to what extent it could be utilized, either now, or when coming events may have increased the strain on the physicians and surgeons of the country.

If any of those interested in this subject will communicate with me, I shall be glad to have their suggestions, and perhaps arrange to have a meeting called should the response to this letter seem to warrant it.—I am, etc.,

ALEX. OGSTON,
President of the British Medical Association.

252, Union Street, Aberdeen,
January 30th, 1916.

THE SOLDIER'S "IRRITABLE HEART."

SIR,—I have read with great interest the valuable contributions to the etiology and treatment of this important condition which appeared in the JOURNAL of January 22nd. The causation of "irritable heart" is undoubtedly complex, but I was surprised to discover only one reference—casually by Dr. Poynton—to a cause which I am convinced is largely responsible, in combination no doubt in most cases with other causes, for disordered cardiac action, namely, tobacco. That tobacco smoked to excess—more especially the cigarette—is competent to upset the heart is a well recognized fact. I have had personal experience of the effect of smoking too many strong Burma cheroots. Intermittent action, palpitation and excitability of heart, breathlessness, anorexia, giddiness and general slackness were the principal symptoms. Probably hard work in the trying climate of Calcutta contributed to the development of these indications. They disappeared with a more moderate use of milder tobacco, and have not recurred. That the heart was not organically or permanently damaged is proved by the fact that, at the age of 75, I am able to negotiate a fairly stiff incline on my bicycle without palpitation or breathlessness. That soldiers in this war smoke to excess is, I think, unquestionable; and in the treatment of "irritable heart" the limitation of pipe and cigarette smoking should, I submit, constitute a leading item.—I am, etc.,

Westend, Hants, Jan. 25th. KENNETH MACLEOD.

THE DIAGNOSIS OF FUNCTIONAL HEART DISEASE IN THE RECRUIT.

SIR,—Even at this, which might be termed the eleventh, hour in the medical examination of recruits, I am convinced that the haziest notions are prevalent amongst medical men in the diagnosis of functional heart disease.

In spite of the writings of Sir James Mackenzie and others, the examiner of recruits is frequently undecided in coming to a conclusion regarding a particular case, more especially when the recruit brings a note from his doctor which states that the bearer has tachycardia, heart weakness, or arrhythmia, rendering him totally incapable for military service.

The following simple rules I have found most useful, and I hope will be useful to others:

1. *Medical History.*—Has the recruit had rheumatic fever, syphilis, or does he indulge to excess in alcohol?

What is his occupation, and if laborious, does he complain of any of the classical symptoms of cardiac deficiency? In other words, ascertain if his "field of cardiac response" is normal. Inquiries in this direction need only take a few seconds. The question of anaemia with haemic murmurs does not obtain in examining recruits, as they are practically confined to women. If the recruit's medical history is above suspicion, a glance at the apex beat and application of the stethoscope at the various regions of the heart at once proclaim the healthy heart.

2. *Physical Examination.*—Having obtained a suspicious medical history, noticed a misplaced apex beat, or heard a murmur, I would advise a systematic examination, which only takes a few minutes, when done in the following manner:

(*a*) Note apex beat and rapidly percuss out left side of the heart. This should be the first and is the most important examination.

(*b*) Granted the apex beat and size of the heart as obtained from percussion are normal, it is almost certain there is no incapacitating heart disease, but to make doubly sure listen to the mitral area. An organic murmur heard there will be propagated to the axilla. A functional murmur is immediately lost to the left of the apex beat. It may increase in intensity as it is traced inwards, and it always can be heard in the pulmonary area, where it is louder than at the apex. Compare the intensity of the murmur in these two areas by going immediately from the one to the other. If the murmur is louder in the pulmonary area than the mitral and is not propagated to the axilla, it is functional heart disease we have to deal with. An additional proof of a functional murmur, if one were needed, is that the second sound at the pulmonary area is only accentuated when we have organic mitral disease.—I am, etc.,

T. STEWART ALLAN ORR, M.B., Ch.B.Edin.,
Recruiting Surgeon,
Central London Recruiting Dépôt, Whitehall.

London, W.C., Feb. 1st.

THE SOLDIER'S HEART AND THE STRAINED HEART.

SIR,—In the genuine functional collapse of a physically overstrained heart the sudden onset may be regarded as a climax in a gradual exhaustion of the myocardium, and primarily as a myocardial failure. In the analogous functional heart-stroke induced in a nerve-worn subject by some overwhelming shock we may safely assume some degree of underlying myocardial inadequacy, but his disabling attack is primarily a nervous heart collapse. The soldier's heart might be regarded as a combination of both types. But in each sufferer the individual myocardial quality and the nerve quality are varying personal characteristics. That personal factor is the main difficulty in any attempted generalization as to differential diagnosis, prognosis, and treatment. There is great encouragement in Sir J. Mackenzie's favourable estimate of myocardial recuperativeness. But we cannot underrate Dr. Morison's misgivings as to the prospect of a complete restoration of the integrity of the nerve function. Neither should we underrate Dr. J. S. Manson's reminder as to the etiological importance of excessive smoking. I therefore regard total abstinence from tobacco as a first indication, though it need not be permanently enforced in those possessing a natural or acquired tobacco immunity.

It is comparatively easy to restore myocardial tone by rest and graduated exercise. The cure of the neurasthenia of the heart struck is much more difficult. Suggestion is probably its most powerful remedy. We are thoroughly justified by our uncertainty as to the nature and extent of the trouble in the individual patient in suggesting to him that there is no heart damage, but only the transient and curable effects of over-fatigue, and, perhaps, of too much tobacco.

As regards the significance in otherwise healthy subjects of occasional irregularity in cardiac action, and of occasional murmurs, I am in practical agreement with Sir J. Mackenzie. For some hearts an irregular gait seems to be the easier one under stress of external pressures. For others an imperfect systolic valvular closure may be the best compensation for any undue intraventricular pressure; but most frequently, perhaps, a harmless murmur, reputed mitral, is nothing more than a disguised reduplication, an overlapping of the normal but asynchronous first sounds. Mere loudness is not a reliable measure for the size of the leakage, if any should exist. As in whistling, the intensity of the sound varies directly with the degree of the pressure, and inversely with the diameter of the lumen.—I am, etc.,

London, W., Jan. 30th. WILLIAM EWART.

DYSTOCIA DUE TO CONSTRICTED OS.

SIR,—Amongst the memoranda in the JOURNAL of January 29th, Drs. Owen-Jones and Morris record an interesting case of a nulliparous woman who, they were informed, had previously suffered from procidentia uteri, which had been treated by ventrifixation, and had completely recurred. She then became pregnant for the first time, and, when she went into labour, delivery was delayed because the os externum did not open out.

But nulliparous women do not have procidentia uteri (the final or complete stage of prolapsus uteri). When they habitually wear the cervix outside the body, as the writers aptly put it, the condition is quite a different variety o genital prolapse. This begins with a developmental error, elongation of the cervix. The overgrowth of the cervix occurs at puberty, and often proceeds until the uterus is