

The Lady Mayoress, in asking Sir Frederick Treves to deliver an address, said that every other county in England and Wales had its own branch of the Red Cross Society and the City of London must not be behindhand in the work. Sir Frederick Treves, after explaining the work of the Red Cross Society, said that the work was essentially a woman's work, and reminded his hearers that the Queen, on the inauguration of the British Red Cross Society at Marlborough House in 1905, had appealed to the women of England to assist her in carrying out her great scheme on that ground. On the motion of the Lord Mayor, seconded by Sir Melville Beachcroft, a resolution was unanimously adopted expressing the desirability of establishing a branch of the society in the City and referring the matter to a committee under the presidency of the Lady Mayoress, and consisting of Lady Dimsdale, Lady Savory, Lady Mackinnon, and such other members as might desire to serve, in order that the necessary steps might be taken to bring a branch into existence.

On March 14th the Mayor of Kensington, Sir Walter Phillimore, presided over a meeting held at Kensington Town Hall for the purpose of forming a branch of the Red Cross Society. Sir Frederick Treves delivered an address. The movement in Kensington has been initiated by Lady Phillimore, who will be president of the new branch.

INDIAN MEDICAL SERVICE DINNER.

The annual Indian Medical Service dinner took place at Lucknow on Feb. 10th, Lieutenant-Colonel G. F. A. Harris, the officiating Inspector-General of Civil Hospitals in the United Provinces, presided and about 40 members sat down. The guests included the chief military medical officers in Lucknow.

THE RECTORSHIP OF THE IMPERIAL COLLEGE OF SCIENCE.

Sir Alfred Keogh, K.C.B., who until recently was Director-General of the Army Medical Service, has accepted the Rectorship of the Imperial College of Science.

Correspondence.

"Audi alteram partem."

THE PREVALENCE OF TUBERCULOSIS AMONG SCHOOL CHILDREN.

To the Editor of THE LANCET.

SIR,—Any communication from such an eminent tuberculosis specialist as Dr. R. W. Philip on the above subject must be of general interest to readers of THE LANCET, and his letter in to-day's issue touches on many points of vital importance for physicians specially concerned with the welfare of children. The very acceptance of the meaning of the term "tuberculosis" appears to be changing among scientific clinicians, and I am consequently emboldened to ask Dr. Philip for an answer to these questions, How does he define tuberculosis? What does he mean when he says a patient is suffering from tuberculosis?

Personally, I concur most fully with him in his aspiration that the standard of clinical training should be as high as possible, and most distinctly agree with him that the amount of tuberculous infection in young children is enormous. But are we to consider as standard tests of "the stigmata of tuberculosis" in young children the tests mentioned—namely, "(a) palpation for evidence of glandular enlargement of the anterior cervical and supra-clavicular areas (only cases showing at least a dozen such enlarged glands were included as positive); (b) percussion of the apices; and (c) auscultation of the apices"?

I understand from what he says that children disclosing "stigmata of tuberculosis" under examination by these tests, children who are otherwise "in fairly good health" and who have no other distinct morbid physical signs, are those he would class as suffering from the latent, in contra-distinction to "aggressive," disease. I cannot help thinking that the three tests mentioned are not wholly reliable as conclusive proof of the presence or absence of tuberculous infection in children of school age, and more especially in the younger of these children. The characteristics of tuberculous infection in the early years of life are largely peculiar to that age period, and while bowing to the

experience of Dr. Philip I would suggest that post-mortem findings do not altogether tally with this description of "clinically determinable infection."

I am wholly at one with Dr. Philip in realising the vital importance of the right recognition of all the aids and methods at hand for the determination of the existence of tuberculous disease, but at the same time, in striving after "refinement of examination," it is certainly possible to overlook the obvious, and the detection of a small patch of bodily tissue possibly, or even probably, containing live tubercle bacilli does not necessarily prove that we have unearthed the root of the present evil.

A girl of 7 or 8 years of age was brought to see me a short time ago at the Royal Hospital for Sick Children. Three months previously she had suffered from an attack of measles, and since that time had been troubled with a constant cough. The mother was informed by the physician whose advice she sought (three days before she came to the hospital) that her daughter was suffering from consumption, that the upper part of her right lung was diseased. I could, however, discover no abnormal physical signs in the chest. The child looked distinctly ill, pallid, anæmic, and thin; there was loss of appetite, lethargy, and general debility. There was no sputum obtainable, and there never had been. To von Pirquet's tuberculin test the reaction was negative. There was, however, present a condition of pharyngitis and caries of the teeth in a marked degree. With attention primarily directed to the dental caries steady improvement in the general condition at once occurred, and as seen to-day the child is apparently in "normal health."

And this is no isolated case. I have seen many such, not all due to dental caries, but to conditions other than tubercle infection. And though "refinement of examination" may in such cases disclose latent foci of tuberculous infection I consider that it is positively immoral to hall-mark these children consumptive or tuberculous without the most careful exclusion of all other causes for the condition present at the time.

I am, Sir, yours faithfully,

Edinburgh, March 12th, 1910.

A. DINGWALL FORDYCE.

THE UNDER-FEEDING OF BOTTLE-FED INFANTS.

To the Editor of THE LANCET.

SIR,—The subject of infantile mortality and the rearing of infants is receiving much attention nowadays, and doubtless many a medical officer of health besides myself prides himself on good work done in this direction and can point to annual tables of statistics showing a steady decline of the infantile death-rate.

One of the principal errors we have to combat is the systematic under-feeding of bottle-fed infants, the prevailing notion seeming to be that cows' milk is three or four times stronger than human milk and that it needs corresponding dilution. The point is clearly dealt with by Playfair, who in the second volume of his book on "Midwifery," speaking of the feeding of infants with cows' milk, says:—

A common mistake is over-dilution, and it is far from rare for nurses to administer one-third cows' milk to two-thirds water. The result of this excessive dilution is that the child becomes pale and puny and has none of the firm and plump appearance of a well-fed infant. The practitioner, should, therefore, ascertain that this mistake is not being made, and the necessary dilution will be best obtained by adding to pure fresh cows' milk one-third hot water, so as to warm the mixture to about 98°, the whole being slightly sweetened with sugar of milk or ordinary crystallised sugar. After the first two or three months the amount of water may be lessened, and pure milk, warmed and sweetened, given instead (fourth edition, p. 295).

This is wise advice, and an experience of 25 years' practice, during which I have paid particular attention to this point, has convinced me of its wisdom. The difference in an infant who has first been fed with the excessively diluted milk, and then has been given for a few weeks the more generous mixture, needs only to be seen to be appreciated.

In teaching these facts to patients and to the public I have found practically that the chief obstacle to be overcome almost invariably is the argument that a nurse or doctor had ordered this extreme dilution, and now it appears that no less an authority than "The National League for Physical Education and Improvement" is advising the same underfeeding. I enclose a leaflet on "How to Bring up a Baby" which the League has recently sent to me; it is numbered fiftieth thousand and has

evidently been extensively circulated. In paragraph 15 a table is given for the preparation of infants' food from cows' milk. This advises, as you will see, during the first fortnight a dilution of *3 parts of water with 1 of milk*. Equal parts of milk and water are not reached until the third month, 2 parts of milk to 1 of water are arrived at in the sixth month, and when the baby is 9 months old a strength of 3 parts of milk to 1 of water is finally recommended!

Besides excessive dilution, the total amount of food advised is very small. Nothing is said as to the varying capacity of different babies, but it is laid down that "the exact quantities of milk and water should be measured out," and then the maximum daily amount allowed for a child from 5 to 6 months old, if fed regularly day and night, is 32 ounces, in eight meals of 4 ounces each, each meal containing $2\frac{1}{2}$ ounces of milk—exactly one pint of milk a day. Such feeding as that recommended here is, for ordinary healthy babies, nothing short of semi-starvation, and issued, as it is, authoritatively, it is a serious thing, for the point is of such importance as to outweigh all the good advice on other points given in the leaflet.

Incidentally, I notice that two bottles are recommended. Practically, the obligation to keep the bottle clean is less easily avoided if only one bottle be used and the simple rule be made that when not in use the bottle is to be kept in a basin of clean water. At any visit the doctor or health visitor has only to ask, "Let me see the bottle," and it should be found in its basin. I write this only because I am convinced that a serious error is being made in advising such free dilution of milk for the feeding of infants, and in the hope that this protest may lead to the correction in this point of an otherwise excellent leaflet.

I am, Sir, yours faithfully,

Bromsgrove, March 9th, 1910.

CAMERON KIDD.

THE ÆSTHETICS OF ANÆSTHETICS.

To the Editor of THE LANCET.

SIR,—The publication in THE LANCET of March 5th of Dr. Hewitt's exceedingly interesting and instructive lecture on the Æsthetics of Anæsthetics raises some important questions from the surgeon's point of view. In the first place, it is evident that when the anæsthetist has more facilities for attending to the æsthetic principles of his art the better will be the result, and it is abundantly clear that the better the anæsthetic result the easier is the operation to perform and the less troublesome is the after-effect. "*I am convinced that many, and perhaps most, of the discomforts which one often hears attributed to general anæsthetics should in reality be attributed to a want of appreciation of certain details to which I shall to-day refer.*" Apart from the fact that many of these discomforts may also be due to the nature of the operation or to the position in which it has to be performed, there still remain several difficulties that the anæsthetist has to contend against, more especially in hospital practice. Speaking quite generally, nitrous oxide is the anæsthetic for the induction of anæsthesia. We can say to the patient, "You will smell nothing except perhaps a slight smell of rubber, and you will know nothing after 30 seconds." I venture to say that in hospitals generally there are very few pieces of apparatus that allow this ideal to be attained. Almost all the inhalers in hospitals leak ether vapour when the pointer is turned to "O." The patient smells the vapour at once. The fittings of the spindles, &c., are in the first instance accurately ground and the slightest injury to them is seldom perfectly reparable. The same thing applies in the case of ground valves to gas cylinders, any rough usage of which by porters or others is harmful to an easy and regular supply of gas. In addition the ether inhaler being metal attracts the attention of the nurse, who polishes the outside till it shines like a mirror and incidentally fills the threads of the screws with metal polish or whiting. When the anæsthetist arrives the rapid adjustment of the spindle so that he may make the apparatus odourless is impossible. "Cleanse first the inside that the outside may be clean also."

As Dr. Hewitt indicates, the smallest sensory stimulus is greatly magnified to the semi-conscious patient, and in addition to the causes he mentions as being especially disturbing, the cutting of bandages, preparation of the skin,

pulling up of stockings, or adjustment of bed-clothes may indirectly completely mar a surgical procedure which otherwise the anæsthetist would have rendered safe and easy of performance. Some patients raise a hand at a certain stage to indicate that they are still conscious or perhaps to relieve an itching of the skin. As often as not the hands are at once seized and held down, an automatic muscular contraction being thereby brought on and a general struggle ensuing. Just as there are stages at which it is correct to restrain a patient's struggles so there are others at which it is wrong. Some patients struggle against their own muscles or body weight, and if left alone merely alter the position of their limbs or raise their bodies, matters of no real disadvantage which settle themselves in due course without attention, but the onlookers are hardly ever able to know the exact stage of unconsciousness that the patient has arrived at and they willingly, and perhaps by order, assist when they should, properly speaking, do nothing.

The dread that some patients have of anæsthesia quickly spreads in a surgical ward. Conversely, when the induction has been by nitrous oxide and well conducted and main, tained, and when the after-effects are consequently slight the patients in a large surgical ward are much more willing to submit to operation. And how little credit does the anæsthetist get! It is quite usual for him to send the patient off the table conscious to such degree that if roused up he answers to his name, but on the removal of sensory stimulus he sleeps soundly for four or five hours and is not sick as a result of the operation. The anæsthetist has been greeted with the remark: "I hope you will not get the patient to-day so deeply under that he will require so much attention afterwards."

The constant change in the *personnel* of a large hospital renders it extremely difficult to ensure a succession of correct proceedings. The discontinuity needs endless patience on the part of the teacher and greatly hampers him in research work. It behoves everyone as far as possible to try to secure a more perfect environment for the patient and anæsthetist, so that operations may be performed with greater comfort to both patient and surgeon. Dr. Hewitt will receive the thanks of the medical profession for having drawn attention to so important a subject.

I am, Sir, yours faithfully,

March 7th, 1910.

G. H. COLT.

ON THE VARIATIONS OF TEMPERATURE IN PHTHISIS DURING THE MENSTRUAL PERIOD.

To the Editor of THE LANCET.

SIR,—Dr. C. G. Welch in his interesting analysis of 500 cases of phthisis in relation to the effect of menstruation on the temperature in THE LANCET of March 5th does not quite do justice to previous published work on the subject.

Turban¹ (Davos) described 11 years ago the principal varieties of premenstrual, menstrual, and post-menstrual fever, with a note of their prognostic significance, and he returned to the subject in a paper of great interest read before the Twenty-fifth Medical Congress at Vienna, 1908. He describes here seven types of temperature elevation, the most frequent (73 per cent.) being the premenstrual, in which the rise occurs at a time varying from some hours to 14 days before the onset of the menses. This form is but an exaggeration of the *lebenswelle*, or the temperature curve of the normal healthy woman, has no baleful significance, and generally lasts on into convalescence. Post-menstrual fever is, on the other hand, often the expression of an exacerbation of the lung trouble occurring at this time, and almost always of bad import. Other types are rarer and more in the nature of clinical curiosities. Turban concludes that for many tubercular women menstruation must be regarded in the light of a complication.

Cornet² (Berlin) in his great compendium alludes to the occurrence of pre-menstrual rise of temperature in two-thirds of cases of tubercular disease in the female, adding that it has no influence on the course of the disease, but has a certain value in diagnosis. He gives a list of references to the work of others.

¹ Beiträge zur Kenntnis der Lungentuberkulose, Wiesbaden, 1899.

² Die Tuberkulose, Wien, 1907.