

a Professor, vice Lieutenant-Colonel A. M. Davies, retired (dated Sept. 17th, 1908).

ROYAL ARMY MEDICAL CORPS.

Lieutenant-Colonel William B. Day is placed on temporary half-pay on account of ill-health (dated Sept. 30th, 1908).

Captain E. T. Inkson, V.C., from London, is appointed for duty in India.

ARMY MEDICAL RESERVE OF OFFICERS.

Surgeon-Major Joseph Adams to be Surgeon-Lieutenant-Colonel (dated Sept. 22nd, 1908).

TERRITORIAL FORCE.

Yeomanry.

Buckinghamshire (Royal Bucks Hussars): The undermentioned officers from the Buckinghamshire (Royal Bucks Hussars) Imperial Yeomanry are appointed to the regiment with rank and precedence as in the Imperial Yeomanry (dated April 1st, 1908): Surgeon-Captain Leonard Arthur Barwell and Surgeon-Captain Francis Ernest Marston. Queen's Own Oxfordshire Hussars: Surgeon-Lieutenant Archibald Henry Hogarth, from the Oxfordshire (Queen's Own Oxfordshire Hussars) Imperial Yeomanry, to be Surgeon-Lieutenant, with precedence as in the Imperial Yeomanry (dated April 1st, 1908).

Royal Field Artillery.

2nd South Midland Brigade: The undermentioned officers from the 1st Worcestershire Royal Garrison Artillery (Volunteers) are appointed to the brigade, with rank and precedence as in the Volunteer Force (dated April 1st, 1908): Surgeon-Captain Arthur Charles Oldham, Surgeon-Captain George Herbert Rutter, and Surgeon-Lieutenant George Mackie (to be supernumerary).

Royal Garrison Artillery.

Devonshire: The undermentioned officers, from the 2nd Devonshire Royal Garrison Artillery (Volunteers), are appointed to the unit, with rank and precedence as in the Volunteer Force (dated April 1st, 1908): Surgeon-Captain James Philip Stephens Ward and Surgeon-Lieutenant George Douglas Kettlewell.

Infantry.

4th Battalion, Cheshire Regiment: The undermentioned officers, from the 1st Volunteer Battalion, The Cheshire Regiment, are appointed to the battalion, with rank and precedence as in the Volunteer Force (dated April 1st, 1908):—Surgeon-Captain Conrad Theodore Green, Surgeon-Captain John Brown Yeoman, and Surgeon-Captain Andrew Robertson Wilson (to be supernumerary). The undermentioned officers from the 3rd Glamorgan Volunteer Rifle Corps, are appointed to the battalion, with rank and precedence as in the Volunteer Force (dated April 1st, 1908): Surgeon-Major Arthur Lloyd Jones, Surgeon-Captain George Arbour Stephens, and Surgeon-Lieutenant Charles Leonard Isaac (to be supernumerary). 7th (Fife) Battalion, The Black Watch: The undermentioned officer, from the 6th (Fifeshire) Volunteer Battalion, The Black Watch (Royal Highlanders) is appointed to the battalion, with rank and precedence as in the Volunteer Force (dated April 1st, 1908): Surgeon-Lieutenant David Elliot Dickson. 5th Battalion, Loyal North Lancashire Regiment: The undermentioned officer, from the 2nd Volunteer Battalion, The Loyal North Lancashire Regiment, is appointed to the battalion, with rank and precedence as in the Volunteer Force (dated April 1st, 1908): Surgeon-Captain James Wood. The Herefordshire Battalion, The King's (Shropshire Light Infantry): The undermentioned officers from the 1st Herefordshire Volunteer Rifle Corps, are appointed to the battalion, with rank and precedence as in the Volunteer Force (dated April 1st, 1908): Surgeon-Captain James Neil Macmullan and Surgeon-Lieutenant Arthur Llewellyn Baldwin Green. 6th (Banff and Donside) Battalion, Gordon Highlanders: Surgeon-Lieutenant Ellington Reed Turner from the 4th (Donside Highland) Volunteer Battalion, The Gordon Highlanders, is appointed Surgeon-Lieutenant, with precedence as in the Volunteer Force (dated April 1st, 1908). 5th (Renfrewshire) Battalion, Argyll and Sutherland Highlanders: Surgeon-Captain Claude William Marshall, from the 1st (Renfrewshire) Volunteer Battalion, Princess Louise's (Argyll and Sutherland Highlanders), to be Surgeon-Captain, with precedence as in the Volunteer Force (dated April 1st, 1908). 6th (Renfrewshire) Battalion, Argyll and Sutherland Highlanders: Surgeon-Captain Wallace Ainsforth Pride,

from the 3rd (Renfrewshire) Volunteer Battalion, Princess Louise's (Argyll and Sutherland Highlanders), to be Surgeon-Captain, with precedence as in the Volunteer Force (dated April 1st, 1908). 7th Battalion, Argyll and Sutherland Highlanders: Surgeon-Lieutenant Peter McFadyen, from the 4th (Stirlingshire) Volunteer Battalion, Princess Louise's (Argyll and Sutherland Highlanders), to be Surgeon-Lieutenant, with precedence as in the Volunteer Force (dated April 1st, 1908). 9th (The Dumbartonshire) Battalion, Argyll and Sutherland Highlanders: Surgeon-Captain William Buchan Armstrong, from the 1st Dumbartonshire Volunteer Rifle Corps, to be Surgeon-Captain, with precedence as in the Volunteer Force (dated April 1st, 1908).

Correspondence.

"Audi alteram partem."

THE PREVENTION OF TUBERCULOSIS (IRELAND) BILL.

To the Editor of THE LANCET.

SIR,—It is satisfactory to find that Dr. J. C. McWalter's opposition to the Prevention of Tuberculosis (Ireland) Bill is lessening, for in his letter in your issue of Oct. 3rd, p. 1035, he says: "Everyone could see that compulsory notification may be an excellent thing in a city where a whole population works together in crowded factories and a doubtful experiment for a whole country where the conditions are absolutely different." Now, if Dr. McWalter had shown that phthisis occurred only in such cities and not in other places there would be some weight in his opinion. For instance, Belfast is, practically speaking, the only big city in Ireland where a large number of the population work in large factories, and on Dr. McWalter's reasoning compulsory notification should apply to that city alone in Ireland; but unfortunately in both Cork and in Dublin the death-rate from phthisis is higher than in Belfast; and, further, in every other city in Ireland—nay, more, in every district in Ireland—this fell scourge has its victims. During 1907 of the 8828 deaths from phthisis (tuberculous phthisis and phthisis not otherwise defined) 2596 occurred in Leinster, 2178 in Munster, 3100 in Ulster, and 954 in Connaught—that is, in every part of Ireland, urban and rural. Now of these, 1054 occurred in Belfast; yet that city alone with only 1054 deaths is to be under compulsory notification (according to Dr. McWalter's plan), while the whole of the rest of Ireland with 7774 deaths is not. Such a line of reasoning carries its own reply. Dr. McWalter says the example of an odd city goes for nothing, he wants me to point out an entire country where compulsory notification prevails and causes no hardship. The cities I enumerated were Sheffield, Bolton, Edinburgh, and New York, and their united population is 3,335,314—that is, only about 1,000,000 less than the population of the whole of Ireland. In each of these cities the phthisis death-rate had steadily fallen before they adopted compulsory notification, but not content they are determined it shall fall still more, and yet, sad to say, during all this period the death-rate from tuberculosis has risen in Ireland. If the compulsory notification of the disease is adopted it must apply to every part of Ireland (urban or rural) until the disease is stamped out.

As to a country where notification is adopted: 1. Let me give, if not a country, what is practically the same, a great state of a country. New York State is larger than England, it has a population little less than twice that of Ireland—viz., about 8,000,000—and in it the notification of even incipient cases of tuberculosis is rendered obligatory; the same is true of New Jersey and the District of Columbia. Compulsory notification will soon exist in the whole of the United States. 2. On Sept. 28th, 1908, at the International Congress on Tuberculosis in Washington, Dr. A. News-holme stated, on behalf of Mr. Burns, that the Local Government Board had decided to issue an order compelling all Poor-law medical officers to notify forthwith the medical officers of health of any sanitary authorities making application for such notification, all cases of phthisis occurring amongst parochial patients. This order would also render it obligatory on other Poor-law officials to

notify changes of address of parochial patients suffering from phthisis. Does this not portend the extension of notification soon to the whole of England? 3. In Scotland in 1906—that is, in a country where the mortality from pulmonary tuberculosis has gone down 40 per cent., while in Ireland it has risen during the same period 20 per cent.—the Local Government Board issued a circular to the effect that the sections of the Public Health Act applicable to other infectious diseases are equally applicable to pulmonary phthisis and that the obligation resting on the local authority to deal with and control infectious disease extends to pulmonary phthisis. It is believed that Scotland will soon go for an Act making notification of phthisis (pulmonary tuberculosis) compulsory all over the country. With such examples, why can Ireland not be allowed (as through the genius and foresight of Her Excellency the Countess of Aberdeen she has taken a step in time in advance of these countries) to have notification of pulmonary tuberculosis applied to every part—urban or rural district?

Finally, Dr. McWalter says: “The fact that in 1864 the Irish death-rate from tuberculosis was the lowest in the three kingdoms, although no sanitary precautions were heard of, whereas now, after a quarter of a century’s sanitary legislation, it is the highest, gives one to think furiously about the net result of these measures in actual practice.” He should have also added that during the same period the English and Scotch rates have steadily fallen until now the death-rate from tuberculosis in England is 1·6 (1906), in Scotland 2·1 (1906), and in Ireland 2·7 (in both 1906 and 1907), and further that in all three countries typhus fever has declined, until in Ireland in 1907 there were only 56 deaths, while in 1869 there were 891 from this fever. Why, Sir, it is these very facts which are the cause of the agitation in Ireland which has culminated in Mr. Birrell’s Bill.

1. We have not made the same progress in Ireland as in England or in Scotland in the sanitary measures taken to improve the dwellings of the people all over the country. 2. As pointed out in the report of the Belfast Health Commission in reference to the Births and Deaths Registration Act, “The absence of this (one of the provisions in the English and Scotch Bills) provision in Ireland has had the effect that no local authority appears to have the power of obtaining information which is of fundamental importance to them in their primary duty of searching for and coping with causes of ill-health and death among the population committed to their charge.” As a result more is known in England and Scotland by the health authorities than in Ireland as to where the disease exists. 3. The difference between Ireland as compared with England and Scotland is that in the former far more patients are relieved medically at their homes under the Poor-law system which favours the treatment of even advanced cases at home. The tendency in England and Scotland is, under their Poor-law system, rather for more of such cases to be treated in institutions, such as union infirmaries, &c. As I have pointed out before,¹ Dr. Newsholme has, I believe, shown that typhus fever has been brought to the point of extinction by its institutional treatment, acting in conjunction with the removal of the motives for vagrancy. Phthisis has been rendered even more prevalent than formerly by increasing for this disease domestic at the expense of institutional treatment and by thus continuing the enormous number of domestic foci of this disease which are implied by the home medical treatment of phthisis among the poor.

In dealing with phthisis in Ireland we want (1) to know where the disease is and not alone where the deaths occur; (2) provision of hospitals, sanatoriums, and dispensaries for its treatment; (3) improvement in sanitary conditions; and (4) education of the people in the hygiene of the prevention of the disease. And it is because these are the main principles of Mr. Birrell’s Bill that those (like myself) who have tried to do some work for their country in this anti-tuberculosis campaign hope it will pass.

I am, Sir, yours faithfully,

Oct. 5th, 1908.

JOHN BYERS.

PS.—Since writing this letter I see that the International Congress on Tuberculosis at Washington on Oct. 3rd (last Saturday) passed resolutions advocating the adoption by all

Governments of compulsory notification of cases of tuberculosis.

To the Editor of THE LANCET.

SIR,—Let us see where we are. A Bill is before Parliament making the notification of tuberculosis compulsory in Ireland but not in England. I, as a humble member of a sanitary authority, venture to object to this special legislation. If Great Britain decides to adopt compulsory notification of phthisis, I am willing that Ireland be also included, but I object to penal legislation for one country more than another. I insist that no sufficient case has been made for exceptional treatment and that the statistics in Ireland are unreliable, as some 20 to 25 per cent. of deaths registered here are not certified by medical men. I have also hinted that although Lady Aberdeen’s campaign seemed to favour compulsory notification, it should not be taken too seriously—that, in fact, it was not controlled by those representing the majority of the people.

My friend Dr. M. F. Cox takes me to task. Let me say that I consider him, with Dr. McWeeney and others, as altogether on the popular side, and as my masters in medical science, but I am unconvinced of their wisdom in this matter. Let us take, as my Lord Bacon would say, a crucial instance. Dr. Cox has probably one of the largest practices amongst consumptive patients in Ireland. He argues strongly that on every medical man should be imposed an obligation, enforceable by fine or imprisonment, to notify every case. Now for many years past the corporation of Dublin has begged practitioners to voluntarily notify cases of phthisis, in order that they might disinfect premises, &c. How many cases has Dr. Cox notified for the past five years? How many cases have all the Court physicians who now clamour to have their humbler brethren made common informers by Act of Parliament notified for the past five years? I venture to say not 2 per cent. of the entire number which they have attended, and I shall be glad to be corrected if I have understated the fact. Dr. Cox chides me for not repressing the discontent which is arising amongst public boards about this Tuberculosis Bill, but seriously I am gravelled for lack of argument, and I beg to be helped. It happens that I am the only medical practitioner on the various city public boards—the Dublin corporation, the Richmond Lunatic Asylum, and the North and South Dublin board of guardians—and I am called on to excuse or explain the action of the medical faculty to my colleagues whenever they find fault with it. What answer can I give as to why the doctors did not think it necessary to notify consumption voluntarily when begged to do so by the corporation, except in a few trivial cases, and why it becomes a matter of the gravest importance for the nation’s weal to notify every case, provided a half-crown fee is attached by Parliament? Far be it from me to suggest that any of my medical brethren is influenced in the slightest degree by the fee, but I am only recounting a fact when I state that the public boards who are called on to pay the half-crowns contain many members who think otherwise, and that I find it almost impossible to persuade them to the contrary when they have practical experience that when the fee is paid cases are notified, and that when practitioners are asked to notify without fee in order that sanitary matters may be set right very few are found to do so, although surely the necessity is the same.

Dr. S. Agnew takes rather a broader view of the subject, but probably he will agree that in a country where no doctor attends some 24 per cent. of deathbeds it is futile to expect people to go to a physician and be booked as consumptives for the rest of their lives. Seriously, what are the sanitary authorities to do when you have notified a person as phthisical? If you tell us that a patient has typhus, typhoid, plague, or small-pox we are at least logical; we are prepared to provide for him with proper care in a hospital until he is well—or dead. But what are we to do with the consumptive? Of course, we can send him tracts about his disease, a nurse to advise him to keep open his windows, a sanitary inspector to look after his drains—but what of that? He will be dismissed from his employment; obviously, and as a principle of common law, you can compel no man to work or live with a certified consumptive. Shall we send them all to sanatoriums? If there are 100,000 in Ireland, as Lady Aberdeen’s friends say, the cost, based on English experience

¹ THE LANCET, Jan. 25th, 1908, p. 209.

of establishment and upkeep, will be ten millions a year, and then if a local authority wish to build a sanatorium they are faced with the express declaration of Dr. Cox's College of Physicians—that it is an extravagant and impossible outlay for a country like this.

The only real effect of the Bill will be to drive patients from the physician to the quack. There will be compulsion on the doctor to notify every consumptive who comes before him, but none on the consumptive to go to the doctor; he can roam at large and go where he will, spreading contagion as heretofore, impossible to check as long as he avoids the physician. The latter may indeed be called in at the end, but only when curative or preventive measures are alike futile. If it is granted, then, that compulsory notification can only do practical good when all cases of phthisis are notified, what percentage of people will present themselves for notification in a country where already nearly a quarter of the people die without calling in the doctor?

I am, Sir, yours faithfully,

Dublin, Oct. 4th, 1908.

J. C. McWALTER.

THE FEEDING OF ELEMENTARY SCHOOL CHILDREN.

To the Editor of THE LANCET.

SIR,—The beginning of the provision of meals for school children has, of course, opened the question of methods to be used in selection. The public and many of its committees, accustomed to hearing evidence given by medical men on the subject of starvation and looking also to the profession to dogmatise on all aspects of dietetics, have erroneously assumed that by inspection and examination of children the medical man is able to say that one child should be fed by the ratepayers whilst another may be left to the care of its parents. Anyone with experience must be aware that this is a mistaken conclusion. Starvation may, of course, be recognised, but what is wanted in the case of the children is the recognition of *underfeeding* which may perhaps have continued only for a week or so. In the majority of cases such a diagnosis is absolutely impossible.

Weighing and measuring, however useful in providing evidence of "tendencies," give practically no certain information as to the individual. The average healthy child seems to have an extraordinary vitality and may be *underfed*, I do not say *starved*, for long periods and yet remain apparently in excellent health, though it is probable that its future growth is being injuriously influenced. If measurements and appearances are not to be relied on, by what is the diagnosis to be made? Even in cases where it is obvious that the tissues of the child are not being sufficiently nourished it is always possible that the absorption from the digestive tract or metabolism is at fault. We have all seen cases of children from good homes who if dirty and dressed in rags would at first sight have been considered as insufficiently fed.

Leaving aside such cases where the appearance makes it obvious that something is wrong either with the child or its feeding there remain the underfed children of whom I first spoke; these, healthy in appearance, cannot be recognised with certainty by anyone as being insufficiently fed. It is possible to point out cases that should be fed but it is not possible for the medical man on inspection and examination to affirm that children are not underfed. The only possible method, if selection is to be exercised and mistakes are to be avoided, is that of visiting the homes and acquiring information there. Of course, I do not suggest that the doctor should do this.

My reason for writing this letter of truisms is that already in places where the medical men are helping in this work—and it is certain they should help—there is a tendency to leave the decision on the question of feeding individual children entirely in the doctor's hands. If he reports that "there is no evidence on examination that the child A. B. is underfed" it is immediately concluded that he means that the child is sufficiently fed at the time of examination, a statement which no medical man would think of making without further information than inspection affords. The fallacy has arisen in the lay mind from the confusion of "starvation," which is recognisable, with "underfeeding," of which it is very difficult to be certain. It seems to me

important that we should make it clear that we cannot be sole judges in this matter in all cases.

I am, Sir, yours faithfully,

Blackburn, Sept. 29th, 1908.

MILES B. ARNOLD.

CANTHARIDES POISONING.

To the Editor of THE LANCET.

SIR,—Since communicating with you recently *re* a case of acute cantharides poisoning in an adult,¹ a second case of a very similar nature has come under my notice and I venture therefore to record these few additional facts.

The patient, an Austrian subject, was admitted to one of the private wards of Johannesburg Hospital on July 26th, under the care of Dr. H. B. Currie, giving a history as follows. He was taken ill on Saturday, July 18th, with (1) stabbing pain in the left side just at the costal margin, and (2) pain in the knee-joint (right). On the 24th he developed a cough, which was associated with scanty mucopurulent expectoration of a greenish tint, whilst the pain previously in existence became intensified and shortness of breath on exertion was experienced. Accordingly, he consulted a practitioner in town who advised the application of a blister. At 8 A.M. on the 25th a piece of plaster (emplastrum cantharidis B.P.), measuring 5½ inches by 4½ inches, was applied to the chest wall below and to the outer side of the left nipple. 13 hours afterwards (at 9 P.M.) the first symptoms appeared. The patient states that he felt a desire to pass urine every hour or so and could not keep (i.e., retain) it for a longer period. Pain was experienced at the end of the penis when the act was nearing completion; the urine voided was the colour of beetroot water. Headache developed in conjunction with the other symptoms, but there was neither vomiting nor purging; indeed, it appears that for the first 48 hours the bowels remained inactive.

On admission, on Sunday, July 26th, the physical signs indicative of disease were those of pleurisy with effusion on the left side. There was a raw surface measuring 5½ inches by 4½ inches below and to the outer surface of the nipple. The temperature was 102° F., pulse 106, and respirations 39 per minute. The patient's tongue was heavily coated. His bowels had not been opened since the 24th. The right border of the heart extended a finger's breadth beyond the edge of the sternum; the apex beat was well defined, being visible in the fifth left interspace at a point one inch internal to the nipple line (very little displacement noted). The first and second sounds were clear at the apex and there was no suspicion of a murmur. The belly wall was not rigid and there was a complete absence of abdominal pain and tenderness. The patient apparently did *not* experience pain in the region of the kidneys. There was no undue frequency of micturition though a good deal of pain of a burning nature was present just within the orifice of the urethra towards the end of the act of micturition. The urine was loaded with amorphous urates and red cells and yielded after careful filtration a well-defined cloud of albumin. The specific gravity of the filtered urine was 1028, and it was acid in its reaction to litmus paper. A subsequent analysis made on July 28th yielded results as follows: Specific gravity of filtered urine, 1027; reaction of filtered urine, acid; fairly dense cloud of albumin precipitated on warming the solution; centrifugalised deposit found to consist of amorphous urates, leucocytes, red blood cells, granular casts, and a few kidney cells. A third analysis carried out on the 30th demonstrated the existence of numerous kidney cells. The specimen of urine selected for examination proved turbid from precipitation of mucus and urates but cleared up on gently warming. Its specific gravity was 1022 and reaction was acid as on previous occasions. The centrifugalised sediment yielded one or two red blood corpuscles, a fair sprinkling of leucocytes, several short granular and hyaline casts, a few epithelial cells from the urinary passages, and quite a number of renal epithelial cells with coarsely granular protoplasm, scattered and in groups of from 20 to 30 or more. On August 1st the chief change noted was a diminution in the number of formed elements. Beyond a few truncated granular casts and kidney cells all in an advanced stage of degeneration there

¹ See THE LANCET, Sept. 12th, 1908, p. 800.