With regard to the admission of the senior members of the profession—of persons who have not gone through the university course—to our degrees, which has been referred to by yourself and some of your correspondents, the University would require to be convinced that some real benefit would be likely to result from this to the profession and the public. The proceedings of the University of St. Andrews have been mentioned, which gives me occasion to say that my experience as a visitor of the examination there, and my consequent conversations and correspondence with the professors of that University, have convinced me of the great difficulty of discharging such a function as this, whether by examination or in other ways, satisfactorily and advantageously. That the University of Cambridge has no inherent reluctance to undertake a duty of this kind is shown by the readiness with which it opened an examination for a certificate in sanitary medicine to all the registered members of the profession when it perceived that it could, in that manner, supply a want, and that it was in its power to do a good thing for the profession and the public. If a similar case can be made out in the case of its degrees in medicine, I doubt not it would produce a similar result. It must not be forgotten that a degree at Oxford or Cambridge is esteemed on account of the general, scientific, and social education which it implies. Divested of this it would cease to be an object of ambition, and rightly so; and if the suggestions of some of your correspondents were adopted we should, I fear, soon find that our medical degrees were so far curtailed of their fair proportions as to lose their attractions in the eyes of those who now desire to possess them.—I am, Sir, yours, &c.,

G. M. HUMPHRY.

Anatomical Museum, Cambridge, March 17, 1876.

THE SPHYGMOGRAPH IN MEDICINE.

To the Editor of THE LANCET.

SIR,—I am sorry that the tracings I have given in my paper as indicative of the existence of arterial rigidity and increased vascular tension do not satisfy Dr. Inglis. He thinks that my lever-point pressed too strongly on the glass because the primary rise does not extend above the level of the rise of the tidal wave. Surely he does not mean to affirm that all flat-topped tracings are “abortive,” and “do not truly write the character of the pulse.” If so, such errors, I am afraid, are very common. Several of M. Lorain’s tracings seem quite as objectionable as mine (see pp. 230, 232, 251, 238, 239, 235). If he does admit that flat-topped tracings may be true ones, why does he condemn mine? Unless he had examined the patients for himself, I do not think he is in a position to judge. The tracings themselves disprove, I think, Dr. Inglis’s charge. In three of them the top in some or all of the beats slopes upwards. Now, if undue pressure of the lever-point on the glass cut short the primary rise, how comes it that it did not also prevent the tidal wave line from rising still higher?

I am well acquainted with the effect of excessive pressure of the writing-point on the glass, and subjoin a marked example of a false tracing made in this way, which I noticed and corrected at the time. Perhaps this may satisfy Dr. Inglis that I was not likely to commit the error he lays to my charge. (See Fig. 1, *a*, *b*, taken from a female, aged twenty, suffering from anæmia and debility; *a*, false tracing in consequence of lever-point pressing too much on glass; *b*, correct tracing with lessened pressure.)

The chief cause of the upstroke being cut short is, undoubtedly, the employment of an undue spring-pressure, to which Dr. Inglis does not allude. This is well seen in the subjoined figures, which tell their own story. The pressure may be too much or too little, yet the result may be the same. (See Fig. 2, *a*, *b*, *c*, *d*; and Fig. 3, *a*, *b*. Fig. 2 from male aged fifty-three; *a*, bowels confined some days; *b*, taken next day after free purging, with same spring pressure, 112; *c*, taken at same time, with pressure 56; *d*, with 28 grammes. Fig. 3, from male aged fifty-two. Pressure in *a*, too weak; in *b*, stronger, producing a higher rise.)

I may add that the tracing given by Dr. Inglis, illustrating his view, contains evidence that cutting short the upstroke does not essentially alter the significance of the tracing. In the five left beats the top is more or less flat,

in the others it is peaked; but in all the latter there is evidence, in the projecting shoulder below the peak, of delay of the tidal wave—i.e., of increased arterial tension. The import of the flat top is the same, therefore the difference is more apparent than real. In Fig. 2 the difference between

b and *d* is apparently enormous, yet both indicate increase of arterial tension. The occurrence of high primary rise from diminution of the spring-pressure signifies that the radial artery is relaxed, and that the obstruction is in the arterioles or capillaries. The distinction between this state and that of rigid radials as well as arterioles—to which I maintain my cases belong—was made by me in the second part of my paper.

I may take this opportunity of mentioning the interesting fact that the prolonged second sound heard in Case 8 has now, six weeks later, developed into a well-marked diastolic murmur, audible at midsternum and xiphoid, but not at the apex. The valve has clearly given way under the arterial pressure.

I remain, Sir, yours very truly,

Green-street, W., March 21st, 1876.

C. HANDFIELD JONES.

PUNCTURE OF THE TESTIS IN ACUTE ORCHITIS.

To the Editor of THE LANCET.

SIR,—It is a relief to read the temperate observations of Mr. Rivington on the subject of orchitis, and the treatment of this disease by puncture of the testis, and I am pleased to find that although this gentleman has not, as far as we can see, had any personal experience of the operation in question, he is willing to put faith in my statements, and