Correspondence.

"Audi alteram partem."

THE PHARMACIST AND THE PROPRIETARY MEDICINES BILL.

To the Editor of THE LANCET.

SIR,—In approaching the Proprietary Medicines Bill from the standpoint of the pharmacist, I must first of all express the regret that one of the most brilliant members of the pharmaceutical profession of our time, and the one whose patient work perhaps did more than that of any other man to enlighten the public mind on the follies of quackery, has not lived to see his efforts so near fruition. I refer to the late Lieutenant-Colonel E. F. Harrison, who before working himself to death in order to find means of protection for our troops against the German poison gases, devoted years of his life to unravelling the secrets of secret remedies and so demonstrating how the vast majority of the population of this country was being fooled by a handful of nostrum mongers. *Omne ignotum pro magnifico*. After Harrison had finished his labours there was little left to be known about the secrets of the quacks.

It will be understood that these references to quackery do not embrace every maker and vendor of proprietary medicines; probably scores of proprietary articles could be enumerated which not only do not merit condemnation, but are almost as good as they are claimed to be. The class of compound I have especially in mind in making this reservation is that which depends for its vogue on some special manipulative method which makes the medicine superior in one way or another to others of its kind, and is as different from the offensively advertised "cure-all" as chalk is from cheese.

If proprietary medicines had been confined to the better type, or even to such as are made in almost every pharmacy in the country, it is possible that restrictive legislation would not have been needed. What made the business an offence to public decency was the long and rapidly lengthening list of worthless mixtures, pills, and salves, foisted on a credulous people by men of the get-rich-quick type, who knew nothing and cared nothing about the properties of drugs so long as they brought grist to the mill. As I read the provisions of the Bill, there is nothing in it to prevent any man from turning an honest penny, but if it does not prevent the public from being fooled it will fail in its purpose.

Coming to the details of the measure as they affect the conduct of the maker or vendor of proprietary medicines, the most noteworthy provision is that which prohibits the sale of alleged cures for cancer, consumption, deafness, fits, epilepsy, amenorrhoea and other diseases peculiar to women, diabetes, paralysis, locomotor ataxy, and rupture. I have yet to meet the pharmacist who would deny that it is wrong to sell "cures" for incurable diseases, and if that description of the object of the provision is hardly complete, I hasten to add that I have met no pharmacists who would not admit the justice of putting a stop to the exploitation of persons suffering from any one of these diseases. Next in importance comes the provision that the composition of proprietary medicines must be disclosed in confidence to the Registrar in a Government department. That the notorious quack will find many specious reasons why he should not do this there is not the least doubt, but with him we are not concerned. Will the pharmacist object? I do not think so. Some years ago, following a new interpretation of one of the sections of the Medicine Stamp Act, practically all the pharmacists in practice in Great Britain disclosed some of their most prized formulæ, and had them printed in a book that ran into thousands of copies. Is it likely that a pharmacist who will publish the names of the ingredients of his compounds for all the world to see will object to have them placed in the hidden archives of the Ministry of Health?

There is, however, one provision to which pharmacists may possibly take exception—namely, that which makes

it an offence for anyone selling a proprietary medicine to enclose within the wrapper an advertisement of another proprietary medicine. In whose interest this is made an offence I do not know, but it is certainly not in the interests of the public, since we find nothing in the Bill to prohibit the advertising of proprietary medicines in the public press, with the exception of medicines for the diseases specifically named. As a matter of fact, this clause has already been withdrawn. Another objection which pharmacists may raise is that the Minister should not have the power to add to the schedule of diseases remedies for which may not be sold.

Finally, it should be remembered that proprietary medicines are almost as old as the hills, and that reasons against the interference with the immemorial way of life must be heard with patience. A lesson may be learned from the Australian Royal Commission, on the results of whose inquiry into secret medicines the law affecting their sale in Australia was based. This Commission made a strong point of the fact that while in England makers of feeding-stuffs for animals and manures for the ground must disclose the composition of these articles, the English law allowed human beings, whether babies or adults, to be dosed with secret compounds. Unless it is proved that cattle and turnips are more precious than human lives, an answer will have to be found to the remonstrance.

I am, Sir, yours faithfully,

August 10th, 1920.

PHARMACEUTICUS.

THE TREATMENT OF ACUTE INFECTION OF THE KNEE-JOINT BY ACTIVE MOVEMENT.

To the Editor of THE LANCET.

SIR,—The allusion in your annotation of July 10th (p. 81) to this method of treatment reminds me of a series of cases which I treated when in France. Willems's method, in my hands, gave only a small measure of success, because I was unable to persuade the patients to carry out the movements unaided. I therefore designed a contrivance which, by means of a mobile splint and counter-weights, overcame the force of gravity. By this the movements were made as easy as possible, and the initial pain and weakness did little to hinder them.¹ The immediate effect was striking. After the first day or two pain was definitely eased by active movement, tracking appeared to be prevented, and the vascularity of the limb was maintained. During treatment the joint secretion tended in two or three weeks to become clear, resembling normal synovial fluid, and the wounds rapidly granulated and healed.

I ascribe the beneficial effect not only to the mechanical expression of pus by the movements, but also to the maintenance of a good blood-supply. In a part functionally at rest the blood tends to stagnate, especially in the lower extremity, where venous return is largely dependent upon muscular activity. Given a good blood-supply, a synovial secretion more potent in its bactericidal property is reasonably to be expected. This property appears to be maintained, provided that the fluid is prevented from stagnation by arthrotomy in the more severe cases, or by aspiration in the milder.

Several of my cases bore a marked resemblance to that published by Dr. F. B. Lund. Of a series of 23 septic knee-joints which I treated in this way, 11 obtained good mobile joints; 1 only was amputated, and that for other reasons. Though in civil practice we are not often confronted with the problem of the infected knee, I have had a few instances where the principles evolved, as the outcome of experience gathered during the war, have been further established. For example, a girl of 6 was admitted under my care into King's College Hospital, having run a rusty needle into her knee-joint. In three days the joint had become distended with a fluid which was found on aspiration and examination to be rich in pus cells and staphylococci. Three aspirations, combined with active move-

¹ A New Method of Treatment for Suppurative Arthritis of the Knee-joint, British Journal of Surgery, April, 1919.

ments, brought about complete resolution in three weeks, and she left hospital walking perfectly. Such a case would, I think, undoubtedly have been treated by the majority of surgeons in pre-war days by wide incisions and drainage-tubes placed in the synovial cavity. The results of such treatment are too well known to require description.

The rarer form of gonorrhoeal arthritis—namely, synovitis with effusion—I have recently been treating in a similar fashion by aspiration with active movements. The result has been stimulating to further endeavours. I am, Sir, yours faithfully,

JOHN EVERIDGE.

Upper Wimpole-street, W., August 3rd, 1920.

EMBOLIC ANEURYSM OF PERIPHERAL ARTERIES.

To the Editor of THE LANCET.

SIR,—In your interesting annotation dealing with the communication by Mr. Douglas K. Adams on Embolic Aneurysm of Peripheral Arteries, which appeared in the *Glasgow Medical Journal*, you refer to the critical review on bacterial endocarditis by Irving Simons, published in the *Quarterly Journal of Medicine* for April, 1914, as giving “a list of the recorded cases of embolic aneurysms.” This list is not, of course, confined to “peripheral” aneurysms; it is intended to include those found in other vessels, such as the branches of the coeliac axis and the renal and cerebral arteries. The list is prefaced by the remark: “The distribution of embolic aneurysms is of extreme importance,” and in a note following his table the writer says: “These cases are all that I have been able to find in the literature.”

I have always regarded the omission from Simons's review of any reference to aneurysm of the coronary arteries of the heart as a serious flaw in his admirable contribution to our knowledge of bacterial affections of the endocardium. In the *British Medical Journal* of Feb. 2nd, 1901, in putting on record two cases of embolic aneurysm of the coronary arteries of the heart, associated with infective endocarditis, I gave a list of all the cases of aneurysm of those vessels which I had been able to collect from the literature. Although it is not likely that this list was a complete one, it dealt with 24 instances, including my own two, the earliest of these being that which was put on record by Bougon in 1812. I was able to read the original account of 18 of these, and I found that in six of them infective endocarditis was seen on autopsy. This is, of course, strong presumptive evidence that the aneurysms were embolic, and in discussing the remaining 12 cases I gave what I considered good reasons for thinking that most of them also were due to this cause.

Subacute infective endocarditis is an affection which appears to be on the increase. Its frequency during the war was very striking and it may be that its continued frequency is an aftermath of war. I would urge that every opportunity be taken by those who are engaged in making autopsies in cases of infective endocarditis to include a careful examination of the coronary arteries for embolism. If the common cause of aneurysm of the coronaries in infective endocarditis is indeed embolism, the proof of this will be found not in the demonstration of an embolon in association with the aneurysm, for an embolon may well have disappeared after the infection of the arterial wall has led to softening and dilatation, but in the frequency of coronary embolism being shown to be greater than is usually supposed. It is a remarkable coincidence that the two cases of coronary aneurysm I put on record were seen in autopsies done by me on the same day, and that the next autopsy I performed was also on a case of infective endocarditis in which the patient had died suddenly, and in which I found both coronary arteries plugged by detached vegetations.

One of the points I desired to emphasise in my paper of 1901 was the probability of aneurysms of the coronary arteries “sharing the peculiarity of aneurysms on small vessels elsewhere in being embolic in origin.”

I am, Sir, yours faithfully,

Leeds, August 9th, 1920.

T. WARDROP GRIFFITH.

STANDARD ARTIFICIAL LIMBS.

To the Editor of THE LANCET.

SIR,—I notice in your issue of July 31st that you have published an article on Standard Artificial Limbs, and I am surprised that the information you have received has not any reference to the services rendered to the Ministry of Pensions by the British Artificial Limb Makers' Association.

Throughout the whole of the work of devising standard artificial limbs a large proportion of the research and experience necessary to arrive at satisfactory solutions of difficult problems devolved upon the British Artificial Limb Makers' Association, and Sir Charles Kenderdine has acknowledged at more than one meeting of the Advisory Council to the Ministry to what a large extent the work has been indebted to the Association for assistance and suggestions. The Limb Makers have combined to place their experience at the disposal of the Ministry to arrive at the most satisfactory forms of limb for standardisation, and I shall feel greatly obliged if you will accord the same publicity to this letter as to the article referred to.

I am, Sir, yours faithfully,

W. R. GROSSMITH,

Honorary Secretary, British Artificial Limb Makers' Association.

12, Burleigh-street, London, W.C. 2, August 6th, 1920.

URBAN VITAL STATISTICS.

(Week ended August 7th, 1920.)

English and Welsh Towns.—In the 96 English and Welsh towns, with an aggregate civil population estimated at nearly 18 million persons, the annual rate of mortality, which had been 9·9, 9·8, and 9·9 in the three preceding weeks, fell last week to 9·6 per 1000. In London, with a population of nearly 4½ million persons, the annual death-rate was 9·1, or 0·4 per 1000 below that recorded in the previous week, while among the remaining towns the rates ranged from 2·7 in Enfield, 4·3 in Ealing, and 4·9 in Walthamstow, to 15·4 in Bury, 16·3 in Stockton-on-Tees, and 17·2 in Hastings. The principal epidemic diseases caused 168 deaths, which corresponded to an annual rate of 0·5 per 1000, and comprised 87 from infantile diarrhoea, 28 from diphtheria, 22 from measles, 17 from whooping-cough, 9 from scarlet fever, and 5 from enteric fever. Measles caused a death-rate of 2·0 in Aberdare, but the mortality from the remaining diseases showed no marked excess in any of the towns. There were 2022 cases of scarlet fever and 1469 of diphtheria under treatment in the Metropolitan Asylums Hospitals and the London Fever Hospital, against 1956 and 1481 respectively at the end of the previous week. The causes of 34 of the deaths in the 96 towns were uncertified, of which 8 were registered in Birmingham and 4 in Hull.

Scotch Towns.—In the 16 largest Scotch towns, with an aggregate population estimated at nearly 2½ million persons, the annual rate of mortality, which had been 11·1, 11·6, and 11·2 in the three preceding weeks, fell to 11·1 per 1000. The 256 deaths in Glasgow corresponded to an annual rate of 11·1 per 1000, and included 8 from infantile diarrhoea, and 2 each from small-pox, measles, diphtheria, and whooping-cough. The 56 deaths in Edinburgh were equal to a rate of 8·6 per 1000, and included 1 from infantile diarrhoea.

Irish Towns.—The 107 deaths in Dublin corresponded to an annual rate of 13·4 per 1000, or the same as that recorded in the previous week, and included 4 from whooping-cough, 3 from infantile diarrhoea, and 1 each from enteric fever and diphtheria. The 95 deaths in Belfast were equal to a rate of 12·4 per 1000, and included 10 from infantile diarrhoea, 2 from scarlet fever, and 1 each from enteric fever, measles, and whooping-cough.

ROYAL COLLEGE OF PHYSICIANS, EDINBURGH: DR. JESSIE MACGREGOR PRIZE.—The trustees of the Dr. Jessie Macgregor Prize announce the award, for the present triennial period, to Miss Lucy Davis Cripps, M.B.E., M.B., Ch.B. Edin., for her work on tetral. The prize, which is open to medical women graduates of Edinburgh University or to women who have taken the triple qualification, is given to the applicant who presents the best record of original work in the science of Medicine, done not earlier than three years prior to the date of the award.