Lieutenant-Colonel W. D. Sutherland has been appointed Lecturer in Forensic Medicine under the Government of India. Lieutenant-Colonel J. G. Jordan, civil surgeon at Monghyr, has been granted six weeks' leave of absence. Lieutenant-Colonel S. Browning-Smith has taken up duty at Lahore as Chief Plague Medical Officer in the Punjab. The services of Lieutenant-Colonel R. Robertson have been placed temporarily at the disposal of H.E. the Commander-in-Chief in India by the Home Department of the Government of India.

Major M. Corry, civil surgeon at Multan, has taken up duty as Officiating Professor of Forensic Medicine and Toxicology at the Government Medical College, Lahore, relieving Major E. S. Peck, granted leave of absence. Major A. E. Walter, superintendent of the X Ray Institute at Dehra Dun, has arrived home on one year's leave of absence from India. Major G. Y. C. Hunter has taken up duty under the Behar and Orissa Administration on transfer from the Bengal Jail Department. Major W. G. Richards has arrived home on leave of absence from Madras. Major C. B. Harrison has been granted six months' extension of his leave of absence on medical certificate. Major C. Bowle-Evans has been appointed to the substantive Medical Charge of the Second Battalion of the 8th Gurkha Rifles, rendered vacant by the appointment of Lieutenant-Colonel P. Hehir as Assistant Director of Medical Services to the Burma Division. Major A. M. Fleming, civil surgeon, Central Provinces, has been granted leave of absence for four months and 28 days for purposes of study in extension of the combined leave already granted.

Captain F. C. Fraser has been appointed to the substantive Medical Charge of the 108th Infantry at Bangalore, vice Major W. H. Cox, D.S.O. Captain J. C. Fraser has returned to India at the expiration of his leave of absence home. Captain K. S. Thakur has been selected for appointment as Specialist in Radiography and Electrical Science. Captain D. S. A. O'Keefe has been granted six weeks' privilege leave of absence. The services of Captain F. P. Mackie, officiating chemical examiner and Government analyst to the United Provinces of Agra and Oudh, have been replaced at the disposal of the Government of India in the Home Department. Captain R. Kelsall has been granted six weeks' privilege leave of absence. Captain C. H. Fielding has been appointed to officiate as Superintendent of the Insein Central Jail in relief of Captain A. S. Leslie, transferred. Captain J. H. Horne has been placed on deputation to Amritsar in connexion with the suppression of malarial fevers. Captain T. C. Rutherfoord has taken up duty as civil surgeon at Bilaspur on termination of his leave of absence. The services of Captain C. A. Godson have been transferred from the Assam Administration to the Bengal Government. Captain S. A. Russak has been granted general leave of absence for one year. Captain E. B. Munro has been selected for appointment to the substantive Medical Charge of the 89th Regiment of Punjabis stationed at Meiktila, Burma, in succession to Lieutenant-Colonel C. J. Sarkies.

ROYAL NAVAL VOLUNTEER RESERVE.

Surgeon Arthur Douglas Cowburn to be Staff-Surgeon (dated Oct. 29th, 1912).

SPECIAL RESERVE OF OFFICERS.

Royal Army Medical Corps.

Henry Brice Parker to be Lieutenant (on probation) (dated Oct. 11th, 1912).

TERRITORIAL FORCE.

Royal Army Medical Corps.

London Mounted Brigade Field Ambulance, Royal Army Medical Corps: Lieutenant Hugh S. Beadles to be Captain (dated Sept. 5th, 1912).

4th London Field Ambulance, Royal Army Medical Corps: Lieutenant William Cowie to be Captain (dated Oct. 7th, 1912).

Attached to Units other than Medical Units.—Lieutenant Kenneth S. Storrs to be Captain (dated Sept. 6th, 1911). Captain William A. Taylor to be Major (dated Oct. 30th, 1912).

DEATHS IN THE SERVICES.

Deputy-Surgeon-General Joseph Christian Corbyn, at Cheltenham, on Oct. 24th, in his eighty-third year. He served for some years in the Bengal medical branch of the Honourable East India Company, and was actively employed during the whole of the Indian Mutiny, being present throughout the siege and final capture of Delhi and the taking of Lucknow, and engaged in the pursuit of Nana Sahib. He served also with the Sikh cavalry, and in consequence of his linguistic ability he was frequently employed on delicate and dangerous outpost work (mentioned in despatches). Surgeon-General Corbyn was the founder of the first female medical school in India.

BRITISH RED CROSS SOCIETY.

In THE LANCET of Oct. 26th, p. 1168, we called attention to Lord Rothschild's important appeal on behalf of the British Red Cross Society in connexion with the sick and wounded in the Balkans. The public response to that appeal has so far been about £13,900, of which some £7500 have been expended in equipping and despatching six units in all in three expeditions to Montenegro, Greece, and Turkey. A further appeal has now been issued for funds to equip and maintain two other units which have been offered. The total expenditure of the society is about £1000 per week. Contributions should be sent to Messrs. Coutts and Co., 440, Strand, W.C.; or the secretary, British Red Cross Society, 9, Victoria-street, London, S.W.

Two units left Victoria Station on Nov. 3rd for Bulgaria, one of which was subscribed for entirely by Sussex people. The units will be met at Belgrade by Surgeon-General Bourke, who will travel with them to Sofia.

Mr. J. Lynn Thomas, C.B., is organising a British Red Cross Society Welsh unit for service in Servia, which it is hoped will be despatched by to-day (Friday).

STAFF TOUR FOR MEDICAL SERVICES IN IRELAND.

A staff tour for practising the Medical Services in the Irish Command was held last week at Glengariff, county Cork The directing staff consisted of Colonel G. F. Milne, C.B., D.S.O., General Staff, Sixth Division; Colonel M. W. J. Edge, Assistant Director of Supplies and Transport, Irish Command; Colonel R. H. S. Sawyer, A.M.S., Acting Deputy Director of Medical Services, Irish Command; Major C. Dalton, R.A.M.C., Deputy Assistant Director of Medical Services in the Irish Command; Major W. H. F. Weber, Commanding 148th Battery, R.F.A.; Major J. C. Dorgan, R.A.M.C.; Major J. H. Brunskill, R.A.M.C.; and Captain H. L. G. Bell, R.E. The following Royal Army Medical Corps officers took part in the exercises: Colonel H. O. Trevor; Lieutenant-Colonels W. C. Beevor, C.M.G., and N. Manders; Majors C. B. Martin, H. G. Martin, R. L. Popham, F. G. Richards, and W. M. B. Sparkes; and Captains O. L. Harding, C. H. Turner, W. F. H. Vaughan, P. Dwyer, and R. J. Franklin.

Correspondence.

"Audi alteram partem."

ON THE TREATMENT OF PULMONARY TUBERCULOSIS BY THE PROLONGED INHALATION OF ANTISEPTIC AND SEDATIVE VAPOURS.

To the Editor of THE LANCET.

SIR,—I see it announced in THE LANCET that on Tuesday, Nov. 5th, Dr. D. B. Lees will deliver the Bradshaw Lecture at the Royal College of Physicians of London, when the above subject is sure to come under notice.[1] In November, 1909, Dr. Lees narrated, before the Royal Society of Medicine, a series of cases of early pulmonary tuberculosis which he had treated by the continuous inhalation of mingled antiseptic and sedative vapours, with the result that of the 30 cases detailed, 22 were restored to health, while the remaining 8 were signally improved. When Dr. Lees announced these remarkable results[2] it is no wonder he was tempted to exclaim: "The practical extinction of the disease known as pulmonary phthisis is within our grasp."

It might have been expected that the publication of results so startling, obtained by means easy of application, devoid of risk, and within the reach of the humblest sufferer, would

[1] See page 1268.

[2] Royal Society of Medicine, Therapeutical Section, Nov. 2nd, 1909.

have led to the early and extensive trial of a method that had so much to commend it to the attention of practical men. Yet the announcement which Dr. Lees made with such high hopes and which he based on a long series of cases, most of them treated in collaboration with other practitioners, all carefully observed and recorded, not hurried into print, but gradually accumulated in the course of four years' practice before they were submitted to the Royal Society of Medicine, roused so little interest in that learned body that in 12 months no observations, whether favourable or unfavourable to Dr. Lees's claim, had been recorded in its Proceedings. A year later Dr. Lees published in THE LANCET [3] a second series of cases collected during the year that had just elapsed and yielding results very similar to those of the earlier series. On the same occasion the history of those earlier cases was brought up to date, when it was found that the 22 patients reported as having recovered had stood the severest of all tests, the test of time, while several of the remaining eight had since been transferred to the category of the cured.

After commenting on this article, you, Sir, added the practical and significant remark: "It would be interesting to know whether other physicians obtain the same results." This pointed appeal to other physicians to make trials and publish results drew but one solitary reply. Dr. I. Burney Yeo, who had years before done pioneer work in this province, having, indeed, originally devised the simple orinasal apparatus as well as the plan of continuous inhalation of creosote and its allies, of which Dr. Lees is now the champion, gave an account of his experience in former years of the treatment of phthisis by this method, and stated that he had seen remarkable improvement in many of his patients, although he had never obtained the supreme reward—arrest of the disease.[4]

It is difficult to explain this paucity of the testimony to which the Editor opened these columns. But certain it is that whilst the treatment of the victims of phthisis by pneumothorax (among other portents of the day) has found some following, a sane, safe, and simple procedure, tested and advocated by a distinguished practical physician, and intended to arrest the beginnings of the disease, still awaits an adequate trial. It may be that the generous enthusiasm of the advocate, instead of inspiring his brethren with hope, has but moved them to a sceptical smile at the contrast between the simplicity of the means employed and the magnitude of the results obtained. The traditions of pulmonary consumption are, indeed, still so sombre that we are too ready to assume that its arrest is not to be effected by simple measures. Yet the pathologist often comes upon traces of colonies which had thriven for a time, but had ere long become quite extinct, in the lungs of persons whose histories betray no indications of such episodes. Equally strong and still more frequent evidence of an abortive pulmonary tuberculosis is to be drawn from clinical observation, as where a young adult in the apparent plenitude of health is surprised by hæmoptysis, where either the detection of the bacillus or the physical signs establish the diagnosis, yet where recovery follows upon a holiday on the Alps, or under simpler conditions still, such as that if a man's work must be in the city his home shall be in the country. These evidences that the bacillus is often entertained unawares, only to be checked and destroyed without observation, or by purely hygienic measures, may give encouragement to try the simple methods under consideration.

Dr. Lees is aware that so fair an array of successes could not have been obtained unless the disease had been detected and treated in its early stage. And on the momentous question of early diagnosis he has a message to deliver, insisting that we must attain it long before the bacillus can be found, for that definite characteristic physical signs are present for weeks or months before the patient begins to expectorate, and that to suspend the diagnosis until tubercle bacilli are discovered in the sputum is like delaying the diagnosis of cancer until the glands are involved. He maintains that the text-book statements of the earliest physical signs are erroneous in assigning greater importance to auscultation than to percussion, and quite inadequate in the information given as to the regions of the thoracic wall where we may expect to find the earliest changes. Dr. Lees's teaching on the regional distribution of the physical signs forms an application to clinical procedure of the interesting results of Sir James Kingston Fowler's important investigation into the topographical anatomy of pulmonary tuberculosis. This pathologist was the first to show, in his article on the Site and Progress of the Lesions of Phthisis,[5] that the upper and posterior part of the lower lobe of the lung primarily attacked is only second in vulnerability to the apex itself, and that it is usually affected at a very early period of the disease. "The infiltration of the lower lobe at this site in the early stage ..... is one of the most constant features in the pathological anatomy of the disease, and its recognition is a point of the greatest clinical importance, as the existence of a lesion at this spot, coincident with the physical signs at the apex, even though the latter are in themselves of doubtful import, is ..... almost positive proof of the presence of tubercular disease of the lung. It may be of great service in cases where tubercle bacilli are absent from the sputa." Guided by these and other facts of pathological topography, which have not yet found their way into many of the text-books, and of which he sets forth the details in the papers above cited, Dr. Lees points the way to an earlier diagnosis of phthisis. The opinion that in this inquiry percussion is of greater value than auscultation has also been maintained by Skoda, Walshe, and Fowler.

The following case, which made a strong impression on more than one observer, was treated in accordance with Dr. Lees's principles.

A lady of fine physique and in the prime of life began, in the spring of 1909, to be harassed with cough, catarrhal expectoration, and hoarseness. There was no general indisposition. The expansion and resonance of the chest were unimpaired and the temperature was normal. But rhonchi were abundant in the larger and middle tubes, greatly preponderating on the left side; and the tubercle bacillus was found. An eminent laryngologist detected a rough thickening in the interarytenoid space. The months of July and August were passed in the Engadine, where, although the summer was cold and stormy, the cough became mitigated and the expectoration easier, whilst appetite and sleep were excellent. But, forbidden to use her voice, and placed with one companion in the remote station of Maloja, tired of foreign life and fare, she formed, on leaving the Engadine, the unfortunate resolve never to revisit the Alps in quest of health. On her return the bronchial catarrh was found to be less extensive, pulmonary resonance and expansion continued unimpaired, the interarytenoid infiltration was less marked, and the temperature was normal.

The greater part of the winter was passed on the south coast, where bronchial attacks became frequent and where for the first time hæmoptysis occurred. On her return to London in the spring the left upper lobe was found to be the seat of massive consolidation, with close and fine bubbling, and indications of small cavities. The right lung remained as resonant as before, with but little rhonchus. The cough was distressing, the voice hoarse, there were night perspirations, and hæmoptysis soon recurred. Tubercular infiltration was now found in both aryepiglottic folds and in the epiglottis. At this juncture, when this fine frame seemed to be within measurable distance of becoming a total wreck, Dr. Lees's plan of prolonged inhalation was adopted, the inhaler being charged with creasote and menthol. The prompt relief afforded and the successive salutary changes that took place in the physical signs shall now be recorded, and will embody the observations of the eminent authority who shared in the management of the case.

The patient's own report was that the inhalation "miraculously stopped cough, expectoration, and sickness." In two months' time the left upper lobe was found to be quiescent and the rhonchi much less extensively moist. The larynx was greatly improved, the voice was almost clear, and the patient declared herself to be "fit." By the end of four months the left lung had become resonant in the main, with bronchial breathing in places, and some rhonchus. The patient seemed marvellously well. At the end of six months, but for one's knowledge of the condition of the chest when the inhalation was begun, there would have been the greatest possible difficulty in diagnosing tuberculosis, the physical signs over the left lung being almost too like the signs over the right lung for one to distinguish the affected parts. The larynx was pronounced to be normal.

In the second winter some months were again spent on the

[3] Nov. 19th, 1910.
[4] THE LANCET, Jan. 17th, 1911.
[5] Fowler and Godlee: Diseases of the Lungs, p. 350.

south coast, where there was a disposition to attacks of bronchial catarrh and to fatiguing fits of wheezing rhonchus. After leaving the south coast the tendency to chills ceased, and although the noisy wheezing attacks continued the patient felt perfectly well, and during a summer holiday in North Wales could bathe in the sea every morning and walk 12 miles or more with ease.

Such a result, although not perfect, is wonderfully good. And it is to be noted that whereas Dr. Lees postulates that his method be applied in the early stages, in the case just narrated the disease was advanced and advancing. So that if the argument *a fortiori* be ever applicable, it may be fittingly employed here, where some slight and apparently inert organic damage is all that remains to testify to the severity of the past invasion of the lung. The course of the illness would doubtless have proved less eventful and its issue even more perfect had the patient, still fairly vigorous, instead of lingering on the south coast, passed the first winter in some lofty and sheltered Alpine valley and shared in the Alpine pastimes. But simple measures and home life, a conjunction not brought about until the disease was far on its way, have here been followed by results that might still be claimed as admirable had they ensued upon a winter spent among the wonder-working heights of Switzerland.

I am, Sir, yours faithfully,

Queensborough-terrace, W., Nov. 2nd, 1912. S. N. BRUCE.

THE USE OF ANÆSTHETICS IN EXPERIMENTS ON ANIMALS.

To the Editor of THE LANCET.

SIR,—I find that a passage in the Report of the Royal Commission on Vivisection has conveyed the impression that I regard the frequent use of anæsthetics as unnecessary in experiments on animals. I wish to state in the most unqualified manner that I regard the use of anæsthetics as right and necessary in every case where appreciable pain would otherwise be inflicted, except in the cases (provided for in existing legislation) where the object of the experiments is of sufficient importance and would not be attained if anæsthetics were used, or where, if the animal were allowed to recover, the after-effects of the anæsthetic would cause more pain or discomfort than the operation. I also wish to state that in any experiments I may do I comply strictly with the existing law, although, as I stated in my evidence before the Commission, it in some respects defeats its own objects and causes much unnecessary trouble to those engaged in the advancement of medical knowledge.

I am, Sir, yours faithfully,

London, Nov. 4th, 1912. M. S. PEMBREY.

THE MEDICAL PROFESSION AND THE NATIONAL INSURANCE ACT.

To the Editor of THE LANCET.

SIR,—With reference to the appointment of the district medical officer of health as a part-time assistant tuberculosis officer, it was none too soon for the council of the Society of Medical Officers of Health (on the motion of a district medical officer of health) to pass a resolution to the effect that the position and responsibility of the district medical officer of health should be fully recognised in any tuberculosis scheme. I shall leave it to others to advocate the claims of the *part-time* district medical officer of health, and shall for the most part confine myself to the case of the *whole-time* district medical officer of health—for example, one who is medical officer of health for a combination of districts, and perhaps a school medical inspector as well, and one who has some time to devote to additional work.

In large areas the chief tuberculosis officer will probably require the assistance of one or more assistant tuberculosis officers to take his place occasionally at the hospital, institute, dispensary, or visiting station, or even to call at the patient's home in consultation with the patient's doctor. One or more *whole-time* assistants could, of course, be appointed. Considerations of economy may, however, point to the appointment of local men. In that case who should be more able to render such assistance than the average whole-time district medical officer of health? Take the tuberculosis dispensary as an example. What, according to the model scheme of the British Medical Association, should the work of the dispensary consist of? Diagnostic, consultative, bacteriological, and statistical work, with perhaps certain special forms of treatment (e.g., by tuberculin) approved of by the patient's doctor. Working as he would be under the supervision of the chief tuberculosis officer, would not the average whole-time district medical officer of health be capable of doing such work? As regards diagnostic and consultative work, he has had the usual clinical training in a general hospital, he has had further clinical training in a fever hospital, and, in fact, is often called in consultation in fever cases. He has also had in most cases experience of private practice, and if a school medical inspector as well he gets experience in diagnosing disease in scores of school children every week. Dr. R. A. Lyster, in his exhaustive tuberculosis scheme for Hampshire, has in mind apparently the utilisation of assistant school medical officers for this work.

Even apart from previous special training in tuberculosis work the opinion of the assistant medical officer of health would still be useful to the general practitioner, for two heads are better than one, and further, by frequent contact with his chief and this special kind of cases, he would soon become by no means a mean substitute. As for bacteriological ability, of course, his diploma would be sufficient guarantee for that, and with regard to statistical work, his previous experience as a health officer would eminently qualify him.

It seems to me that several advantages would attach to the district medical officer of health being also assistant tuberculosis officer. As against appointing a practitioner to such an office, it would be but natural for the bulk of practitioners in a locality to prefer consulting (in the absence of the chief officer) with the medical officer of health rather than with a rival practitioner, who would thus be in a manner enhancing his own prestige at their expense. The medical officer of health would also have a chat with the patient about housing matters, which might lead to administrative action. He would also enjoin precautions in the interest of the public health. One great advantage a whole-time medical officer of health would have over a general practitioner would be that he could arrange to attend the dispensary at a fixed hour or make an appointment and keep it without having to leave a patient or run the risk of being some distance from home when an urgent call came. Again, while all cases of pulmonary tuberculosis are expected to be notified to the district medical officer of health, the latter, as far as the Government orders already made are concerned, is expressly forbidden to publish the patient's name and address. In fact, there are responsible persons who advise the district medical officer of health to comply strictly with Article VII.(a) of the Public Health (Tuberculosis) Regulations, 1911, which provides solely for the inspection of registers by certain persons and does not require a medical officer of health to give any information in writing. Further, it has been stated that in the event of a patient incurring pecuniary loss through leakage of information, the medical officer of health might be held liable to damages. A medical officer of health, however, whose active interest had been enlisted in the campaign against tuberculosis could be trusted to make the utmost legitimate use, tempered by due discretion, of the information in his possession. This would lead to the discovery of "contacts," as would also action following upon the death of a person from tuberculosis, such deaths being, of course, immediately notified to the medical officer of health by the registrar.

As a conference of representatives of the British Medical Association with representatives of the Society of Medical Officers of Health is to take place on Nov. 12th, I trust that some such considerations as the above will receive adequate attention. Another matter that might well be pressed forward by the latter society is that on the Local Medical Committees to be formed the district medical officer of health should have adequate representation, and also the British Medical Association might be urged to exert their influence to secure a due representation of the district medical officer of health on the County Insurance Committees, so that he might not be present in a subordinate position and to give information only, but be on equal terms with the other members of the committee. In Wales, at least, the district councils, being the original, and until lately the only, sanitary authorities, are moving to get direct representation on the County Insurance Committees.

What is the basis of the anticonsumption crusade but the fact that tuberculosis is an infectious disease, and in whose province has the control of infectious diseases been regarded