before will now be able to judge of its value when the next case of small-pox develops in their midst. They are now accustomed to the operation and to the appearance of vaccinating officers in their district, so that the country may be now considered to be ready for the final step to which we have looked forward so long—i.e., a compulsory vaccination Act.

The Vaccination Law of B.E. 2456.

On Feb. 19th of this year B.E. 2456 (1914) His Majesty was graciously pleased to sanction the enactment of a vaccination law for Siam. The law was drafted by the Local Sanitary Department for application in the Bangkok province, and was revised by His Royal Highness Krom Phra Damrong, Minister of Interior, so that it is now applicable to the whole of Siam. At present it will only apply to the monthon of Bangkok, but at any time it may be proclaimed for other monthons in the interior.

A few words may now be said with regard to the chief provisions of this law. The basal idea is the desire to have every person now in the kingdom or who may enter the kingdom rendered immune to small-pox. Therefore as soon as this law comes into force every person who has not previously been successfully vaccinated must become vaccinated, unless it can be shown by a certificate from a duly qualified public vaccinator that he or she is immune to vaccination. Immunity may mean that he or she has previously suffered from small-pox or has been repeatedly vaccinated without a successful result.

Every parent or guardian of a child over one month old must take the earliest opportunity of having such child vaccinated. No definite time limit is laid down in the law, as, for example, during the first three, six, or 12 months after birth, owing to the many difficulties which might be experienced under local conditions. It will be left to the superintendent of vaccination to make such arrangements as are necessary from time to time, and to notify the time and place for vaccinations in any district. This will enable us to commence work during the cooler months of the year when vaccination is more popular in Siam. The origin of this preference is doubtless due to the fact that it was only in cool weather that vaccine lymph could be transported any appreciable distance when transport was slow and difficult. Nowadays, with railway communication, ice and thermos flasks, efficient vaccine lymph can be transported to almost every corner of the country at any time during the year.

Another point of importance in the law is the provision that the vaccinated child must be brought back to the vaccinator on the eighth day after vaccination so that the result may be verified. This will enable us to repeat the vaccination when necessary, and to check the efficiency of the lymph and the capabilities of the vaccinator. Certificates showing the result of vaccination will be granted. We look forward to the day when no child will be admitted as a scholar into any school whatever unless he can show a certificate of vaccination or of immunity from small-pox.

One of the most important clauses in the law is Clause IX. This gives the Minister power to issue a public notice enforcing vaccination or revaccination upon all the inhabitants of a district or locality within a specified time. Such power would only be taken in the possibility of small-pox becoming epidemic in such district or locality. No definite age is prescribed by this law for revaccination, but it is hoped that an addition will be made to it, definitely laying down that revaccination during the ninth year will be compulsory. The usual clauses permitting of postponement of vaccination in case of sickness of the child are included in the law.

Public vaccination will be performed free of charge at such times and places as may be notified by the superintendent of vaccination. Any person may, however, apply to a public vaccinator to perform vaccination at his residence, and in such case if the public vaccinator is employed by the Government a fee will be charged at a rate prescribed by the Minister. No restrictions are placed upon private medical practitioners as to time and place of vaccination and the fees to be charged. They will, however, require to take out licences as public vaccinators, if they wish to have their certificates recognised, for in accordance with Clause XI. the certificate of a public vaccinator shall be the legal proof of being vaccinated in accordance with the provision of the law. The reason for this is the necessity of protecting the public. No unqualified person will be recognised as a public vaccinator, and the lymph to be used must only be that which has been authorised by the Minister. The dangerous practice of inoculating with small-pox virus is now declared to be a criminal offence, and the offender will be liable to heavy penalties.

In conclusion, it may be stated that the "conscientious objector" has not been recognised in this law.

Bangkok.

PERIOSTEAL WHITLOW.

BY HUGHES R. DAVIES, M.R.C.S. ENG., L.R.C.P. LOND.,
PHYSICIAN TO THE SPANISH AND PORTUGUESE JEWS' HOSPITAL, MILE-END, E.

THE literature upon this subject appears to be scanty and unsatisfactory, and, with one exception available, that of the late H. W. Allingham, I find little that bears intimately upon the particular case I now record. From a paper read before the St. George's Hospital Hunterian Society and afterwards published[1] I make the following important excerpts, and desire to draw special attention, by italics, to the sound deduction of that lamented and brilliant surgeon, which the case I now bring before the profession amply verifies.

"The last phalanx has no real periosteum, its deficiency being supplied by the cellular tissue covering it."

And then his theory that—

"There being no periosteum to the bone its place is supplied by the soft tissues of the finger; consequently when an inflammation attacks the tissues it strangulates the vessels running in it to the bone, and so cuts off the blood-supply, and as a result of such a proceeding causes the phalanx to necrose. ..... It is well known in cases of necrosis that the new bone is formed from what remains of the periosteum, fascia, tendons, and whatever was near the original bone. *I therefore cannot see why new bone should not be formed from the cellular tissue surrounding the cavity from whence the phalanx is removed, and of course helped by the remaining epiphysis.*"

He remarks that:—

"The flexor profundus is attached to the proximal end (the epiphysis) of the terminal phalanx, the sheaths of which blend with the periosteum."

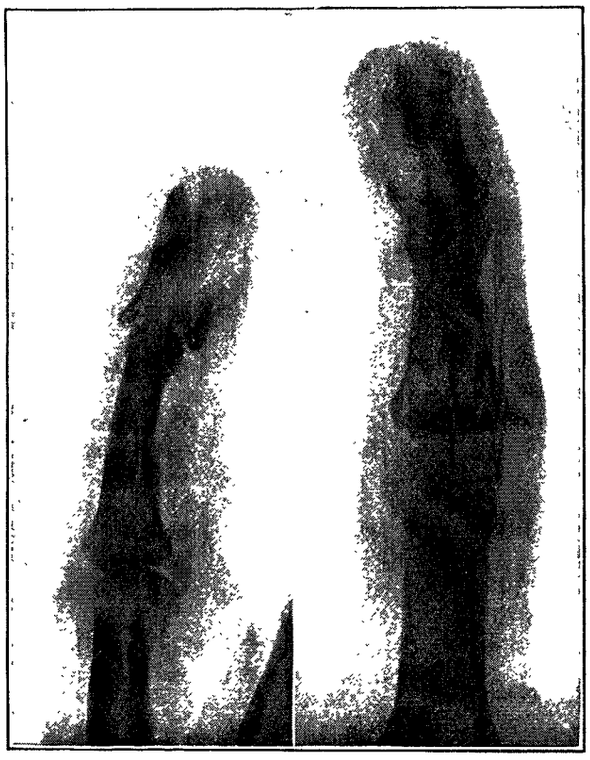
This epiphysis, Allingham declared, always remained behind after necrosis of the terminal phalanx.

[1] Medical Press, Sept. 29th, 1883.

With this short introduction I will now record my interesting experience.

On Feb. 6th, 1914, I was consulted by a man, aged 57 years, on account of a whitlow on the terminal phalanx

FIG. 1.



Radiogram taken July 4th, 1914. Shows the asymmetrical condition of the distal end of phalanx as well as the immaturity of the ossification of the new bone at the base of the phalanx.

FIG. 2.

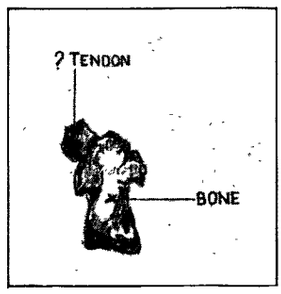
Radiogram taken Oct. 4th, 1914. Shows a more definite ossification after three months' interval; but the deficiency in symmetry of the distal end is still evident, probably due to the intense inflammatory destruction of periosteum in the early septic stage.

of the second finger of the right hand. The patient was in a very low state of health generally, and there was tenderness in the axilla, together with marked enlargement of the cubital gland. A bootmaker by trade, it is quite possible that the examining finger may have been wounded by a septic nail in the sole of a boot, and his ill-health have been a contributory cause of the trouble. I incised the centre of suppuration at once, and advised constant boracic fomentation. Within a few hours the condition of the finger was deplorable on account of numerous discharging sinuses which appeared all over the terminal phalanx. These sinuses I broke down immediately, making one general exit for the pus. A probe revealed exposed bone, and the finger nail seemed fated; indeed, as the inflammatory condition spread rapidly towards the hand I was much tempted to advise amputation of the offending phalanx. Fortunately, I refrained, and continued expectant treatment; but the discharge was profuse and lasting.

On March 2nd, the discharge still continuing, I passed a pair of forceps and gripped the terminal phalanx, which came away easily, bearing evidence of ligamentous and tendinous attachments. Again the question arose as to the advisability of amputation. But as the nail was rehabilitating itself so wonderfully well, stiffening the terminal joint, and as the swelling of the second phalanx showed evidence of subsiding, I again refrained from operating. However, the sinus and the discharge persisting, I was compelled to believe that there still existed some bone necrosis—or that all had not come away.

On May 8th this fear proved actual fact, for two small portions of necrosed phalanx came through the sinus, which then happily closed, leaving a satisfactory finger for use. It was then that I noticed that a surprising stiffening of the flaccid phalanx was commencing, principally at the base, and a radiograph on July 4th revealed the presence of a

FIG. 3.



Sketch of necrosed phalanx removed by forceps March 2nd, 1914. In this instance apparently, in the removed necrosed phalanx, the tendon of the flexor profundus has attachment to the distal end of the phalanx, and not to the epiphysis as asserted by Allingham.

perfectly new phalanx. The upper portion of the negative plainly showed a deficiency in the symmetry of the new growth—probably the site of the recently ejected pieces of bone, which had prevented an earlier closing of the sinus by reason of their presence.

I take it that the necrosed original phalanx must have shelled out from the periosteum when seized by my forceps on March 2nd, since which date time, and hopeful patience, accomplished an apparent miracle—or the unexpected.

I present a sketch of the removed necrosed phalanx (or, according to Allingham, the phalanx *minus* the epiphyseal end), actual size, and the two radiographs, taken at the interval of exactly three months. They are worthy of study.

I venture to hope that this record will be valuable as showing what nature, guided, can perform; and also as a warning that a too-hurried use of the scalpel is not always desirable. During the course of treatment Allingham suggested that the nail, after the necrosed bone has been removed, should be strapped back to a small dorsal splint, to militate against an unsightly curving of the nail before the new phalanx has grown. In theory this sounds well, but in actual practice, as in my case, it would scarcely be feasible, since the slightest rough treatment would have torn the dead nail at once from

its bed, and the flaccid terminal would have lost a certain temporary support. Besides, the strapping would have interfered with the frequent and necessary dressing of the sinus.

Woodford Green, Essex.

Medical Societies.

ROYAL SOCIETY OF MEDICINE.

SECTION OF DERMATOLOGY.

Exhibition of Cases.

A MEETING of this section was held on Oct. 15th. Before opening the proceedings, Dr. J. J. PRINGLE, the President, announced that the meetings of the section would be held as usual during the forthcoming session.

The PRESIDENT showed a Lichenous Eruption in a woman 57 years of age. The lesions, which occupied large areas of the body and limbs, consisted of papules of both plane and acuminate type. He questioned as to whether the case was one of pityriasis rubra pilaris or of lichen planus, or whether it was possibly a combination of the two conditions due to some common underlying cause.—Dr. J. H. SEQUEIRA had seen a similar case.—Dr. H. G. ADAMSON and Dr. J. M. H. MACLEOD were in favour of the diagnosis of pityriasis rubra pilaris, towards which the President leaned.

Dr. W. KNOWSLEY SIBLEY brought up a boy whom he had shown at a previous meeting on account of a peculiar generalised nodular eruption; the lesions had increased in size and number and the blood now showed the characteristic changes of lymphatic leukæmia.

Dr. GRAHAM LITTLE showed (1) a case of (?) Infective Granuloma occurring on the site of an old pigmentary nævus and (2) a case of Lichen Planus.

Dr. SEQUEIRA showed: 1. A patient with an indurated, slowly growing Nodule on the chin for which he suggested the diagnosis of sarcoid, and in this the PRESIDENT concurred. 2. A case of Myxo-sarcoma of the skin of the forehead and face in a patient who had had an amputation of the foot four years previously for chondro-sarcoma of the tarsus.

Mr. H. C. SAMUEL brought up a patient with Symmetrical Pigmentation, Atrophy, and Telangiectases of the skin of the beard region resembling an X ray burn, but with absence of a history of exposure to X rays. He suggested a diagnosis of xerodermia pigmentosa commencing in an adult.—In the discussion which followed several speakers expressed the view that the patient was deliberately withholding the history of exposure to X rays.

Dr. S. E. DORE showed a case of Multiple Soft Fibromata.

Dr. ADAMSON brought a patient with peculiar Nodular Lesions about the face which gave it the leonine appearance of leprosy; there was, in addition, definite thickening of the bones of the nose. Dr. Adamson thought that the nodules might be analogous to rheumatic nodules.—The PRESIDENT stated that the case reminded him of erythema diutinum, while Dr. F. PARKES WEBER thought it a form of leontiasis ossium.

Dr. ADAMSON also showed an atypical form of Lupus Vulgaris on the Thigh, the diagnosis of which from ulcerating syphilide had been extremely difficult.

Dr. GEORGE PERNET demonstrated cultures of Favus and Ringworm.

Dr. H. MACCORMAC showed a case with Lichen Spinulosus-like Lesions which on the face gave rise to atrophic patches like lupus erythematosus; he thought it was a tuberculide.—Dr. ADAMSON agreed as to its nature.—Dr. MCRELLE (Brussels) had also seen a somewhat similar case.

Mr. P. P. ATAL (for Mr. CHARLES GIBBS) showed an extensive case of Keratodermia Blennorrhagica.

MEDICO-PSYCHOLOGICAL ASSOCIATION OF GREAT BRITAIN AND IRELAND.

Restraint in Mental Disease.

THE autumn meeting of the Midland and Northern Division of this association was held by invitation of Dr. GRAEME DICKSON at Wye House, Buxton, on Oct. 22nd. Dr. Dickson presided.

Dr. R. C. STEWART read a short paper on Restraint in Mental Disease with the object of opening up a discussion on this subject. He dealt with restraint in its widest sense, and considered briefly mechanical restraint, the use of single rooms, the question of locked doors in asylums, treatment by sedatives, &c. He was of opinion that everything that took away the feeling of restraint tended to benefit the patient.

The paper was followed by an interesting discussion, in which every member present took part, and various opinions were expressed on the numerous points raised. One speaker held very strong opinions about mechanical restraint, and thought it ought never to be used, or only in very rare cases. He considered it had a bad moral effect on the nursing staff. Seclusion appeared to him only a lesser evil, and he did not like using drugs. It had always been a difficult problem with him to decide what was the best treatment for perverse old chronic patients. A distinction was drawn between acute and chronic cases, and it was generally agreed that the difficulty of finding a suitable means of restraint lay in the case of the latter. The use of verandahs and sleeping out of doors for noisy patients were considered beneficial. The various forms of sedatives in use were referred to, and special reference was made to the use of bromides. The limitation of airing courts by unclimbable fencing and the old question of the locked asylum door were to some extent dealt with. It was suggested that too many single rooms were provided in many asylums, and that they might be better used as "privilege" rooms than for the isolation of noisy patients.

Dr. STEWART replied, after which a hearty vote of thanks was accorded to Dr. Dickson for his kind hospitality.

ÆSCULAPIAN SOCIETY.—A meeting of this society was held on Oct. 23rd, Dr. David Ross, a past President, being in the chair.—Mr. Wallace C. G. Ashdowne showed: 1. A man, aged 37, admitted for treatment of femoral hernia, who showed marked signs of Acromegaly, giantism, sexual undevelopment, and prominent lower jaw being well marked. 2. A man, aged 47, with a Tumour in the left side of the pelvis, extending to the inguinal region and round to the perineum, and it could be traced through the obturator foramen. A second tumour could be felt higher up in the position of the descending colon. Some occult blood was found, and since admission 2 or 3 ounces of bright, pure blood were passed. Operation was deemed out of the question on account of the extent of the tumour. 3. A man, aged 60, who had his penis removed for Epithelioma of glans. The penis was entirely removed and the mucous membrane attached to the skin in the perineum. The man was able to micturate in comfort by means of a funnel-shaped aluminium instrument devised by himself. Spinal anæsthesia was used for the operation, as the man had aortic aneurysm. 4. A man suffering from Tertiary Syphilitic Ulceration of the Pharynx, who had one injection of neosalvarsan in addition to mercury and potassium iodide. He was improving. 5. A young man, aged 19, who injured his left hip ten years ago through a fall from a swing. No inconvenience followed for three weeks, when pain occurred on walking. Tuberculous disease of the hip was suspected and extension applied for 18 months; extension had again been used more recently. On admission to the Metropolitan Hospital it was found that the head of the femur was dislocated upwards and forwards and the leg shortened $\frac{5}{8}$ inch. The patient could walk up to three miles without pain. It was thought unnecessary to interfere. 6. A skiagram demonstrating Stones in Gall-bladder. 7. A Stone about 2 inches in length and $\frac{3}{4}$ inch in diameter found post mortem in the cystic duct of a woman who died from chronic bronchitis aged 88. The gall-bladder was quite free and there were no symptoms during life. 8. A boy, aged