

of his treatment of the subject was that it is the power to form propositions that is affected, and not the memory of words or faculty of language; the higher the propositional value of the task the patient is asked to carry out the less he will be able to respond. The teaching of Jackson remained without fruit, first, owing to the profundity of its thought; and secondly, owing to the rise of a succession of brilliant dogmatists, led by Bastian, who propounded schemes and diagrams which gave apparently simple explanations of the phenomena. Recognition of the fact that it was only by twisting of the clinical findings that a case could be fitted into any particular scheme resulted in the publication in 1906 by Pierre Marie of his "Revision of the Question of Aphasia." He maintains that the aphasia of Broca was a combination of two distinct troubles, anarthria and aphasia, the former being simply inability or difficulty of articulating words without any defect of internal language, the latter corresponding to the "sensory aphasia" of Wernicke, which term should disappear. There followed the great discussion at Paris in June, 1908, which resolved itself mainly into a verbal battle without any real advance. Having closely studied the writings of Jackson, devised a new method of examination, and applied it to a large number of cases, Head propounds a new classification of these "disorders of symbolic thinking and expression," claiming that the observed facts show disturbance of these higher psychological processes and not of particular physiological functions subserving speech. The diagram makers worked on the assumption that we think in words; Jackson and Head maintain that we think in symbols, ranging from simple matching of two sensory patterns to recognition of abstract propositions.—The number closes with a discussion on Aphasia at the Royal Society of Medicine, in which Dr. J. Collier, Sir James Purves Stewart, Dr. Kinnier Wilson, Mr. Herbert Parsons, Dr. Stanley Barnes, and Dr. Head took part.

In the *Military Surgeon* for March Lieutenant-Colonel E. E. Irons, Medical Corps, U.S. Army, discusses in a long and valuable paper the pneumonia which, in the last four months of 1918, followed influenza in the camps in the United States. There were more than 365,000 cases of influenza, and some 20,000 deaths. The case mortality of this pneumonia varied between 6 and 11 per cent. In one camp of 35,000 men the mortality during seven weeks was 3 per cent. of the total force. Influenza, also the complicating pneumonia, attacked more heavily the recruits and men from country districts. To struggle against the disease, or to attempt to carry on in spite of it, was dangerous. Hence non-commissioned officers and regular army nurses had a high mortality. On the other hand, there was little pneumonia amongst patients already in hospital who were attacked with influenza. The essential pathological condition produced in the lung by influenza was an enormous oedema with little consolidation, and many hæmorrhages due to necrosis of the interalveolar capillaries. No bacillus was at this stage recognised, but influenza lowered resistance and gave opportunity to the infections already in the naso-pharynx to develop, and so set up pneumonia. The microbic character of the pneumonia varied from camp to camp and period to period. Colonel Irons describes the morbid anatomy of the pneumonia, differing as it was due to pneumococcus, streptococcus, Pfeiffer, or staphylococcus. Tuberculosis as a sequel was rare. The best treatment proved to be early rest in bed, good nursing, and the prevention of complicating infection. No routine treatment could be advised. Convalescence was prolonged. Convalescents got double rations, and being still hungry were given bacon and beans additional. They were put through graduated exercises, beginning with a short five-minute walk twice a day, and went on to games and hard work. Care was taken that they were not discharged too soon, for their resistant powers had been severely taxed. A paper by Captain Ivy A. Pelzman discusses the high venereal rate of the U.S. Army in China. Of 100 men, 89 risk infection and 23 get it. Why? Prophylactic treatment in Tientsin is a long way from the centre of the town, and it is therefore proposed that tolerated houses be established on the U.S. Concession. The women would be kept clean, and prophylactic measures would be close at hand for the men, and there would be a lower venereal rate.—There is a most entertaining article, *Doctors in Uniform*, by Dr. H. W. Dana, of Boston, Massachusetts, giving account of the experiences and training of civil practitioners called up for the war. He tells of the difficulty there was in getting special chances of leave and the excuses that were not accepted. "Grandmothers' funerals did not go," he says. One doctor who arrived with a black umbrella was induced to travel three miles to exchange it with a quartermaster for another in a regulation khaki shade. The drill was beneficial, the discipline was improving, and the post-graduate special courses were wonderful. One candidate for a commission asked to

mention intestinal parasites could only mention two—typhoid and paratyphoid. Dr. Dana is certain that no man who went to the Medical Officers' Training Camp left camp without getting vast benefit physically and professionally. Many officers have apparently been writing at Christmas from the United States to Sir John Goodwin, the Director-General of the Army Medical Service, and he has sent them a letter of thanks addressed to Surgeon-General M. W. Ireland, at Washington, recalling how generously their service supported us in 1917, and how much the support and help of those 1000 medical officers and 700 nurses meant to our armies.

## New Inventions.

### A URETHRAL AND SINUS DRAINAGE BOUGIE.

BEING interested in the treatment of gonorrhœa as practised by the Australian medical officers at Codford Camp I have had made for me a drainage bougie with a view of improving the technique. It is simply a tubular mesh of white silk closed at one end (see figure) through the centre of which runs a thin vegetable fibre. Its length is about 2 inches, the central core being several inches longer and its flexibility allows easy insertion into the urethra or sinus. Its mode of application is painless. The urethra being cleared by urination a sterilised urethroscope tube with the pilot is inserted; the pilot is then withdrawn and the drainage bougie saturated with any desired solution, such as permanganate of potash, protargol, acriflavine, and so forth, is introduced. The urethroscopic



tube is now withdrawn leaving the drain in situ. Finally, the central core is pulled out, leaving the drainage-tube in the urethra. The drain gives no discomfort and is well tolerated. The advantage of this form of treatment is that all parts of the mucous lining come into contact with the antiseptic employen and there is no risk, as in syringing, of driving the pus into the posterior urethra, which I believe is a common cause of cystitis, prostatitis, and orchitis. I can conceive no more rational treatment of gonorrhœa than by the employment of this method. I have treated several cases with excellent results, but the number is too small for statistical purposes. I am having a glass, endoscopic tube made for introducing the drainage-tube which could be used by the patient. This method might also be employed for the drainage of small sinuses, fistulæ, and for other purposes.

The silk bougies have been made for me by the Aurorascope Co., Ltd., Fulwood House, Fulwood-place, Holborn, W.C.

BERKELEY-STREET, W. HENRY DUTCH,  
M.D., M.R.C.S., L.R.C.P. Lond.

### A TUBE FOR BLADDER DRAINAGE.

It has always appeared to me that the methods of bladder drainage commonly employed after cystotomy are a reproach to surgery, and that if the care exercised in the modern theatre was extended to the obtaining of a water-tight and aseptic bladder the results of vesical surgery would be much improved. The usual method of placing a stout tube in the bladder and sewing the incision around it permits the bladder to retract into the pelvis, and invariably allows leakage around the sides of the tube, and contamination of the prevesical space. In some cases the tube presses painfully on the trigone and tenesmus results. In a few, I imagine, the bladder withdraws itself over the end of the tube; in any case prevesical infection is common and ammoniacal decomposition and deposit of phosphates occur in a large proportion of cases.