

Captain, with precedence next below T. E. Fielding (dated June 26th, 1908).

ARMY MEDICAL RESERVE OF OFFICERS.

Surgeon-Lieutenant Frederick E. Bissell to be Surgeon-Captain (dated June 30th, 1908).

VOLUNTEER CORPS.

Rifle: 2nd Volunteer Battalion, The Hampshire Regiment: Surgeon-Lieutenant-Colonel Arthur B. Wade is granted the honorary rank of Surgeon-Colonel (dated March 30th, 1908). Surgeon-Lieutenant-Colonel and Honorary Surgeon-Colonel Arthur B. Wade resigns his commission, with permission to retain his rank and to wear the prescribed uniform (dated March 31st, 1908). Surgeon-Lieutenant Herbert G. Harris resigns his commission (dated March 31st, 1908).

ROYAL ARMY MEDICAL CORPS BUILDINGS AT WOOLWICH.

We understand that it is proposed to erect buildings for the Royal Army Medical Corps on the north side of Shooter's Hill-road, Woolwich, opposite to the hospital buildings.

THE GOVERNMENT AND THE MEDICAL DEPARTMENT OF THE ROYAL NAVY.

In the House of Commons on July 13th, on the vote of £258,700 for medical establishments and services, Mr. McKenna, in reply to Mr. Claud Hay, said that the Admiralty was always endeavouring to improve the medical and hospital service. No special work had been done during the past year, except perhaps in respect of Malta fever. Efforts were being made to eliminate this fever in Malta. Mr. Hay asked whether there had been any increase in the medical staff of the navy during the last twelve months. Had there been any increase in the number of nurses? Had there been any increase in the number of comforts for sailors suffering from diseases in these naval hospitals? Had anything at all been done this year?

TRAINING OF THE ROYAL ARMY MEDICAL CORPS (TERRITORIAL FORCE).

In a memorandum which was issued in 1907 to the members of the medical profession the general principles of the methods of training for the Royal Army Medical Corps (Territorial Force) were enunciated. A memorandum has now been issued by the War Office indicating in detail the method by which these principles are to be applied.

THE NAVAL MEDICAL SUPPLEMENTAL FUND.

At the quarterly meeting of the directors of the Naval Medical Supplemental Fund, held on July 14th, Sir C. Inigo Thomas, K.C.B., in the chair, the sum of £55 was distributed among the several applicants.

Major F. Kiddle, R.A.M.C., has been instructed to visit the stations of Secunderabad, Bangalore, and Wellington and to examine the eyesight of the children of British soldiers at these places.

Lieutenant-Colonel W. M. James, A.M.S. (retired), has been noted for appointment at Guildford as medical officer in charge of troops.

Correspondence.

"Audi alteram partem."

REMOVAL OF APPENDIX AFTER PERITYPHLITIC ABSCESS.

To the Editor of THE LANCET.

SIR,—I was pleased to see Mr. W. H. Battle's paper in THE LANCET of July 11th drawing attention to the importance of this matter. I have for several years past made it a routine procedure, having been gradually compelled to advise it owing to my experience of trouble after such abscesses had healed.

I agree thoroughly with Mr. Battle that the appendix is more likely to give trouble after abscess formation. I do not agree, however, with his statement that "it is never obliterated." I should place the proportion in which it is destroyed at about 2 per cent. in my series of cases. One cannot apparently decide from the character of the abscess whether such obliteration has occurred. I have repeatedly seen the appendix intact in its whole length after very acute

abscesses, while in one case of complete obliteration, and in another case where only three-quarters of an inch of a stump was left, the abscesses had been comparatively mild. The proportion of cases of obliteration is so small that it may be neglected.

Mr. Battle gives no hint as to when he thinks the second operation should be carried out than merely the remark, "Operation at an early date after closure of the abscess." Personally I recommend the second operation and carry it out when possible immediately the abscess has healed. This I do for several reasons. 1. The patient's resistance to the organisms causing the inflammation is at a high level, as is shown by the healing of the abscess, indicating victory over such organisms. 2. Adhesions are less difficult to deal with at this period than at a later date. 3. Much time is saved to the patient who otherwise must usually undergo a somewhat prolonged convalescence. The average time taken for complete healing of such abscesses, if properly treated, is slightly over three weeks. The second operation, carried out in the majority of cases almost identically as Mr. Battle describes, does not detain the patient longer than another 14 days. The procedure is justified by the results—no deaths in 45 cases.

In dealing with the primary abscess it is best to make an opening large enough only to admit careful examination of the interior of the abscess by the finger for diverticula, concretions, &c. Prolonged or rough manipulations at this stage simply delay healing and are liable to cause fæcal fistula. Diverticula should be drained, concretions removed. Healing is stimulated by the use of Klapp's suction, even before the removal of drainage-tubes, and by the injection of suitable vaccines—staphylococcus, streptococcus, or bacillus coli, one or all. If oozing of blood or other reason during the second operation seems to indicate drainage, this may be carried out by a "cigarette" drain pulled through a puncture corresponding to the recently healed sinus.

So resistant may the appendix be to the destructive power of such abscesses that I have seen in one case three abscesses, and in several cases two abscesses, fail to destroy the appendix. In the first case the intervals between the abscess formation were two years and six weeks. The first abscess was incised and drained, the second burst into the bowel, and the third was opened by me and the intact appendix removed when this had healed. In another case a large abscess was opened surgically and 14 years after a second large abscess was drained by me and thereafter the appendix, perforated at its tip but otherwise quite intact, was removed.

With regard to the time of operation after acute attacks without abscess formation, for the reasons given above I consider that the best time for operation is towards the end of the first week after subsidence of the acute symptoms.

I am, Sir, yours faithfully,

Aberdeen, July 13th, 1908.

H. M. W. GRAY.

THE LAVATORY AND SEATING ACCOMMODATION AT THE FRANCO-BRITISH EXHIBITION.

To the Editor of THE LANCET.

SIR,—I was very pleased to see an article in THE LANCET of July 4th calling attention to the lavatory accommodation at the Franco-British Exhibition. Last week I was there with my wife and a friend, but during most of the time my wife had a very severe headache, so much so that she was obliged to lie down most of the time, and I would like to bring to your notice the fact that she had to lie down on a form in the grounds and afterwards in an unfinished shed. As far as I could ascertain there is no accommodation for people who are taken ill, where they can lie down or get some water; there is an ambulance there but no nurses until about 6 o'clock.

Another thing I noticed there was the absence of free seating accommodation, and I consider this unreasonable, as it prohibits school parties and working people with their children from resting. Very few of the uniformed men in the ground know anything about the place and could not direct me to any chemist. If you think these matters worth investigating and could bring them to the notice of the

public health authorities through the columns of your journal, I am sure visitors would be benefited.

I am, Sir, yours faithfully,
H. S. BURNELL-JONES.

Tower Gardens-road, Tottenham, N., July 7th, 1908.

THE TECHNIQUE OF OPSONIC ESTIMATION.

To the Editor of THE LANCET.

SIR,—The method of estimating the resistance of a patient's blood to infection in use in this laboratory presents certain advantages over the ordinary procedure and hence we beg to submit it to your readers. (1) A truer estimate of the antibacterial powers of the blood is obtained as the individual's serum and leucocytes are both examined; (2) the procedure is more simple and rapid, as the patient's leucocytes, which are freely obtained in the preparation, are used; the tedious collection of washed leucocytes is saved; (3) by varying the dilution of the serum and by use of a thick emulsion of bacteria a truer estimate of the quantity of opsonin is obtained (W. E. Marshall); and (4) the staining qualities of the preparation are excellent and the addition of sodium citrate solution does not practically affect the results, as shown also by Dr. R. M'L. Veitch.

Method.—One large volume of the patient's blood is taken up into the capillary pipette, then five equal volumes of citrated salt solution (sod. cit. 1.5 per cent., sod. chlor. 0.75 per cent.) and one equal volume of thick bacterial emulsion in salt solution (0.75 per cent.). This is well mixed and sealed and a similar preparation of a "normal" blood is made and both incubated in the horizontal position in the incubator at 37° C. for 20 minutes.

Three slides of each are prepared and stained and 50 leucocytes counted in the usual way, the bacteria per leucocyte of the control slide is taken as unity; the methods in use in estimating resistance to infection are: (1) the well-known one of Sir A. E. Wright, Professor W. B. Leishman, and Captain Douglas in which the phagocytes are regarded as indifferent factors. (2) The procedure of dilution (Simon, Klien, &c.) based upon numbers of leucocytes capable of phagocytosis ("phagocytizing leucocytes") in varying dilutions of the serum. Dr. C. E. Simon states that the phagocytic power generally diminishes with the dilution, but it may be rapidly exhausted. In the latter case Simon assumes that the amount of opsonin is materially less, the use of a concentrated serum might show an apparently normal opsonic serum content for a given number of organisms which would be inadequate for a larger number. Such inadequacy becomes manifest when the serum is diluted, a rapid exhaustion of phagocytic power occurring. Dr. G. Dean regards this method as affording some check upon the opsonic index as obtained by Wright's technique. The leucocytes are regarded, again, as indifferent. For some years workers in Brighton saw that the index of a patient's resistance would be bound to be more representative if his or her leucocytes were used. It was simple to prove that eosinophiles and myelocytes have less powers of phagocytosis than polymorphonuclears, and that the polynuclear leucocytes of workers in this laboratory were possessed of a threefold phagocytic power to those of a myelocythæmic patient. Dr. J. C. G. Ledingham showed this independently and that the opposite condition held in the polynuclears of a patient with chronic lymphatic leukæmia.

Rosenow showed that pneumonic leucocytes are more active *per se* than normal ones. Opie emphasises the necessity of leucocytic digestion as compared with mere ingestion of bacteria and demonstrated the powers of digestion on gelatin of leucocytes removed from serum. Glynn confirms the variation in the functional activity of leucocytes and Shattock and Dudgeon in a recent valuable paper clearly show the importance of estimating the "hæmophagocytic" powers, including both leucocytes and serum. In our experience the functional activity may be diminished or increased in immunes, and as we believe that it comes within the unavoidable margin of error of the present technique we have not so far been able to detect the factors that guide it. This we hope to do.

We are, Sir, yours faithfully,

F. G. BUSHNELL.

Sussex County Hospital, July 10th, 1908.

A. G. TROUP.

A LURID STORY.

To the Editor of THE LANCET.

SIR,—The following story has several morals, the most obvious perhaps being the need for a proper system of nurses' registration and for the inspection of nursing homes and institutions.

Early this year a lady applied for admission as a nurse at a general hospital but as she was 34 years of age she was considered too old to be engaged for the full period of four years' training. As in all other respects she seemed very suitable the matron consented to take her on trial for three months as a paying probationer. She obtained a medical certificate stating that she was in good health and gave two references, one from a lady who said she had known her for about 12 years and in whose family she had at different times done some nursing; the other from the superintendent of a suburban nursing home, under whom she had worked for the previous three months. Both ladies spoke very highly of her. Both the applicant and her referees had to answer printed inquiries about her previous health and the diseases from which she had suffered and said nothing whatever about any mental disorder. For about two months she did her work quite satisfactorily as a junior probationer in the hospital, when suddenly she developed symptoms of acute mania, addressed a postcard to the King, became incoherent, and had all kinds of delusions, religious, sexual, &c. Her nearest relation, a married sister living many miles away, was at once informed of the circumstances. She evidently telegraphed to a private asylum, from which a nurse was promptly sent, provided with an Urgency Order under the Lunacy Act, and as soon as this had been filled up at the hospital the patient was removed to the asylum. From this nurse it was ascertained that the patient had been under treatment in the same asylum on either four or five previous occasions and that the last attack had been a very severe one, so that she had been detained about 12 months, and had only been discharged about a year ago.

Inquiries were now made from the matron of the nursing home who had been one of the patient's referees. She acknowledged that when she engaged her, being rather pressed at the time for nurses and satisfied with the applicant's appearance and address, she had accepted her without any references whatever, that she had nursed some patients in the institution and others in their own homes, and had given complete satisfaction. Thus we have an instance of a woman being taken on to the staff of a nursing home without having had any hospital training whatsoever and without any inquiries being made. She is then placed in charge of patients, sometimes at their own homes, presumably as a fully trained nurse, yet she had not long been discharged for the fourth or fifth time from an asylum and was liable at any moment to a fresh attack of acute mania.

As it happened, when the recurrence did occur no particular harm was caused, but had the nurse been in a private house in sole charge of a patient seriously ill instead of being merely a junior probationer in a hospital the consequences might have been very different.

I am, Sir, yours faithfully,

July 13th, 1908.

F.R.C.P.

ROYAL COLLEGE OF SURGEONS IN IRELAND.—

The following prizes were awarded for the summer session:—Barker anatomical prize (£31 10s.): G. C. Sneyd; special prize £26 5s., Miss I. M. Clarke. Carmichael scholarship (£15): J. S. Pegum. Mayne Scholarship (£8): T. C. Boyd. Gold medal in operative surgery: R. Adams; silver medals, C. Greer and G. C. Sneyd. Stoney memorial gold medal in anatomy: H. G. P. Armitage. Practical histology: J. T. Duncan, first prize (£2) and medal; and L. W. Roberts, second prize (£1) and certificate. Practical chemistry: B. Kelly, first prize (£2) and medal; and W. N. Harrison, second prize (£1) and certificate. Public health and forensic medicine: F. W. Warren, first prize (£2) and medal; and H. R. Tighe, second prize (£1) and certificate. Materia medica: J. S. Pegum, first prize (£2) and medal; and Miss N. Williams, second prize (£1) and certificate. Biology: M. J. Hillery, first prize (£2) and medal; and G. E. Pepper, second prize (£1) and certificate. The winter session will commence on Thursday, Oct. 15th.