The caval mesentery is really a special development of the dorsal mesogastrium, at first bilateral but which with the displacement of the stomach to the left disappears on that side and becomes prominent on the right. The caval mesentery unites right lung bud to liver and posterior body

FIG. 8.

The posterior body wall of a human embryo about 28 days. The position of the diaphragm is shown by the line (interrupted in the middle) running transversely from S.T. to S.T. The lung buds, right and left (R.L. and L.L.) are seen to be partly thoracic and partly abdominal in position. D.M., Dorsal mesocardium. The arrow points upwards to the peri-oesophageal coelom. $\times 25$.

wall to liver and its hepatic attachments are clearly seen by a reference to one of the diagrams of the liver (Lecture II.). It occupies the ground which will subsequently be taken by the inferior vena cava, and probably the

FIG. 9.

Schema of the pharyngeal pouches and their derivatives in the human embryo. M.T., Median thyroid. I to VI, One to six pharyngeal pouches. Th¹ and Th², Thymus rudiments. PA¹ and PA², Parathyroids. P.P.B., Post-branchial body (rudimentary fifth pouch). L.B., Lung bud, representing a sixth pouch.

main reason for its existence is to provide the track along which the inferior vena cava may extend across the back of the liver. In rabbit embryos, according to F. T. Lewis, the fate of the caval mesentery is briefly this. It forms

more than a nidus for the laying down of the inferior vena cava, since the part most cephalad is invaded by the right lung, of which it forms the lobus inferior medialis of Krause. Lower down it meets and unites with the liver, hepatic tubules grow into it, and it becomes a part of the liver.

SCHEMA OF PHARYNGEAL POUCHES.

If we regard the post-branchial bodies (lateral thyroids) as representing rudimentary fifth pharyngeal pouches (Fig. 9), and the lung buds as representing pharyngeal pouches also, arising behind them, then we can construct a schema of such pouches in the human embryo, which shows six pairs in all. But it should be clearly understood that there is normally no period in the human embryo in which there are at one and the same time six clearly recognisable pouches in connexion with the gut on each side. In the diagram shown of the 2.5 mm. embryo (Fig. 7), there are clearly five pouches present, the rudimentary fifth having not yet formed. At the end of a month—i.e., in the 7 mm. embryo—all the pouches are recognisable, but the sixth or pulmonary now appears at the end of the trachea.

It is interesting and significant that six pairs of aortic arches are developed in the human embryo as in some other mammals, and that the fifth should be so transitory and leave no vessel, as far as is known at present, derived from it. This is in conformity with the rudimentary nature of the fifth pouch, whilst in connexion with the sixth pair of arches the pulmonary arteries are developed and are distributed to the lungs, organs phylogenetically related either to the gill-pouches or to the swim-bladder.¹

A Clinical Lecture

ON

ITCHING DISEASES OF THE SKIN AND THEIR TREATMENT.

Delivered at the Medical Graduates' College and Polyclinic on March 17th, 1910,

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GENTLEMEN,—To the practitioner there are no more unsatisfactory cases, to the patient there are few diseases which cause greater discomfort, than itching eruptions of the skin. Whether the case be one of pruritus, eczema, urticaria, lichen planus, scabies, or other affection of the skin, the constant irritation, restlessness, discomfort, and want of sleep are a source of worry and anxiety which soon tell upon the patient's temper and general health, and in many cases drive him almost to despair, and occasionally, in neurotic individuals, even to self-destruction.

CLASSIFICATION.

To the student unnecessary difficulties are presented by the inability of different dermatological schools to agree upon a simple nomenclature or classification of the itching diseases of the skin, and it is not only the student who is sometimes in doubt whether pruritus is a symptom or a disease, and how it is related to, or differs from, prurigo. To speak of an itching skin lesion as "pruriginous" is only to complicate matters still further; indeed, in my opinion, the use of the adjective in this sense is entirely unjustifiable.

The view which I personally hold, and which is held by the chief French dermatologists (especially Brocq and Darier), is that pruritus and prurigo are diseases in which itching is the primary factor, and which differ from one

¹ In a paper "On Certain Features in the Development of the Alimentary Canal in Lepidosiren and Protopterus," published in the *Quarterly Journal of Microscopical Science*, February, 1910, Professor Graham Kerr says "that he feels compelled to accept the general homology of the organs known in various subdivisions of the vertebrata under the name of lung and swim-bladder or air-bladder." In this paper Professor Kerr brings forward evidence to show that migration of the air duct from a ventral to a dorsal position may take place.

another only in the fact that in prurigo the scratching gives rise to certain cutaneous reactions in the form of papules or lichenification. I repeat that in prurigo, as in pruritus, itching is the primary phenomenon, and that prurigo is pruritus accompanied by certain definite lesions of the skin which are brought about by scratching. This definition makes the differential diagnosis between the two affections quite easy, it clears the ground of all misapprehensions, and makes it clear that the itching is the primary affection and the skin lesions entirely secondary.

In pruritus, as distinguished from prurigo, some traumatic lesions may be brought about by scratching, such as pus infection, impetigo contagiosa, and secondary eczema, but there are no prurigo papules and no lichenification. Inasmuch as in prurigo the itching is primary, this forms a distinction from those cases of eczema which become lichenified and therefore come to resemble an eczematized prurigo. A secondary prurigo may of course arise, just as a secondary pruritus may and does exist.

ETIOLOGY.

It has been argued that itching is not necessarily pathological, that the brushing of a hairy portion of skin lightly with a feather gives rise to intense itching which persists for some time when the stimulus is removed, and that there are special nerve endings and end organs for this sensation, as there are for the sensations of pressure, touch, heat, and cold. But that these end organs can be centrally stimulated and itching arise from a disturbance of the central nervous system alone has never been demonstrated, and we are fully justified in maintaining that a peripheral stimulus is necessary. The commonest peripheral stimuli causing pruritus are the bites of insects, such as fleas, and many vegetable and chemical substances. Want of cleanliness is of itself a sufficient stimulus to many skins, and when combined, as it so often is, with other sources of irritation, acts as a powerful factor to intensify their action.

Secondary pruritus is, of course, common in many dermatoses, such as eczema, lichen planus, scabies, urticaria, mycosis fungoides, and the dermatitis of Duhring. In such cases it follows or accompanies the outbreak of the skin lesion, and there can be no question of the sequence. Some diseases are, of course, never itchy, such as lupus, syphilis, and psoriasis.

Primary pruritus is a functional affection of the skin, the sole symptom of which is the subjective sensation of itching. The skin appears healthy and shows no pathological changes to which we can point as a cause for the irritation. Such pruritus occurs in neurasthenia, chorea, and excessive emotion, and may perhaps be ascribed to an over excitability of the special end organs in the skin, if not to an ill-defined auto-intoxication. Such an auto-intoxication does undoubtedly cause pruritus in diabetes, uræmia, gout, and jaundice. The same effect is produced by subcutaneous injections of morphia when these are repeated too frequently or in too large doses; excessive doses of belladonna also have much the same action. It is well known that certain kinds of food and articles of diet greatly aggravate any pruritus or may even give rise to an attack, especially sugars, malt liquors, coffee, and some kinds of tinned fish. In all these cases the poison is circulating in the blood stream, and diffuses thence into the lymph which is in contact with the nerve endings in the skin, so that these are directly attacked by the toxic substance.

Other etiological factors are excess of any kind, whether mental or physical; depression, whether preceded or not by over-excitement; and a neurotic taint. Rapid changes of temperature or pressure often bring on an attack in predisposed individuals. Thus, there is a well-known form of summer pruritus, and some individuals who work exposed to high temperature are especially liable to pruritus; in others a draught or stream of cold air has the same effect. Many women experience itching when at night they remove articles of clothing which have caused pressure, such as corsets, garters, or tight shoes, and this is almost certainly due to dilatation of the capillaries of the skin following the prolonged constriction to which they have been subjected during the day. The vaso-motor disturbance is only a temporary one and soon passes off, but the pruritus may persist for an hour or more.

CLINICAL VARIETIES.

The clinical varieties met with may be divided into

(1) generalised and (2) local. Of the two, generalised pruritus is far the more troublesome and may make life absolutely unbearable to the sufferer. The itching is not continuous but comes on in spasms, during which the patient cannot possibly refrain from scratching and may tear his skin almost to pieces, using not only his nails but any instrument he can find which seems to promise relief. These attacks are brought on especially by the warmth of bed, so that many patients absolutely dread going to bed, knowing that they will be unable to sleep until their continued and forcible scratching has so benumbed the cutaneous nerves that they fail to respond any longer to the sensation of pruritus, or the smarting produced by their scratches has so overpowered the feeling of itching that the latter is no longer perceived. Of course, no skin, however thick or resistant, can stand such treatment for long without resenting it, and it soon begins to show the effect of the mechanical irritation to which it has been subjected. Bacterial infection is added before long and impetigo, ecthyma, furunculosis, and other staphylococcal diseases are superadded to the abrasions of the skin wrought by the patient's nails. The most severe cases are those in old persons in whom degenerative changes have taken place. In them the skin becomes dry, excretion is deficient both by the kidneys and the skin, and toxic substances, whether of a gouty, alcoholic, or other nature, act readily upon a dry and susceptible skin.

Local pruritus may involve the most distant portions of the skin. The palms of the hands and soles of the feet, especially in hyperidrotic persons, are often affected, and pruritus of the nose is not uncommon. But pruritus of the genitals is much more troublesome—in men, of the scrotum and anus, and in women, of the vulva.

The itching is usually intense, especially at night, and leads to agonised scratching and its usual consequences—thickening of the skin and mucous membrane. Kraurosis vulvæ comes to be simulated in women, especially in diabetic patients, where the sugar-containing urine acts as a continual source of irritation. In such cases the mucous membrane of the vulval orifice is dry and irritable, the epithelium having a glazed, whitish appearance accompanied by atrophic changes, and no treatment short of excision of the affected strip of mucous membrane can relieve the itching. Uterine discharges, diseases of the rectum, such as hæmorrhoids, fissure, or carcinoma, are similarly potent factors, and bring about a condition which cannot easily be distinguished from a primary chronic eczema.

Prurigo is an itching eruption, not contagious and not hereditary, starting in most cases in early infancy. It may be defined as pruritus *plus* papular or lichenified lesions of the skin. The itching is the primary factor, but is soon accompanied by an eruption which presents all the picture of an urticaria. This consists of small papules, pale or pinkish, at first only perceptible to the touch, distributed especially on the exterior surfaces of the legs and arms, but also involving the trunk. Under the influence of scratching these papules become inflamed, excoriated, and crusted. Later on the skin becomes pigmented, dry, and thickened, the lines of the skin are deepened, and the appearance is typically that of "lichenification" of the affected area. The neighbouring lymphatic glands become enlarged. The clinical picture is complete by the second or third year of life, but the disease usually persists for many years, or even, in severe cases, until the patient's death, influenced but little by treatment.

DIAGNOSIS.

In making a diagnosis of the cause of itching the age of the patient is an important factor.

In *children*, the most common causes are urticaria, scabies, pediculi, and ascarides. The presence of papules and wheals, the history of the lesions appearing "as if the child had been stung with a nettle," are diagnostic of urticaria, while the distribution of a scabies eruption, the presence of "burrows" on the hands and wrists, and the identification of the acarid leave no room for doubt. Thread-worms are a frequent cause of pruritus and in children, and when these have been got rid of the itching will be found to disappear.

In *adults*, especially among the poorer classes, scabies is also a very common cause of itching. The lesions are vesicular, pustular, or occasionally bullous, irregularly grouped, extending from the sternum to the knees in front, and posteriorly involving the buttocks and lower part of the

back. Between the fingers, on the wrists and umbilicus, numerous small vesicles are intermingled with the typical dirty track or burrow along which the acarus has made its way after entering the epidermis. This burrow contains the eggs and excrement, and at the distal end the acarus itself, which may be made out with a lens as a greyish pearly body. On the proximal side of the acarus is often a small vesicle, and in extracting the acarus it is wise not to open this vesicle. It is only the female acarus which is found in a burrow, and it remains there until its death, a period of a month or two, depositing eggs which become hatched out as the oldest are brought nearer the surface by the fraying away of the superficial layers of the epidermis. With the point of a needle it is easy to pick out the acarus, or the burrow may be excised entire for the purposes of diagnosis with a tenotomy knife, or even the demonstration of the presence of the ova is sufficient proof of the nature of the disease. In addition to the essential lesions of scabies there are usually numerous secondary lesions, partly scratch marks, partly due to staphylococcal infection superadded. Ruptured vesicles, scabbed patches, and superficial hæmorrhagic lesions are distributed irregularly over the trunk and arms, but the face is very seldom affected.

Although, of course, destruction of all the acari and eggs necessarily cures scabies, patients often complain of itching for some time afterwards, and one has seen mentally unstable patients who maintain that they still have scabies years after they have been cured. But these are rather cases of scabies of the brain than of the skin. In other persons the itching persists because the sulphur or other substance used to kill the acari has, through being used for too long a time, set up a dermatitis which is hardly less irritating than the original disease.

Urticaria is also a cause of itching in adults; eczema, of course, is only too common, but perhaps the two diseases which may cause the most intense itching are the less common affections of the skin, mycosis fungoides and lichen planus. Only recently I showed here the case of a man with mycosis fungoides whose life was made absolutely miserable by the irritation, not only when the disease was fully developed and there were fungating tumours, but also in the premycotic stage when there was only an ill-defined pinkish dermatitis. Similarly in lichen planus the itching may be intolerable, especially in patients who are highly strung neurotic, or neurasthenic. The small number of papules and the apparent slight intensity of the lesions seem to be no criterion of the amount of irritation which they suffer, and the consequent insomnia and want of rest may have a most serious effect on their general health, leading even to suicide.

In adult patients suffering from pruritus, when no signs of pediculi, scabies, lichen planus, or other skin lesions can be found, it is most important to examine the urine for sugar. The onset of diabetes in many patients is very insidious, and one of the earliest symptoms may be a passing attack of pruritus which is at first relieved by a sedative application, only to recur in more severe form when the diabetes has thoroughly undermined the patient's health. This might have been avoided and the disease checked or cured if sugar had been found at first and a strict diet ordered.

In old persons any of the previously mentioned causes of pruritus may occur, but there is a cause of itching which is almost peculiar to them, and that is phthiriasis. That it occurs among the poor and neglected is of course well known, but even among the well-to-do it is not uncommon. Many people of advanced age become careless of personal cleanliness and appear to have a strong disinclination to baths. Moreover, they feel a greater need of warmth than the young and strong, and frequently sleep in their vest under their night attire, so the pediculi are a source of irritation both by day and night. In such individuals the skin is dry and deficient in secretion, and appears to be especially susceptible to the attacks of the insect. The scratch marks are at first most marked on the shoulders and upper part of the back and chest, but may become generalised, and are intermingled with the hæmorrhagic points caused by the bites of the pediculi.

TREATMENT.

Before deciding on the treatment appropriate to any case it is necessary to determine whether it is one of primary or secondary pruritus. No case can be regarded as a true

primary pruritus until all possible causes of external irritation have been eliminated. If after very careful examination no such causes can be found, inquiries must be made as to how far the patient's mode of life transgresses the usual hygienic principles and whether there is any evidence of diabetes, gout, or intestinal disease, as shown by investigation of the urine and blood and general physical examination. Any circumstances which might predispose to, or determine the onset of, pruritus must be inquired into, and the patient's diet and mode of life regulated accordingly. In almost every case alcohol, tea, and coffee must be forbidden, also rich and highly seasoned dishes. Some patients find relief from a vegetarian diet with plenty of milk, or, in default of this, they should live chiefly on poultry, green vegetables, and milk puddings, with plenty of Salutaris or slightly alkaline mineral waters. Rest and absence of worry have a favourable effect on neurotic patients, and it is often wonderful how much good a few weeks in bed or in a nursing home will do. Some pruritics are benefited by a change to the country or the mountains, or to a spa like Royat or Aix-les-Bains.

Internal treatment should begin by giving preparations of salicylic acid; salol, sodium salicylate, and salophen may be given alone or in combination with antipyrin or antifebrin or phenacetin. Carbolic acid in pill form is successful in some cases, arsenic and atropine may be tried, and pilocarpine (10-20 drops of a 1 per cent. solution) occasionally gives good results. But greater success is usually obtained with sedatives, especially bromide of sodium in combination with cannabis indica, or tincture of aconite with tincture of gelsemium. In more severe cases where insomnia is a marked symptom hypnotics are necessary—sulphonal, trional, chloral hydrate, or medinal.

External treatment must, however, always be employed in addition to internal remedies, and one of the simplest and most effectual applications is an evaporating lotion. Equal quantities of eau-de-Cologne and water applied on lint, which is kept moist with the liquid, or lavender water dabbed on every few minutes, often afford great relief, especially if preceded by hot applications. Sponging with hot water, as hot as can be borne, with or without the addition of bicarbonate of soda, or a hot bath, or better still a vapour or Turkish bath, causes dilatation of the capillaries of the skin, and the subsequent constriction of these vessels caused by cooling or evaporating lotions is not only more complete, but also induces a more lasting cessation of the itching. The addition to a hot bath of oatmeal is usually beneficial; or, still better, half a pound of gelatine made into a jelly with warm water and then added to the bath; or one pound of starch worked into a smooth paste with cold water and boiled, or half to one pound of linseed. Creosote and sulphurated potash are somewhat objectionable to sensitive patients, but the sulphur powders are a convenient method of making a sulphur bath which is not unpleasant. A combination of sulphur and pine oil bath is obtained by dissolving piutanol in the bath, and it gives good results. Of cooling lotions the simplest is one containing 2 drachms of liquor plumbi subacetatis to 1 ounce of lavender water and 7 ounces of distilled water. One containing hydrocyanic acid, which is very successful, is the following: dilute hydrocyanic acid ℥iss., spirit of rosemary ℥i., glycerine ℥ss., water to ℥x. Carbolic acid made up in the strength of ℥i. to ℥x. of water, with the addition of ℥ss. glycerine and ℥ss. eau-de-Cologne, gives a useful lotion, and, if necessary, to any of these lotions ℥ii. of cocaine may be added to give a greater anti-pruritic effect.

The best way to apply these lotions is to soak a single layer of lint or linen with the lotion, lay it lightly on the itching surface with no covering over it, and sprinkle or spray on fresh lotion every five minutes so as to keep the lint thoroughly moist.

Alkaline lotions, consisting of either ℥ii. bicarbonate of soda, ℥ii. carbonate of potash, or ℥i. borax to ℥viii. water, are all useful for cases where large areas of skin are involved, and the addition of a little menthol will increase the effect. Ichthyol ℥ss., sodium bicarbonate ℥iss., spirit of lavender ℥ss., water to ℥viii., is a lotion which often gives relief and may be used for weeks without harmful effects.

For general pruritus, ointments, sprays, paints, and varnishes are rarely suitable, but they all find their uses in

the localised forms of pruritus of which I am now about to speak.

In pruritus genitalium, and especially pruritus of the vulva, the hygienic and dietetic rules, already discussed in detail, must be adhered to. In the more usual cases of pruritus vulvæ, where there is a uterine or vaginal discharge, strict cleanliness must be enjoined with plentiful use of soap and water and douches of 1 in 5000 potassium permanganate or 1 in 5000 perchloride or 1 in 1000 zinc sulphate. After this a vaginal tampon must be inserted and the external parts covered with Lassar's paste containing 1 per cent. silver nitrate or lenigallol. An ichthyol ointment or paste may be substituted or an ointment containing 30 minims of chloroform to 2 ounces of lard, or the ordinary aconitine ointment. An ointment which often gives good results is the following: chloral hydrate, menthol, and camphor aa gr. 45, lanolin and vaseline aa ℥ss . The advantage of using an ointment is that the parts are protected from the action of any discharge which, in spite of the tampon, comes in contact with them. In my experience fluid solutions of menthol or carbolic acid usually cause intense smarting and soreness in these cases, and so do many spirit applications. The addition of cocaine in the strength of 5 per cent. is often advantageous and may be combined with oil of cade or anthrasol in the form of an ointment.

The more inveterate cases respond well to applications of a Paquelin cautery, to excision of kraurotic skin areas, or to turning up a flap of skin all round the vulva, and division of the afferent nerve fibres. In cases of diabetes the patient must be strictly dieted, and, if the urine cannot be always drawn off with a catheter, the vulva should be covered with some protective sedative dressing in the form of an ointment or soluble varnish. One of the best of these latter is unguentum casein with the addition of 2 per cent. ichthyol or 1 per cent. tar. Casein ointment is composed of alkali caseinate, glycerine, vaseline, and water, and forms a thick white emulsion which dries on the skin in a minute or two, forming an elastic, dry covering, which is readily washed off. On the one hand, it is porous enough to permit of evaporation; on the other, it contains fat which helps the added ichthyol or tar to make its way deeply into the tissues. It is therefore more than a protective varnish, and holds a position intermediate between the ointments on the one hand and the pastes and powders on the other. Methylene blue given in pill form, one grain night and morning, with a paint of methylene blue, four grains to the ounce, applied at frequent intervals, has the objection that it stains the urine blue, but if this does not contain sugar the treatment is often successful.

Pruritus of the anus is usually accompanied by some secondary eczema with the formation of rhagades and thickening of the skin. This thickening must first be got rid of, either by 3-5 per cent. salicylic ointments and plasters, or by daily applications of diachylon ointment. When the induration has diminished, the rhagades and excoriations have healed, and any hæmorrhoids present have been removed, an ointment of liq. carb. det. ℥ss . to ung. conii ℥i will relieve the itching. Or creosote ℥ss , tinct. aconiti ℥x , adipis ℥i ; or tinct. aconiti ℥iii , zinci oxidi ℥ss , calomelanos ℥ss , ol. rosmarin. ℥x , vaselin. alb. ℥i . These ointments are best used at night, bathed off in the morning with some olive oil, and the following powder applied: chloral hydrate, camphor aa gr. 40, starch ℥i . A 20 per cent. solution of ichthyol painted on frequently gives relief, and I prescribe with success this paint: ol. cadini ℥i , spt. coloniensis ℥ss , aq. dist. ℥i , tinct. quillaie q.s. ut fiat emuls. Equal quantities of lime-water and black wash make an excellent application, or chloroform ℥i to sweet almond oil ℥i , followed by a zinc oxide and calamine powder. Small enemata of half a drachm of medinal to an ounce of water, or 5 per cent. ichthyol in very hot water, may be alternated with suppositories of cocaine, morphia, or medinal, taking care that there is a regular action of the bowels at least once a day.

While speaking of suppositories, I do not wish to be taken as recommending morphia and cocaine suppositories to be taken regularly over long periods of time; indeed, I discontinue their use in any particular case as soon as possible; but as a temporary measure they are to my mind of the greatest service. It must be remembered that many patients scratch quite unconsciously during their sleep until the

cutaneous nerves have been numbed by the vaso-motor dilatation and exudation. And this in spite of any dressings which may be applied unless they are fixed very tightly in position. Such scratching may undo the whole benefit of the treatment employed during the day, and leave an excoriated and inflamed surface which takes some time to heal up. The dry skin of the aged is especially susceptible to such ill-treatment, and these patients also sleep less soundly than the young and robust. In such cases I do not hesitate to give morphia or other suppositories, at any rate when they first come under treatment, with the greatest benefit to the patient.

In the most obstinate cases a rapid application of the actual cautery to the most irritating areas often causes great amelioration of the symptoms. Application of the high frequency current with a glass electrode is occasionally successful, and cases frequently react well to two or three $\frac{1}{2}$ pastille doses of X rays at intervals of a week. The action of X rays on pruritus is not easy to explain, but I have seen cases which resisted all other treatment cured, at least for a time, by this means.

A more permanent cure, and one to be recommended in those intense cases when life has become a misery, is that of surgical operation. Such operations all aim at division of the cutaneous afferent nerves, and if this is done the area supplied is, of course, rendered temporarily anæsthetic. Sensation recurs in from three weeks to a month, but the pruritus does not return for years, if at all, in that area. In Ball's operation incisions are made on either side of the anus and flaps are turned up, leaving a small pedicle of skin which is undercut, as also is the skin in an outward direction. The flaps are separated up to the white line, but the hæmorrhoidal vessels are only slightly interfered with, so that there is no sloughing. The results of this operation are excellent, and for really serious cases it may be strongly recommended.

Time does not permit of my dealing with the treatment of all the diseases of the skin individually which are accompanied by itching, and I need only say that the treatment in every case must be primarily that of the skin disease and only secondarily that of the pruritic symptoms. In mycosis fungoides and some cases of lichen planus these symptoms may be so severe as to overshadow everything else, and under these circumstances it is necessary to resort to some of the principles and remedies which I have already fully discussed under the heading of pruritus. And by the choice of suitable treatment and attention to detail success will be attained, rather than by the employment of the latest and most extensively advertised new drug.

UNIVERSITY OF SHEFFIELD.—The Council at its last meeting made the following appointment: Mr. Alexander Wilson, M.B., Ch.B. Aberd., to the post of demonstrator in anatomy. The Council received the following resignation: Mr. A. Garrick Wilson, F.R.C.S. Eng., as honorary demonstrator in anatomy, in consequence of his appointment to the tutorship in surgery in the University. Mr. H. K. Stephenson was appointed representative of the University on the West Riding County Association.

PRESENTATIONS TO MEDICAL MEN.—Mr. James Waterston, L.R.C.S. Edin., who is the oldest medical practitioner in Sunderland, has been presented with an illuminated address, a specially designed arm-chair, and a smoker's outfit from the staff and committee of the Sunderland Provident Dispensary. Mr. Waterston is one of the medical officers connected with the institution, and for 14 years occupied the position of vice-chairman. For the past 14 years he has acted as chairman.—Mr. W. H. M. Barclay, M.B., C.M. Edin., who is Provost of Grantown, was on April 23rd presented by his patients and friends with a handsome motor-car and a cheque for £241 in recognition of his faithful and untiring services as a medical man in the town and wide district over which his patients are scattered. Mrs. Barclay was also presented with a silver salver bearing the inscription: "Presented to Mrs. Barclay on the occasion of the presenting of a motor-car to Dr. William Barclay, Provost of Grantown-on-Spey, as a tribute of public esteem and in recognition and appreciation of his public services and self-sacrificing labours as a trusted and skilful physician doing 30 years' strenuous professional work in Strathspey. April 25th, 1910."