VOLUNTEER CORPS.

Royal Garrison Artillery (Volunteers): 8th Lancashire: Surgeon-Lieutenant-Colonel A. R. Hopper resigns his commission and is granted the honorary rank of Surgeon-Colonel, with permission to wear the prescribed uniform (dated March 29th, 1905).

Rifle: 2nd (Hertfordshire) Volunteer Battalion the Bedfordshire Regiment: Surgeon-Lieutenant J. B. McBride to be Surgeon-Captain (dated March 25th, 1905). 1st Volunteer Battalion the Royal Welsh Fusiliers: Surgeon-Lieutenant W. F. Byford resigns his commission (dated March 29th, 1905). 4th Middlesex (West London): Surgeon-Lieutenant-Colonel A. Clark (Brigade-Surgeon-Lieutenant-Colonel, Senior Medical Officer, 3rd London Volunteer Infantry Brigade), is granted the honorary rank of Surgeon-Colonel (dated March 14th, 1905). 2nd Volunteer Battalion the Sherwood Foresters (Nottinghamshire and Derbyshire Regiment): Surgeon-Captain W. Moxon resigns his commission and is granted the honorary rank of Surgeon-Major, with permission to wear the prescribed uniform (dated March 29th, 1905). Surgeon-Lieutenant V. J. Greenhough to be Surgeon-Captain (dated March 29th, 1905). 2nd (Westmoreland) Volunteer Battalion the Border Regiment: Surgeon-Major G. W. Brumwell (Brigade-Surgeon-Lieutenant-Colonel, Senior Medical Officer, Lancaster and Border Volunteer Infantry Brigade), to be Surgeon-Lieutenant-Colonel (dated March 25th, 1905). Surgeon-Lieutenant-Colonel G. W. Brumwell (Brigade-Surgeon-Lieutenant-Colonel, Senior Medical Officer, Lancaster and Border Volunteer Infantry Brigade), is granted the honorary rank of Surgeon-Colonel (dated March 25th, 1905). 1st Volunteer Battalion the Northamptonshire Regiment: Charles Humphrey Sedgwick to be Surgeon-Lieutenant (dated March 25th, 1905). 2nd Volunteer Battalion the Queen's Own (Royal West Kent Regiment): Surgeon-Major H. W. Roberts to be Surgeon-Lieutenant-Colonel (dated March 25th, 1905).

DEATHS IN THE SERVICES.

Lieutenant-Colonel Henry William Alexander Mackinnon, D.S.O., A.M.S. (retired), on March 24th, at Weybridge, Surrey, aged 63 years. He joined the Army Medical Service in 1865, became surgeon in 1873, surgeon-major in 1877, brigade-surgeon in 1885, deputy-surgeon-general in 1892, and retired in 1895. He served in the Egyptian war of 1882 and was present at the battle of Tel-el-Kebir, when he was slightly wounded (medal with clasp and the Khedive's star). In the Burmese expedition in 1885-86 he served with the Upper Burma Field Force under Sir George White and was for part of the time principal medical officer (mentioned in despatches, D.S.O., and medal with clasp).

Miss Jane Catherine Shaw Stewart, eldest daughter of Sir Michael Shaw Stewart, sixth Baronet, who died on March 14th at Slinfold, Sussex, at the age of 83 years, was associated with Miss Florence Nightingale in active nursing work in the military hospitals in the Crimea and at the close of the war she was appointed matron-superintendent of Netley Hospital, in which capacity she served till 1868. Miss Shaw Stewart was for some time second Superintendent-General of Her late Majesty's Nurses.

THE ARMY ESTIMATES.

The attention of our readers connected with, or interested in, Army Medical Service matters will very naturally have been drawn to Mr. Arnold-Forster's recent statement on the Army Estimates in the House of Commons. The War Minister was as confident as is his wont as to the importance of his proposals for the reorganisation and reform of the army as a whole and as to the success which would attend and follow upon their adoption. Be this as it may, and it seems clear that he failed to carry conviction to the House on the point, we can only say that uncommonly little can be gathered from what he had to state about the medical services. He repeated his previous announcements that substantial additions had been made to the medical staff, without, however, particularising them, and that a commencement had been made in the construction of the great Military Medical College. It is needless to say that a great deal more than this will have to be done if we are ever to have a medical and sanitary organisation at all adapted to the requirements of modern warfare.

THE WAR IN THE FAR EAST.

The lull at the seat of war still continues but such news as there is from Manchuria does not seem to be of a favourable nature as far as the Russians are concerned. Advices from Harbin state that the Japanese continue slowly to advance. The Russian retreat is described as being still toilsome and dangerous. The commissariat and medical services are completely disorganised. Men who were sick or exhausted from fatigue have had to be abandoned for want of proper transport. Although everything depends now upon the possibility of the success of the Russians at sea, for such an event might alter the whole complexion of the war, little or nothing is really known about the position of the Russian or Japanese fleets.

The Army Council has decided to discontinue the experiment, commenced last November, of providing recruits with artificial teeth and the instructions contained in the War Office letter of the 5th of that month have therefore been cancelled as regards both recruits and trained soldiers.

Correspondence.

"Audi alteram partem."

PROPOSED CONFEDERATION OF THE LONDON MEDICAL SOCIETIES.

To the Editors of THE LANCET.

SIRS,—Attempts have been made from time to time to unite the various London societies representing medical science and practice more closely, so as to form a united Royal Society or Academy of Medicine, in which the existing societies would retain their individuality as sections of the united body.

The present appears a favourable opportunity for again endeavouring to effect this unification and I have gathered from many holding influential positions in the different societies that they would not object to such a confederation being again considered. I have therefore consented to preside at a meeting to be held at the Royal College of Physicians on Monday, April 10th, at 5 P.M., to consider whether it is desirable that the central medical societies of London should unite to form one Royal Society or Academy of Medicine; and, if such union is thought desirable, to take preliminary steps to bring about such federation.

The meeting is open to Fellows and members of all medical societies and it is hoped that there may be a large and representative meeting, as it is desired to gather the opinion of the profession and especially of the junior members of it, as well as that of those who are officially associated with the several societies.

I am, Sirs, yours faithfully,

March 28th, 1905.

W. S. CHURCH.

THE TREATMENT OF EMPYEMA.

To the Editors of THE LANCET.

SIRS,—In THE LANCET of March 25th, p. 789, Dr. Samuel West, who speaks with the authority derived from great experience, lays down the law very positively about the surgical treatment of empyema and makes statements with which I, and I expect other surgeons, cannot agree. They do not, in my opinion, tend to improve the treatment of this disease. He says: "In a case where the choice is open the best place to select is just in front of the post-axillary border and on the transverse level of the nipple. It need not be farther down, because directly the pleura is evacuated the diaphragm rises and soon reaches that level. It need not be farther back, because the patient will not lie upon the tube and with the incision in this place he can lie comfortably on the back. If the incision be farther back the patient will turn over on to the opposite side and the drainage will be no better than with the incision in the place I recommend." The directions for the incision are not very accurate. The position of the nipple varies in different individuals and is elevated about one inch by raising the arm. If Dr. West's instructions are followed the opening will sometimes be made in the fourth interspace. But in any case it is, in my opinion, too high and too far forward. It never allows

proper drainage when the patient is recumbent, unless he lies on the affected side, and often affords imperfect drainage when he is in the erect posture, because, as a matter of fact, the diaphragm seldom comes into contact with the ribs at so high a level in the side. I have often had to make a posterior incision in cases thus operated on. I believe this position was originally chosen (or rather the sixth or seventh interspace in the axilla) because it was the most easy to get at. I think the best place for the opening is through the ninth rib in the scapular line: (1) because it is the most dependent place both when the patient is recumbent and when he is erect; (2) because I do not find that patients object to lying on the back after its performance; and (3) because it seems to me to give by far the best results.

Resection of a piece of rib is not recommended *only* because it provides good drainage, though this is an important object. It allows a free exploration of the cavity and the easy removal of masses of lymph. It also generally prevents the painful gripping of the tube as contraction takes place. No one says that it is always essential, but really Dr. West and some others make too much of this trivial addition to the opening of the chest. It adds practically nothing to the gravity of the operation.

When I hear about shortening the tube in a case of empyema and the tube "preventing the discharge" I feel convinced that too long a tube was employed to begin with. An ideal tube, in my opinion, should be only just long enough not to slip out of the pleural cavity and have one lateral hole only, which should be immediately within the chest wall. It is only in exceptional cases with intricate diverticula that cannot be freely opened up with the finger that long tubes are required. Shortening drainage-tubes in these cases I look upon as a secondary vice induced by the primary one of using too long a one at first. The plan of introducing many inches of drainage-tube is, or ought to be, obsolete. Dr. West talks of two small tubes being as efficacious as one large one; may I recommend him to try two large ones and see if they are not more efficacious still?

Of course, Dr. West knows of Dr. W. Cayley's paper on "Convulsions and Death following the Washing Out of the Pleural Cavity in Empyema" in vol. x. of the Transactions of the Clinical Society. I have seen a case of sudden death in such circumstances *meis propriis oculis*; it was not a pleasant sight. Still, the experience of "many hundred cases" without an accident is large. It makes me hesitate to enter the lists, as it must represent an experience much greater than mine, for I suppose Dr. West will agree that in most cases irrigation is unnecessary. And if unnecessary why add this complication to the dressing if there be even the slightest risk involved in it? After all what a small part of a general empyema can be satisfactorily reached by irrigation unless the cavity be actually filled with the fluid employed for this purpose!

He says: "Estlander's operation is very fatal." This is not my experience if the surgeon does not attempt to do the whole thing at one sitting. That is where the danger comes in. If it be divided into two or three stages, separated by considerable intervals of time, the danger is slight and probably less will have to be done in the end.

Of course, Dr. West will not expect me to agree with him that "the after-treatment of an empyema is better left to the physician than the surgeon," especially if this involves daily irrigation, rapid shortening of the drainage-tube, and probing the cavity every few days.

I am, Sirs, yours faithfully,

March 27th, 1905.

RICKMAN J. GODLEE.

SHOCK AND COLLAPSE.

To the Editors of THE LANCET.

SIRS,—Mr. J. P. Lockhart Mummery in his second lecture on Surgical Shock and Collapse¹ suggests the treatment of shock by compressed air wards. In his first lecture he states that "the blood pressure is maintained within a few degrees of the normal range even under extreme variations in outside pressure."² It is difficult, therefore, to see in what way the proposed compressed air treatment is to take effect. Mr. Mummery does not draw any distinction between the *absolute* and the *relative* blood pressure. It is the relative blood pressure—that is, the blood pressure compared with the external atmospheric pressure—which is the important factor

in the pathology of shock and it is this relative pressure that is recorded in all forms of recording instruments. Alterations in the external atmospheric pressure produce corresponding alterations in the absolute blood pressure but do not materially alter the relative pressure and would not, therefore, be of much value in the treatment of shock. On the other hand, compression of the abdomen—as by the pneumatic suit described by Mr. Mummery in which the head and thorax are not compressed—will raise the relative blood pressure by driving the blood from the dilated splanchnic vessels into the more important areas of the head and chest. It is this form of treatment, therefore, which is of value in cases of shock rather than treatment in compressed air wards.—I am, Sirs, yours faithfully,

CHARLES POWELL WHITE.

St. Thomas's Hospital, S.E., March 27th, 1905.

ISOLATION HOSPITALS.

To the Editors of THE LANCET.

SIRS,—May I be allowed to reply to Mr. E. D. Marriott's letter of Dec. 24th, 1904, published in THE LANCET of Jan. 7th, 1905, in order to remove a slight misunderstanding on his part? The priority that I claimed was that of utterance of my opinions in *your columns*, as will be made evident, I think, by collating my letter (published in your issue of Dec. 17th, 1904, p. 1737) with your leading article of August 27th, 1904, p. 624, on which my letter commented; and I consider that my claim is justified. Your phrase implied that Mr. Marriott was the first person to express disapprobation of isolation hospitals in THE LANCET and I ventured to correct this in my own behalf. Further, if Mr. Marriott will look back to my original letter in THE LANCET of June 13th, 1896, he will see that I had *not* "contented myself with a letter in THE LANCET" but had been for some time contesting with the local board of guardians (St. George's, Hanover-square) and its medical officer of health (the late Dr. W. H. Corfield) and his sanitary inspector the right of these officials to remove scarlet fever patients to the fever hospitals indiscriminately, even contrarily to the wish of the relatives and of the medical man in attendance. I appealed to the Local Government Board and obtained a decision in my favour. The purport of my letter was to publish an account of this dispute with the result; and I also stated my experience of the effects of the infectious diseases hospitals of the Metropolitan Asylums Board. I am glad to hear that Mr. Marriott has been engaged with the question as long as he has been and that he is still carrying on the fight; but his previous writings on the subject were quite unknown to me.

I am, Sirs, yours faithfully,

F. LUCAS BENHAM, M.D. Lond.

Exeter, South Australia, Feb. 10th, 1905.

THE MEDICAL MAN AS EXPERT WITNESS.

To the Editors of THE LANCET.

SIRS,—*Apropos* to Dr. W. B. Ransom's interesting paper on the medical man as an expert witness, in THE LANCET of March 4th, p. 591, will you kindly allow me to point out that the medical witness is frequently not an expert at all; that he is called in by, and employed by, the prosecution; is expected to assist the police in order to secure a conviction; and that, as the crime cannot be reconstituted, it is impossible to appeal against his decision? It must be admitted that this is a very dangerous state of affairs; the prisoner or accused or suspected person ought always to be represented at these investigations by another medical man, practitioner, or expert in the first instance, before the body is buried, if it is a case of death, or the symptoms or condition which are supposed to indicate guilt on the part of the accused have passed off. I recollect a case where a woman was declared to have died from the effects of an illegal operation. Fortunately, the friends were able to employ another practitioner who completed the post-mortem examination by opening the skull and so ascertained that the patient had died from apoplexy. The Grimsby starvation case is another instance in point. Here the symptoms of death from starvation of the prisoner's wife were conspicuously absent and yet the man was convicted and got 20 years' penal servitude, some portion of which he had served when he was rescued by a memorial

¹ THE LANCET, March 25th, 1905, p. 782.

² THE LANCET, March 18th, p. 696.