It will be noted that no mention is made of deaths under ether or other anæsthetics than chloroform and ethyl chloride.

When we turn to Ireland the returns are still more obviously misleading. In the year 1906 there is one death officially attributed to chloroform by the Registrar-General. In 1905 and 1904 three are reported under the same heading for each year. In 1903 two are reported under chloroform and one under anæsthetic.

Conclusions.

1. That present available data as to deaths during anæsthesia are so imperfect as to be useless for the purposes of formal investigation.
2. That the Registrar-General's returns of such deaths are for the most part obtained from coroners' returns of deaths occurring in hospital practice.
3. That only a small proportion of deaths under anæsthesia in private practice ever come to the notice of registrars or coroners.
4. That imperfect as are the returns for England and Wales, those of Scotland and Ireland are still less trustworthy.
5. That with such imperfect data it is impossible to form any trustworthy conclusions as to the absolute rate of fatalities to administrations, or to the relative proportion of deaths to administrations in the case of particular anæsthetic drugs.
6. That it is highly desirable to arrive at satisfactory conclusions as to the precise facts of all deaths under anæsthesia both for the safety of the public and the furtherance of scientific knowledge.

Recommendations.

1. That no general or local anæsthetic shall be administered by any but a duly qualified medical man, except in most exceptional circumstances, which shall be duly reported to some recognised official authority.
2. That full details be kept by the anæsthetist of all administrations of anæsthetics whether in hospital or in private practice, including date, name and address of patient, of operator and of administrator, nature of operation, the drug used and other pertinent details.
3. That a register of all administrations of anæsthetics be kept in all medical charities, Poor-law infirmaries, asylums, and other public institutions.
4. That so far as possible special skilled anæsthetists be appointed to all hospitals and infirmaries and that resident anæsthetists be provided in the larger institutions.
5. That when the administration of an anæsthetic is intrusted to a junior qualified man, he should be supervised by a skilled anæsthetist, except where he can produce a certificate of special skill and experience as an administrator, or where a skilled anæsthetist is not available.
6. That notification be made to the coroner of all deaths occurring at any stage of general anæsthesia by the anæsthetist, or by others concerned.
7. That coroners be required to hold a public inquiry into all cases of death during anæsthesia and that they make a detailed report to the Registrar-General together with the verdict.
8. That a Royal Commission might with advantage be appointed to inquire into the present facts of deaths under anæsthesia so far as may be ascertainable.

Golden-lane, E.C.

GYNÆCOLOGY IN ST. PETERSBURG.—The equipment of the new building of the St. Petersburg Gynæcological Institute has recently been finished and according to local belief the institution surpasses all other existing gynæcological institutes in size. It has 86 wards for patients, of which four are general, and is supplied with all the latest apparatus, including plant for "water cure" and for mud baths, douches, and massage. The operating theatre has been planned with complete regard for the demands of modern scientific surgery. Gynæcological advance in one direction is counterbalanced, however, by retrogression in another, if what we read in the *Novoe Vremya* states the case exactly. Our Russian contemporary announces with regret that there is a proposal before the St. Petersburg town council to close the Suvaroff School of Obstetrics in order to economise the paltry sum of £500. The school was established in 1868.

Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

NOTE ON A CASE OF PANCREATITIS WITH JAUNDICE AND ACUTE PAROTITIS IN SCARLET FEVER.

BY SIDNEY P. PHILLIPS, M.D. LOND., F.R.C.P. LOND.,
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A NURSE from a large metropolitan hospital, aged 27 years, was attacked with sore throat on Nov. 16th, 1907; on the 17th she vomited and a rash appeared; she was admitted under my care at the London Fever Hospital on Nov. 21st with a well-marked rash of scarlet fever and with sore throat, cultures from which showed streptococci and staphylococci. The temperature was 103.4° F. The fever ran the usual course, the temperature falling to 97.4° on the evening of the 25th; on the 27th there was a slight trace of albuminuria, the patient became jaundiced and the stools were colourless; the temperature rose to 101.4° and deep down in the region of the head of the pancreas there could be felt a tender swelling; by the 31st this had become considerably larger, and on Dec. 5th the jaundice was fairly deep; the temperature had fallen on Nov. 29th to normal, and the pulse was 50 per minute; on Dec. 5th it rose to 100.6° and there was pain on the right side of the face, and the parotid gland became swollen, with pain on mastication. On the next day this enlargement was more marked; after Dec. 12th the swelling of the parotid gland soon subsided and the jaundice faded away. The patient left the hospital cured in January, 1908.

Jaundice is not common in scarlet fever. According to Osler it occurred in only 15 out of 5000 cases; in very rare cases the jaundice seems to have been a part of some fatal toxæmia accompanied by fatty degeneration of the liver; in most cases, as in the present one, it is slight in character, temporary, and not dangerous. Such cases are usually looked upon as cases of "catarrhal jaundice." The slight pain and the marked tenderness and swelling in the region of the head of the pancreas that occurred when the jaundice came on rendered it highly probable that it was due to an inflammatory swelling of the gland and the sudden attack of parotitis a few days later was confirmatory of this supposition, for the parotid and pancreatic glands are much allied in structure and several cases are on record of their being simultaneously attacked. In most of these cases the pancreatic inflammation has followed an attack of epidemic mumps; in the present case the swelling of the parotid gland was not due to mumps but was of the non-contagious variety met with sometimes after typhoid fever and various other conditions; and the parotitis followed the pancreatitis instead of preceding it.

The case seems worthy of record as in scarlet fever parotitis and jaundice are each of them uncommon events and I have never before met with the two in the same patient suffering from scarlet fever. The case suggests, too, a probable explanation of the jaundice occasionally occurring in scarlet fever, and incidentally, it may be added, it supports the contention that the so-called "catarrhal jaundice" occurring apart from scarlet fever is more often due to obstruction of the common bile-duct by the pressure of an enlarged head of the pancreas than by thickened mucus within the duct.

Upper Brook-street, W.

DO FLEAS SPREAD CANCER?

BY VERE G. WEBB, L.R.C.P. & L.M. IREL.

THE causes of the formation of cancer are still so obscure that it appears best to record any case in which there seems to be even the slightest clue to follow up. The following case may have some bearing on the point.

The patient, aged 58 years, the mother of seven children, had been in the habit of visiting, from charitable motives, a very poor woman suffering from advanced rectal cancer. On

one of the last evenings of November, 1907, while sitting by the woman's bedside, she was severely flea-bitten on the right breast. On Dec. 2nd, at about 3 P.M., she showed me the breast in which she had not previously noticed any alteration. The skin was hotter than over the left breast and was slightly inflamed, and the whole breast looked like that of a woman on the third day after delivery, except that the nipple was a little retracted. The diagnosis was interstitial mastitis, and the breast was bandaged over a pad soaked in glycerine of belladonna. After about a week's treatment all external signs of inflammation were gone, and the breast was nearly its normal size; but in a few days it had enlarged again, though not nearly to the same extent. There was very little pain and the size kept fluctuating. In the second week of January last the swelling became more localised in the upper and outer segment. Rubbing with ointment of iodide of lead was tried and there was a slight discharge of blood from the nipple. On Feb. 1st the patient went to Miss L. B. Aldrich-Blake, who diagnosed obstruction of ducts by papilloma and congestion. She advised removal and arranged for the operation to be done at the New Hospital for Women, Euston-road, when there was a vacant room. On Feb. 17th the patient was admitted to the hospital and on the 18th Miss Aldrich-Blake removed the entire breast and a gland which was enlarged. The patient made a very quick recovery. The naked-eye appearance of the growth confirmed Miss Aldrich-Blake's opinion.

On microscopic examination the growth showed in parts simple papilloma, but in others the papillary growths had malignant characters—i.e., the case proved to be duct carcinoma. The gland showed no malignant characteristics.

It seems possible that the whole trouble has been due to the flea-bite inoculating cancer germs. Of course this may be wrong and the growth immediately after may have been only a coincidence, but it seems worth while testing whether inoculation can be produced in this way. The points to be emphasised are: (1) that the patient was bitten by fleas from the bed of a cancer patient; (2) that there followed an inflammation (though it was not necessarily *post hoc propter hoc*); and (3) that after about a fortnight a definite growth developed, ending in duct carcinoma.

New Kent-road, S.E.

A CASE OF MULTIPLE CONGENITAL DEFECTS.

By J. SIDNEY PEARSON, M.A., M.B. CANTAB.,

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THE patient, a female, aged eight weeks, was taken to the out-patient department of the Evelina Hospital on account of a discharge from the left eye since birth. On examination the child was found to have the following deformities. 1. Congenital occlusion of the left naso-lacrymal duct, causing a dacryocystitis. There had been a discharge from the right eye also since birth up to four weeks previously, when, as often happens, the duct becoming patent the discharge ceased. 2. The left eye was a microphthalmos with coloboma of the iris downwards and outwards, associated with coloboma of the choroid. 3. The right eye presented coloboma of the iris downwards and inwards with an associated coloboma of the choroid. 4. The right ear was deformed, the pinna being folded inwards upon itself and having two supernumerary auricles in front of it. 5. The left ear presented a pit in the position of the pre-auricular sinus. 6. The anus at birth was so small that only a No. 3 Jaques catheter could be passed. At four weeks the child was almost unable to pass anything through this aperture, so Mr. H. S. Clogg performed a very successful operation, making a good opening and bringing down the mucous membrane. The child appears to have control of the sphincters. The eyelids, lashes, and lenses were normal and no other deformities were detected.

The child is the last of ten, both parents being over 40 years of age. There is no known congenital defect in any of the other children. The pregnancy went to full time and the labour was very easy and non-instrumental. The baby at birth weighed six pounds.

Apart from the rarity of so many associated defects, especially of the eyes, the case is of some interest from the point of view of "maternal impressions." The nurse who brought up the child states that the mother is a very nervous

woman who when seven months pregnant was definitely ill after seeing a friend who had had an eye "gouged out." This seemed to prey upon her mind and she became hysterical a week or two later when seeing a facial contortionist on the stage who reminded her of this friend.

I am indebted to Mr. Sydney Stephenson for his kind permission to publish the case.

New Cavendish-street, W.

Medical Societies.

ROYAL SOCIETY OF MEDICINE.

SURGICAL SECTION.

Lumbar Puncture in the Treatment of Otitic Meningitis.

A MEETING of this section was held on March 10th, Mr. J. WARRINGTON HAWARD, the President of the section, being in the chair.

Mr. ARTHUR E. J. BARKER read a paper on the Possible Uses of Lumbar Puncture in the Treatment of Otitic Meningitis. He suggested that lumbar puncture might with advantage be more freely employed by surgeons than hitherto in cases of meningitis due to ear disease. Its great value as an aid to early diagnosis in obscure cases of this disease was first pointed out. Then the suggestion was made that where the products of the meningeal inflammation had been demonstrated in the lumbar sac their removal should be provided for by repeated tapplings at regular intervals as an adjunct to other forms of surgical treatment. It was pointed out that this frequent unloading of the inflamed arachnoid space of septic products and their replacement by fresh cerebro-spinal fluid was theoretically correct, especially if there were, as many supposed, certain anti-bodies in the cerebro-spinal fluid which were hostile to bacterial growth. Some clinical facts were then brought forward in support of this last view, especially derived from bacteriological study of the fluid removed in the three cases which formed the basis of the paper. The most remarkable fact was that in the two first cases in which the first tapplings yielded turbid greenish semi-purulent fluid swarming with bacteria, the fluid became sterile after a few subsequent punctures although still swarming with leucocytes. The experience of other observers who had treated epidemic cerebro-spinal meningitis by frequent tapplings of the lumbar dural sac was also adduced in favour of the procedure. From that they learnt that recovery had followed the treatment in a high percentage of cases. They also learnt that no ill effect had followed from the puncture, generally or locally, in any case. The fear that local irritation might be produced in the track of the needle by the leakage of inflammatory fluid had been shown to be groundless by published cases and by his own experience in the numerous tapplings of the cases now recorded. The unmistakeable improvement which followed every tapping in the height of the disease in the first case, and to a lesser degree in the second case, was most remarkable, and beyond all doubt contributed to their recovery. The first tapping in the third case appeared to be beneficial, but the streptococcal infection present was too virulent and the complications of widespread cranial thrombosis were too severe to admit of recovery. The turbidity of the fluid drawn off corresponded with the severity of the meningitis, but it was shown by the observations of Dr. F. H. Thiele as well as those of others that a fluid clear to the naked eye might contain multitudes of leucocytes during convalescence but be absolutely sterile on all the usual media. Improvement was indicated by a relative decline of the polymorphonuclear cells and relative increase of ordinary leucocytes, then in the diminution of all cellular elements in the fluid drawn off. Relapses of leucocytosis were seen during convalescence, probably called forth by reinfection from the cranium, but this was not accompanied by reappearance of bacteria; this had also been seen by other observers. The experience in these cases lent support to the views of those who hold that there exists, either normally or as the result of inflammation, certain anti-bodies in the cerebro-spinal fluid hostile to some varieties of bacteria. The following tables refer to the first two cases.