

1. The utility of the Advisory Board has called forth great diversity of opinion. Those who think the institution of such a board most admirable are equal in numbers to those who condemn it absolutely. Considering the very wide range of subjects which must come within the purview of those who are responsible for the administration of the medical services of the army it would seem that an Advisory Board is almost a necessity. It is an Advisory Board and not an Executive Board. The executive rests with the Director-General. There is nothing in the report to justify the comment of one critic that under the new scheme "the Director-General as a personal factor in the R.A.M.C. practically disappears," nor is there any basis for the suggestion that the board is the outcome of a mistrust in the executive. It would not be difficult to show that an Advisory Board, such as is suggested, would greatly strengthen the hands of those who are charged with the varied responsibilities of administration. Those who condemn the board under the impression that promotions are made by it should read paragraphs 14, 18, and 19 of the report in which it is clearly laid down that the Director-General is "responsible for promotion."

2. The system of examinations has led to much adverse comment. It is the purpose of these examinations to make promotion in the service dependent upon professional ability and to grant the fullest advantages to the officer who does his best to keep his medical and surgical knowledge abreast of the times and who has taken the pains to master some speciality in practice. After receiving his commission an officer under the new scheme undergoes three examinations in the place of two which formerly existed, one of which has sunk into abeyance. So great an alteration has been made in the entrance examination that it has ceased to be the vexatious and irritating test that it was. All the examinations are intended to be practical and as far as possible by *viva voce*. The system of testing proficiency by examination is—and always has been—open to considerable question. This applies not only to these particular tests but to all medical examinations. The powers that be, however, have not yet devised any method other than that of examination whereby the entrance of a candidate into the profession can be determined or his fitness for the higher degrees decided. In many hospitals the selection even of house surgeons is by examination. Indeed, at present no other means presents itself which could be regarded as just and adequate except the testing by examination, and it is noteworthy that those who object to such testing in the case of the Army Medical Service have suggested no substitute measure. No one has recommended that promotion should depend upon "confidential reports," and I imagine that no one could be found who would defend that unjust and objectionable system. It must be remembered that while mere promotion is by an examination which tests the officer's capabilities as a professional man, the selection of officers for special appointments rests with the Director-General who will no doubt be influenced by evidence of special fitness in those eligible for such appointments. The examination which has excited most comment is that for promotion to the rank of lieutenant-colonel. This must be passed before the officer has completed 20 years' service and as a preparation for it a period of three months' study is granted. The examination does not deal with medicine or surgery or with any allied science. It is concerned solely with the very administrative work which the officer will—if promoted—be called upon to carry out. Among the subjects are the following: "Hospital organisation, administration, and equipment in peace and war," "The sanitation of towns, camps, troop transports, &c.," "Epidemiology and the management of epidemics," and "The duties of all ranks in the Royal Army Medical Corps." (It is probable that no great stress would be placed upon two of the subjects—viz.: "The medical history of important campaigns" and "The army medical services of other Powers.") The candidate is required to obtain 50 per cent. of the total number of marks. If he fails he is allowed to present himself for a second examination at the end of six months. If he again fails to obtain 50 per cent. of marks he is "compulsorily retired on a gratuity of £2500, or he may, by special permission of the Secretary of State, complete 20 years' service and then retire on a pension." While every possible consideration should be shown to any officer who has been in the service for nearly 20 years it can scarcely be considered a hardship if before he is raised to a position involving very responsible duties he should be asked to give evidence of a minimal knowledge of the matters appertaining to those duties. Moreover, should

it become evident, after two trials, that he does *not* possess that knowledge it would hardly be right to promote him to a post in the qualifications for which he has shown himself hopelessly lacking. No man competent to undertake the duties of the higher rank could object to the examination. The incompetent man naturally would object to it.

3. On the subject of pay I am not competent to speak. I would only say that from a comparison of the proposed rate with that now in vogue it would appear that the increase is substantial and generous. It is possible that the scale will need amendment in certain directions, and it is possible also that the much-cherished "right" to retire after 20 years' service on £1 a day has not been so entirely overlooked as some who have written on this subject suppose.

I am, Sirs, yours faithfully,
Wimpole-street, London, W. FREDERICK TREVES.

To the Editors of THE LANCET.

SIRS,—“I am the commanding officer,” was the reply of the chief medical man on board an American hospital ship, which with regard to equipment and management is described as “approaching perfection,” when he was asked where the captain was. If our Army Medical Service is to approach perfection the chief surgeon with an army in the field must in like manner be his own commander, subject only to the general. At present the chief surgeon is expected to serve many masters, and the highest authority has pronounced that to be impossible. Until the chief surgeon is delivered from the power, amongst others, of the commissariat and ordnance departments he never will be able to do justice to the sick and wounded during a campaign. Transport and equipment should be under his control. This means money, and a great deal of it, and it is imperative that the people of England should know how the matter stands. If they choose to find the money well and good, but it is unfair to blame the surgeons for failing to do impossibilities.

I am, Sirs, yours faithfully,
Oct. 28th, 1901. PROPHYLAXIS.

ARSENIC IN BEER: THE EPIDEMIC OF PERIPHERAL NEURITIS.

To the Editors of THE LANCET.

SIRS,—In answer to your kind request that we should state the facts of our position with regard to the recent epidemic of peripheral neuritis we take pleasure in sending the following particulars:—

In September of last year we noticed the excessive incidence of peripheral neuritis in patients attended both in and from the Chester Infirmary, and quite independently concluded that many of the cases more closely resembled beri-beri than any other disease of which we were cognisant. Knowing of the recent epidemic at the Richmond Asylum, Dublin, we communicated with Mr. Conolly Norman, who very kindly, on Nov. 12th, sent us his notes on the subject. A perusal of these strengthened our opinions, and on Nov. 17th we completed a paper which appeared in the *British Medical Journal* of Dec. 1st. On Nov. 23rd we learnt with some surprise of a similar epidemic in Manchester, and on the evening of that day one of us (J. R. P.) went over, and, through the courtesy of Dr. Corsar Sturrock, was allowed to see several of the cases in the Manchester Royal Infirmary and was able to demonstrate the presence of a peculiar pre-tibial and pre-sternal oedema in each case, a point which had up to then escaped observation there. On the morning of Nov. 24th we called upon the medical officer of health of Chester, and with him saw the chairman of the Public Health Committee, and with a view to eliminating our theory of the disease we urged that an expert in tropical diseases should be asked to see the cases at once. Accordingly on the next day Major Ronald Ross came over, and by the kind permission of the medical staff saw 10 of the home and in-patients of the Chester Infirmary, and expressed his opinion that the disease resembled tropical beri-beri even to the minutest details. Major Ross forwarded a communication to that effect which appeared in THE LANCET of Dec. 8th, p. 1677. With regard to the etiology of the disease we cannot do better than refer you to our conclusions which appeared in the *British Medical Journal* of Dec. 8th. Our main contention was the extreme resemblance which the cases presented to beri-beri, and we expressed the opinion that they were either this disease or

that a condition indistinguishable from it could be produced by some other cause. These ideas were very adversely and, we think, unfairly criticised, and now, after the lapse of nearly a year, appear to be receiving considerable confirmation.—We are, Sirs, yours faithfully,

W. A. NEWALL, M.D., Ch.B. Vict.

J. R. PRYTHERCH, M.B., Ch.B. Edin., M.R.C.S. Eng.,
Oct. 28th, 1901. L.R.C.P. Lond.

THE NEEDS OF THE ROYAL LONDON OPHTHALMIC HOSPITAL (MOORFIELDS).

To the Editors of THE LANCET.

SIRS,—A year has now passed since the governors of the Royal London Ophthalmic Hospital were summoned for rates. At that time, thanks to the publicity given to the case, both by the London and by the provincial press, many friends sent prompt and generous help enabling the committee to meet this demand, and the rates were fully paid. The committee, have now, however, to face a similar demand, and this at a time when they are seriously hampered in their endeavours to meet the ordinary expenses of the hospital, by reason of the calls on the charitable public of other and more national demands. We, therefore, beg you to help them by making known to the public the very grave position of this great charity.

The committee had hoped that during the last session of Parliament an Act would have been passed to relieve hospitals, wholly or in part, from rates, but, although the Select Committee appointed by the House of Commons made their report as far back as July, 1900, there has been up to the present no legislation on the subject. The report called attention to the numerous anomalies existing in the rating of hospitals, some of which are exempted from rates by local statutes, while many have been treated with the greatest consideration by the rating authorities. On the other hand, the rates are a heavy burden to some hospitals, but few are so terribly crippled by them as the Royal London Ophthalmic Hospital, which is still compelled to keep half its beds closed, and although last year the annual subscriptions amounted to £1096, out of these rates and taxes to the extent of £896 had to be paid. This year the hospital has already paid £700 on this account, and now a further demand is made for £250. The local rating authorities say they cannot lower the assessment, and point out as one reason that this great hospital does not exist for the relief of the district or even of the City alone, but receives patients from every part of the kingdom. Therefore, the committee appeal to all for help to enable this national charity to tide over a pressing emergency.

Donations and annual subscriptions may be paid to Williams Deacon's Bank Limited, 20, Birchin-lane, E.C., or to the Secretary at the Hospital.

We are, Sirs, yours faithfully,

AVEBURY,
President.

H. P. STURGIS,
Chairman of the Committee of Management,

HY. DAVISON,
Chairman of the Finance Committee.

Royal London Ophthalmic Hospital (Moorfields Eye Hospital),
City-road, E.C., Oct. 29th, 1901.

"ACUTE DILATATION OF THE STOMACH"

To the Editors of THE LANCET.

SIRS,—The following remarks may be of interest in connexion with the paper on Acute Dilatation of the Stomach, with Illustrative Cases, read before the Royal Medical and Chirurgical Society on Oct. 2nd by Dr. H. Campbell Thomson¹ THE LANCET.² Acute gaseous dilatation is of frequent occurrence, often associated with agonising pain and with a feeling of impending death, yet not fatal. In cases of this sort there is no permanent obstruction; usually unaccompanied by vomiting they tend to be relieved by it when it does occur. In them the pain is due to the excessive pressure of gastric inflation superadded to the normal or to an increased volume of intestinal gas, and the abdomen is

enlarged, but to a great extent into the thorax. Fatal cases such as are brought forward by Dr. Thomson differ from them in all those particulars. The pain is not acute, vomiting does not relieve, the abdominal distension is not necessarily considerable or may be almost absent, the gastric distension makes for the abdomen rather than for the thorax, and the intestine is almost airless. Death occurs from the exhaustion of vomiting rather than from pressure. These are essentially cases of obstruction.

As noted by Dr. Thomson, the dilated stomach is bent at an angle, and, as I have repeatedly demonstrated in the post-mortem room, not only the pyloric portion, but the first part of the duodenum, is apt to take a sharply ascending direction, and the pancreas is also made to slope. The mechanism of the distension is obscure, and although in both groups we may admit a large element of disturbed innervation we are still unable to determine where the gas or the fluid may come from. But the mechanism of the fatal obstruction is capable of explanation and sometimes of relief, at least in a section of the cases. That in these the pylorus is not the seat of absolute obstruction is almost proved by the circumstance, urged by Dr. Voelcker in the discussion on the paper, that bile is vomited: it is entirely proved, as in Dr. Thomson's Case No. 2, by the fact that the first portion of the duodenum is distended as well as the stomach. As to Dr. Thomson's other cases, it may perhaps be allowable to suppose, in the absence of any statement to the contrary and on the strength of definite observations made in other instances, that in them the duodenum may have been in an analogous condition. Collateral evidence of the absence of pyloric stricture is afforded by the 10 cases which he tabulates,³ only one of which presented pyloric disease (described as "narrowing the orifice"), whilst in the remainder no abdominal lesion was found except in two cases where the disease was in the vicinity of the duodenum. The combination of a collapsed intestine and of a distended first part of the duodenum, as in Dr. Thomson's Case No. 2, sufficiently localises the obstruction. The latter is found, as was shown by Rokitsky, and later by Glénard, Kundrat, Schnitzler, Albrecht, and others, at the junction of the jejunum with the transverse portion of the duodenum; this is strangled by the weight of the collapsed intestine which drags the mesentery, and particularly the superior mesenteric artery, as a cord over it. According to this view the collapse of the intestine, howsoever produced, whether from marasmus or more often from shock or exhaustion, is the primary event and not the result of compression by a dilated stomach, and obstructive gastric distension follows. As mentioned by P. A. Albrecht, whose exhaustive essay in Virchow's Archiv⁴ was referred to in a joint communication made by Mr. F. Jaffrey and myself to the Harveian Society of London⁵ "on a case of uncontrollable vomiting relieved by laparotomy and manipulation, and due to the pressure of an aneurysm," the individual length of the mesentery is one of the etiological factors. Intestinal collapse further elongates it so as to allow the intestine, particularly in women, to drop like a dead weight permanently into the pelvis. It is unnecessary that I should dwell upon the other factors and upon the various views which have been advanced, having given a brief account of them in the remarks appended to the paper just mentioned.

This anatomical explanation is probably applicable, with variations, to most cases, and in particular to those which occur after operations involving profound anaesthesia and shock, and to those which arise apparently spontaneously after relatively trivial complications, where the subjects are predisposed to enteroptosis by the original length of their mesentery and by previous malnutrition and exhaustion. I have suggested that in some of the mysterious cases of so-called "hysterical or neurotic" type, with advanced emaciation and prostration, the persistent vomiting may be kept up by analogous conditions independently of any major gastric dilatation.

The treatment of this form of obstruction is suggested by its cause. The stretched mesentery must be relieved by raising the intestine from the pelvic trough. The rational cure for the visceral malposition and the resulting gastric dilatation is posture. The knee and elbow position advocated by Albrecht may not often be available owing to

⁴ Loc. cit., p. 1115.

⁵ Ueber Arterio-Mesenterialen Darmverschluss an der Duodeno-Jejunalgrenze und seine ursächliche Beziehung zur Magenvergrößerung (with bibliography). Virchow's Archiv. Band clvi., Heft 2, 1899.

⁶ THE LANCET, Oct. 28th, 1899, p. 1155.

¹ THE LANCET, Oct. 26th, 1901, p. 1113.

² Loc. cit., p. 1122.