knowledge may, we hope, continue to exist for some years to come.

Should our arrangements meet with the support which we think that they will deserve there will be but little limit to the detail in which they may be carried out. The case is emphatically one in which success breeds success and the larger our members' list the more will each individual member receive for his guinea and the greater will be the attractions which the society can offer to induce others to join it. Already it seems not improbable that our income may soon justify the issue of a printed volume in addition to the four fasciculi of the Atlas to which we are pledged and if our members' list were doubled we might almost double the rate of issue of the fasciculi. It is therefore much wished that we may have a good attendance at our annual meeting and all members of the profession, whether already subscribers or not, will be welcomed at it.

I am, Sirs, yours faithfully,

JONATHAN HUTCHINSON,

Honorary General Secretary, New Sydenham Society.

July 19th, 1904.

HEALTH AND EDUCATION.

To the Editors of THE LANCET.

SIRS,—Now that the medical profession has spoken so emphatically regarding the desirability of the children in the elementary schools being taught, as a matter of routine, the advantages of cleanliness, pure air, temperance, and proper food, it is to be hoped that the suggestions made will soon be put into practice. To this end it is well that the authorities should be made to understand that the teaching required is of the simplest possible kind, and can be quite easily adopted without interfering with other school work. The great canons of health are very simple, easily comprehended, and capable of being written down in a space scarcely larger than that required for the Ten Commandments. There is no need to bewilder the children with high-sounding words and pseudo-scientific explanations, and I earnestly hope that the fatal error will not be made of supposing that in order to learn how to live healthily it is necessary to have any acquaintance with physiology. Even we poor medical men with all the advantage of special training can only attain—strive how we may—to a slender knowledge of this embryonic science, and by attempting to teach it to children we shall only be adding their poor little brains and obscuring the great principles we wish to inculcate. What good does a child get from knowing where his kidneys are, or what they are for? or by studying those somewhat gruesome and assuredly very unlovely pictures of the human "inside" which so frequently disfigure the walls of the school-room? Far better—in my humble judgment, at least—that children should remain in entire ignorance of the structure and functions of their bodies. The body as an object of study should, in fact, be severely ignored by its possessor. It is he who lives in glorious ignorance of the fact that he possesses a heart or a liver that is the happy man. Speaking for myself, I can confidently assert that my own knowledge of the structure and functions of my body has not helped me in the smallest possible degree to live healthily. I find it all-sufficient to live according to a few commonsense principles. The way people nowadays talk of their internal organs—of their livers, kidneys, and vermiform appendices—and the morbid interest they display in abdominal and pelvic surgery are amazing and occasionally embarrassing. These topics are freely discussed among "polite" circles, in the theatre, in the drawing-room, nay, even the dining-room is no longer safe from their intrusion. Verily we are living in a realistic age!

Let me prove my contention that it is possible to learn how to live a healthy life without any knowledge of anatomy and physiology by reference to the subject of ventilation. In teaching this subject to a child there is no surer way to begot him, and to obscure the grand truth that it is sought to bring home, than by attempting to make him understand the anatomy of the lungs and the functions of the red blood corpuscles. All that is necessary is to point out in the simplest possible language the good that comes from breathing pure air and the harm that comes from breathing impure air. The child should be made to realise that human beings need, like the flowers in the fields, fresh air and sunlight and cannot, any more than the flowers can, flourish in dark and stuffy chambers, but without light and fresh air must, like these, wither away and die. The

child's imagination may further be appealed to by telling him how many of our poor soldiers used to die from consumption in the old days when they were huddled together in imperfectly ventilated barracks and how, when they were provided with larger and better ventilated dormitories, this disease became much less common; or, again, by depicting the terrible tragedy of the Black Hole of Calcutta. Having given a few such homely illustrations of the good that comes from fresh air and sunlight, and the evil that lurks in dark and foul-smelling places, what more is there to be said on the matter beyond giving a few practical hints as to the best way of securing proper ventilation in the home?

The mere teaching of principles is, however, not enough: they need to be put into operation; otherwise they are apt to become nothing more than formulæ, like the catechism that is so diligently taught, and so often repeated that it soon becomes a mere jargon of words to be ground out upon occasion after the manner of the phonograph. It was, I believe, Herbert Spencer who insisted that preaching alone does little good: ethics is not only a science but an art—and to some a very difficult one—only to be acquired after much painstaking practice. And so it is with hygiene. If real good is to be achieved in this direction the teacher must not rest content with enunciating its principles, but must see to it that they are as far as possible put into practice.

I am, Sirs, yours faithfully,

Wimpole-street, July 17th, 1904.

HARRY CAMPBELL.

THE MEETING OF THE BRITISH MEDICAL ASSOCIATION.

To the Editors of THE LANCET.

SIRS,—Will you kindly allow me to invite the attention of the profession to the annual temperance breakfast which will be given by the National Temperance League at Oxford, on Thursday morning, July 28th? The occasion will this year be of exceptional interest in view of the recent memorial to the Educational Department and of the evidence which we were enabled to present to the Physical Deterioration Committee of the Privy Council. Among those who have expressed their intention to support Mr. W. McAdam Eccles who will preside, are Sir William Broadbent, Dr. Fletcher Beach, Professor Murdoch Cameron, Surgeon-General G. J. H. Evatt, A.M.S., Sir Victor Horsley, Dr. T. B. Hyslop, Dr. Robert Jones, and Mr. G. Pernet. I shall be glad if those who can attend will kindly apply for tickets at our table in the reception-room.

I am, Sirs, yours faithfully,

JOHN TURNER RAE, Secretary.

Paternoster House, London, E.C., July 18th, 1904.

ROYAL ACCOUCHEMENTS.

To the Editors of THE LANCET.

SIRS,—The following extract from "Mediæval England," by Mary Bateson of Newnham College, shows that the great obstetrician William Hunter was not the first male attendant on an English queen during her confinement:—

Further, the Normans brought with them a knowledge of medicine in advance of that of the English. John of Tours, Bishop of Wells (1088-1123), was famed for his medical skill; the Italian Grimbald, or Grimaldi, was in constant attendance as leech to the court and he, with the Italian abbot of Abingdon, Faricius, attended Henry I.'s Queen Matilda in childbed. When Faricius was near being made archbishop it was urged against him that he attended women in sickness.

I am, Sirs, yours faithfully,

EDWARD H. YOUNG.

Okehampton, Devon, July 18th, 1904.

CALCULOUS ANURIA.

To the Editors of THE LANCET.

SIRS,—The case of calculous anuria related by Dr. Clement Dukes in THE LANCET of July 16th, p. 174, is of much interest. One or two points seem to call for further notice. In the first place, Dr. Dukes says that "the case is remarkable in that suppression of urine resulted instead of distension of the pelvis of the kidney." I think that it is generally admitted that dilatation is only caused by partial or gradual obstruction of the ureters. Sudden blocking commonly causes suppression. Again, the writer expresses surprise that there were no symptoms of uræmia. So far as I have seen it is very rare indeed, strange as it may seem, for these to appear.

This fact is connected in some way with the internal secretion of the kidney. Herter, in an analysis of 41 cases of suppression due to stone, says that convulsions occurred in only five cases, headache in six, and vomiting in 12. As regards the duration, cases are on record where no urine was passed for more than a fortnight. In one case in which the only kidney was removed the patient survived 11 days.

And now let us turn for a moment to the most interesting point. Dr. Dukes asks, "Can a stone in one ureter inhibit the action of both kidneys?" I hold strongly that it can. Two cases that have come under my care during the past year bear upon this question.

In the first, that of an elderly man suffering from malignant disease of the prostate, total suppression came on suddenly. The left kidney was opened from the loin, the obstruction being due to a small stone. Subsequently he passed much urine and on his death six weeks afterwards the right kidney was found to be healthy.

The second case is not so conclusive, as we were fortunately not able to verify the condition post mortem. A young man after having suffered from attacks of renal colic for five years was seized with suppression. On the fourth day the left kidney was opened and a probe was passed down it into the bladder but no calculus was found. He made an uninterrupted recovery and at the end of six weeks was discharged with the nephrotomy wound healed and passing 50 ounces of urine in the 24 hours. The anuria in this case was, I think, probably brought about by a kink in the left ureter which was put right by the manipulation and subsequent fixation of the kidney. It may possibly have been due to a stone which I failed to detect but which escaped during the operation. In neither of the cases was there any dilatation of the pelvis, nor was there anything to point to disease of the opposite kidney.—I am, Sirs, yours faithfully,

Lancaster, July 18th, 1904.

A. S. BARLING.

ON THE POSSIBLE LOCAL NATURE OF SCARLET FEVER.

To the Editors of THE LANCET.

SIRS,—The cause of scarlet fever is generally assumed to be a micro-organism circulating in the blood. There is much evidence in support of the micro-organism, but as far as can be ascertained little or none with regard to its habitat being the circulation. On the other hand, I think there is much evidence in support of the view that scarlet fever is a local faucial disease which produces its characteristic symptoms by means of absorbed toxins. The confirmation or refutation of this local theory is, of course, dependent upon exact bacteriological knowledge, which up to now is not forthcoming. Dr. M. Gordon's summary in the "Encyclopædia Medica" gives the bacteriology up to date and though somewhat indefinite, yet, when taken in conjunction with the obviously infectious nature of the disease, it makes a very strong case for the assumption that the streptococcus conglomeratus is the real cause of the disease. This micro-organism is found in the faucial mucus and nasal discharge, but not in the aural discharge. It is also found in the exudates and in the blood of patients dying from the disease. The absence from the aural discharge is probably due to the ordinary pus cocci, so to speak, getting the victory. Thus far, then, the bacteriology apparently supports the view that the disease is due to a blood infection. The presence of the streptococcus conglomeratus in the exudates implies a transitory passage in the circulation or lymphatic system. The finding of the organism itself in the blood by no means proves that the circulation is the place where it multiplies and produces its toxins. There are other diseases which we know to be local in which the specific micro-organism has been found in the blood in numbers. Moreover, the clinical features of the disease are somewhat against the blood infection view. It is well known that the rash of scarlet fever almost invariably starts on the neck and chest and thence spreads over the body and less markedly upwards over the face and head. The extension of the rash on to the face is not mentioned by all authors but it undoubtedly does occur and is evident if the case is seen early enough. The early desquamation of the face must imply previous rash. This constant point of onset and definite slow march over the body, so much slower than the progress of the blood, is one of the most constant and remarkable

features of the disease. To my mind it implies a constant point from which the toxin is absorbed and a vehicle other than the blood. On looking at the disposition of the lymphatic system and its relation to the tonsils and pharynx it will be seen that the absorption of a rash-producing toxin along these channels would be most likely to give rise to its earliest effects in the neighbourhood of the neck and chest. The enlargement of the glands in the region of the neck is evidence that absorption of some kind is taking place. The blood infection theory cannot in any way explain the rash, for if that theory be true one would expect an irregular rash, making its onset at no particular point and becoming patchy or else a rash which pervades the whole body and gradually deepens.

If the course of the disease be compared with the severity of the initial angina it will be found that there is a very definite relation between them. That is to say the more severe the throat symptoms the more pronounced and enduring will be the rash and the more severe the early course of the disease. This applies only to the early angina and not to the severe faucial inflammation which often supervenes, this latter being due to secondary infection. These conclusions embody observations on some hundreds of cases, but to confirm them I wrote a letter to a number of medical officers of infectious hospitals asking the following questions: 1. In your experience is there any definite relation between the intensity of the initial throat symptoms and the intensity of the rash in scarlet fever? 2. Does the intensity of the subsequent peeling vary with the intensity of the rash, with its persistence, or with both? To the first question I received seven replies in the affirmative and two in the negative. One reply in the negative had a note added to the effect that the throat symptoms depended largely upon the hygienic or unhygienic state of the oral cavity, which rather implies that the answer was meant for the secondary angina. So that there is much evidence to show that throat and rash bear a definite relation to one another. To the second question all the replies stated that the intensity of the peeling depends upon both the intensity and persistence of the rash, but chiefly the former.

Clifford Allbutt, in his "System of Medicine," looks upon the greater prevalence of scarlet fever in the northern hemisphere as being due to the greater prevalence of enlarged tonsils.

In diphtheria we have a throat disease of undoubted local nature, and if scarlet fever is looked at side by side with this disease it will be seen how remarkably alike are the symptoms and sequelæ, the difference being largely those of intensity, time, or frequency of occurrence.

Disease.	Initial symptoms.	Sequelæ.
Scarlet fever.	Throat and nose ; rash.	Albuminuria, arthritis, cardiac, otitis, adenitis, neuritis.
Diphtheria.	Throat and nose.	Albuminuria, arthritis, cardiac, otitis, adenitis, rash, neuritis.

If scarlet fever is a local disease it will certainly follow that the desquamating epithelium is not in itself infectious, that is to say, only becomes infectious from contamination with faucial or nasal discharges. Desquamation of a mild kind of course is a natural process and can be easily observed in the uncleanly and it only requires conditions of hyperæmia, malnutrition, or circulating toxins to bring about pathological desquamation. It may be seen after many diseases and is in no sense a criterion of scarlet fever. It has been seen after typhoid fever, acute rheumatism, measles, and after rashes produced by toxins absorbed through the intestinal canal. With regard to the non-infectious nature of desquamation after scarlet fever, Dr. C. K. Millard produced some very interesting evidence in THE LANCET of April 5th, 1902, p. 959. His principal arguments against the infectious nature of the desquamating epithelium are as follows: (1) the absence of evidence supporting it; (2) infection begins prior to desquamation and often continues long after desquamation has ceased; (3) scarlet fever wards though abounding in desquamating epithelium are not a danger to neighbouring houses; and (4) the proportion of "return" cases does not appear to be increased amongst patients sent out from hospital still desquamating.

There is just one point that requires explanation and that is the apparent flaw in the argument caused by the fact that in scarlatina maligna one may get no rash or throat