or by a coroner after inquest.

I am, Sirs, yours faithfully,

Liverpool, Nov. 12th, 1905.

FRED. W. LOWNDES.

EMPHYSEMA OCCURRING DURING PARTURITION.

To the Editors of THE LANCET.

SIRS,—Mr. F. H. Sprague, in a courteous criticism of my former letter to you, quotes passages from Osler, Rotch, and Erichsen in support of the view that it is possible for air escaping into the cellular tissue of the lung to pass through the root of the lung into the mediastinal connective tissue and thence to the subcutaneous tissue of the body. This is certainly an accepted theory and many other references in text-books could be cited in corroboration. But I do not think that this happens. In mediastinal emphysema with external wound the air is sucked in from the outside. Mediastinal emphysema without external wound is probably associated with pleural adhesion and a sinus connecting the lung and mediastinum, and in such a case a sinus burrowing underneath the skin would make subcutaneous emphysema possible. A gas-producing micro-organism might explain some other cases of mediastinal emphysema.

But this is away from my original contention that in a healthy subject subcutaneous emphysema could not be caused by rupture of air vesicles. In reply to Mr. Sprague's query regarding the possibility of extensive emphysema resulting from a lesion of the mucous membrane of the upper air passages I may say that I had no difficulty in pumping air through a small opening in the buccal mucous membrane and infiltrating the subcutaneous tissue of the same side of the face, neck, and chest as well as the submucous tissue of the mouth and throat. The lesion may be quite insignificant and escape detection when not specially looked for. I think that this form of emphysema will be found to occur in patients who make the expiratory effort with closed lips and open glottis, burying, as they are often told to do by the nurse, their faces in the pillows while straining.

I am, Sirs, yours faithfully,

Glasgow, Nov. 13th, 1905.

DAVID WATSON.

To the Editors of THE LANCET.

SIRS,—With reference to the correspondence of Dr. D. Watson and Mr. F. H. Sprague *re* surgical emphysema

occurring during labour, allow me to quote (a) a paragraph from an article in the *Stethoscope* on the subject by Dr. William Smith of Brabourne, Kent, and (b) my letter commenting on the case published in the same journal (December, 1904). Dr. Smith says: "The patient was a primipara, aged 27 years, healthy but decidedly thin. The labour progressed slowly until the head came in contact with the perineum. The pains then became strong and lasted much longer. At this stage the patient's eyelids suddenly became swollen and she complained that she could not see out of her left eye. The swelling rapidly spread over the whole face, the front and sides of the neck, and over the front of the chest as low as the third rib. Very marked crackling could be felt over this area. The emphysema by the fourth day had completely disappeared."

My comment was as follows: "I think, however, that the course taken by the emphysema gives a clue to the seat of the lesion. I have seen three cases of fracture of the lacrymal bone, in all of which surgical emphysema occurred, beginning by filling out the eyelids on the side involved and spreading with every attempt to blow the nose, until in one case the malar region and cheek were also involved. In the other two cases the patients were instructed not to forcibly blow the nose and the emphysema did not spread. Now, when we remember how exceedingly thin the lacrymal bone may be and how easily broken (in one of my cases the patient had fallen and struck her nose but not sufficiently hard to produce an ordinary black eye), it seems likely that the straining in the case mentioned by Dr. Smith had caused a slight laceration of the bone and of the mucosa covering it, and continued efforts had forced air, first into the eyelids, and from there over the extensive regions he details."

I am, Sirs, yours faithfully,

Bradford, Nov. 10th, 1905.

JAMES PHILLIPS.

THE PROPOSED UNION OF LONDON MEDICAL SOCIETIES.

To the Editors of THE LANCET.

SIRS,—Will you allow me to emphasise the truth of the statement made by Dr. T. G. Lyon in *THE LANCET* of Nov. 11th? Unless the new medical society or academy which is proposed is intended solely for the consultants who live round Cavendish-square it is most desirable that there should be a centre elsewhere and the City is clearly the most easily accessible centre. I hope this will be considered.

I am, Sirs, yours faithfully,

CHARLES F. HARFORD,

Physician to the Church Missionary Society.

Salisbury-square, E.C., Nov. 13th, 1905.

THE RATIONAL TREATMENT OF RUNNING EARS.

To the Editors of THE LANCET.

SIRS,—May I ask you to let me bring before your readers some of the evidence available as to the value of otcotomy in the treatment of obstinate otorrhœa? As one or two specialists make a habit of advising against operation and thereby prevent sundry sufferers from obtaining a cure it is almost obligatory to put before the profession some of the cases which establish my position with respect to the treatment of this dangerous malady. But before doing so I should say that in three recent cases, all of whom had serious secondary symptoms, my patients were influenced by the specialists I refer to not to follow my advice, being told that *no operation* was necessary. It is indeed probable that the majority of aural surgeons and general surgeons would agree with me in insisting on the advisability of relieving these people by operation of some sort, although the special advantages of otcotomy be not as yet generally acknowledged. It is almost certain that the cases I refer to will not recover without operation. My experience entitles me to say they would almost certainly recover after otcotomy. That this treatment succeeds when other methods fail is shown by the following cases, some of which had been unsuccessfully treated by the chief opponent of otcotomy.

CASE 1.—A patient, aged 33 years. Offensive discharge from each ear. Had attended Birmingham Ear and Throat Hospital for several months. Treatment, otcotomy and irrigation. Ears became sweet; discharge ceased. Hearing much improved.

CASE 2.—A patient, aged 35 years. Otorrhœa for many