

of this year. On Oct. 7, 1934, in a review of my book on B.C.G., in which I advocated it as safe and successful, you said: "These views are very similar to those which have been advanced in the editorial columns of the *B.M.J.* during the past few years, and are likely to meet with a considerable measure of approval. The real crux of the matter is how great and how lasting is the degree of immunity produced."

I think Dr. Lillingston's fears are justified; we have been caught napping in this country—but not through any fault of yours, Mr. Editor, or mine.—I am, etc.,

Henley-on-Thames.

K. NEVILLE IRVINE.

Temperature in Pulmonary Tuberculosis

SIR,—There have been a number of articles in the *Journal* about the temperature in pulmonary tuberculosis, especially in connexion with the menstrual cycle: Feb. 9 (p. 209), March 2 (p. 334), and April 6 (p. 523). In the *Journal* of Dec. 29, 1928 (p. 1173), I wrote on "The Temperature in Pulmonary Tuberculosis."

The oral method is the most suitable for taking the temperature, but the patient must keep his or her mouth shut for fifteen minutes, and the thermometer should be kept in for five minutes for accuracy. I noted the following points. (1) There was a definite premenstrual rise in temperature, the average duration of which was five to six days. The long premenstrual rise is present in only 34% of positive cases, but in 52% of negative cases. Two healthy nurses took their own temperatures at my request, and in both cases there was a premenstrual rise. This seems to show that it is not diagnostic of tuberculosis. In fact, if only one record of temperature is taken, it must be considered in relation to the menstrual cycle. (2) I also noted that in 90.1% of males the difference between morning and evening temperatures was more than 1° F. (0.56° C.), and in 56.7% of females less than 1° F.—I am, etc.,

Dorridge, Birmingham.

COLIN MILNE.

Stethoscope versus X Rays

SIR,—Dr. J. Frankland West (Feb. 2, p. 182) describes a case in which the radiological diagnosis was that of a resolving lobar pneumonia, though the patient actually was suffering from pulmonary tuberculosis. From this case Dr. West concludes that a vote of "no confidence" with regard to mass miniature radiography is justifiable, and also that the x-ray film is inferior to the stethoscope in the diagnosis of early tuberculosis. Frankly I fail to see how a medical man with years of training behind him can arrive at such a conclusion on the scanty and feeble evidence put forward.

The clinician who relies on others for his x-ray interpretations is apt to forget that we can ask an x-ray film—and particularly one of the chest—just so much and no more. He feels that in order for such a film to be of any use it must supply an exact answer to the question, "From what disease is this patient suffering?" This belief is often fostered by the unwary radiologist who is tempted to read his films in terms of "bacteriology" instead of "pathology."

The x-ray film is a shadow picture of a disease process in an anatomic structure, and often cannot, and should not, be interpreted in the light of the causative organism. Yet this apparently is what Dr. West feels that it should be capable of doing before he is willing to grant it its rightful place in chest diagnosis. He is asking too much of his chest films, and because on occasions he gets the wrong answer he is ready to condemn the most useful diagnostic means at our disposal. Would Dr. West drive a screw with a hammer? And if he did try to do so without success would he then condemn the hammer as a useless tool? Would he condemn the microscope because it failed to tell him the difference between a tubercle bacillus and, say, a leprosy bacillus?

Nevertheless he attempts to belittle the value of the x-ray film when he once fails to get from it a differentiation between a tuberculous pneumonia and a resolving lobar pneumonia, two conditions which may very strongly resemble one another. Any man with experience of chest radiology will admit that such differentiation is often quite impossible, and in Dr. West's case I have no doubt at all that the fault lay, not in the x-ray film, but in too great a readiness on the part of the radiologist

to give a definite diagnosis on insufficient evidence. Those of us who give our whole time to chest work are constantly running across difficulties in accurate diagnosis on the basis of the x-ray film alone. A lung abscess may look exactly like a tuberculous cavity, while malignant glands in the mediastinum may be indistinguishable from the glandular involvement due to primary infection tuberculosis.

Nevertheless the x-ray film may be relied upon to reveal with accuracy pathological changes in the chest, even though on some occasions it gives no clue to the aetiology of the condition encountered. As a clinician who for the last fifteen years has been listening to patients' chests first and examining their x-ray films afterwards, I have no hesitation in saying that the skiagram will reveal many more early lesions than my stethoscope will bring to light. I use the word "lesions" advisedly, however, as in a number of cases it is impossible to be sure of the actual condition present without further laboratory and clinical examinations, and often another x-ray examination.

Dr. West has missed the point entirely when he expects a cut-and-dried diagnosis always to stare at him as soon as he opens the radiologist's report. Surely he would not ask for a vote of "no confidence" in his car when it failed to negotiate a three-foot depth of water. Yet this is exactly what he is doing when he asks an x-ray film too much and occasionally gets a wrong answer.—I am, etc.,

King George V Jubilee Memorial
Sanatorium, Jamaica.

RICHARD A. S. CORY,
Senior Medical Officer.

SIR,—I hasten to explain that the membership of my "fifth-rate provincial soccer club" (March 16, p. 410) was strictly limited to the clinical methods of investigation which were enumerated in the preceding paragraph. Persons—living, dead, or fictitious—were neither admitted nor included. I hardly thought that this explanation would be necessary, but Dr. Weatherhead's letter (March 30, p. 504) shows that one can never be too careful when using a comparison.

Dr. Weatherhead's statement that I am a "comparatively recent" recruit to the tuberculosis service is not only comparatively but absolutely untrue. If ten years—three and a half of which were spent in full-time hospital appointments (two years in a teaching hospital) and six and a half years in busy tuberculosis clinics—come under the heading of "comparatively recent" then I must admit that my English is considerably worse than Dr. Weatherhead thinks.—I am, etc.,

Woodford Green, Essex.

F. KELLERMANN.

Words and Clear Thinking

SIR,—I read with considerable interest Dr. T. C. Beard's letter (March 16, p. 404). It seems to me that medicine is honeycombed with etymological inconsistencies, in many cases the same word showing a Greek prefix and a Latin suffix, such as that dreadful word "dysfunction." Surely it would be better to show lingual continuity by referring to a "malfunction" or "dyscrasia."

It would be useful if some efforts were made to standardize medical language. Two glaring examples of mental confusion are presented in the numerous alternative names for the barbiturate drugs and in the various pathological subdivisions of the nephritic lesion such as "acute diffuse glomerulo-tubular nephritis." As I once heard a learned physician say, "Azotæmic and hydraemic nephritis are good enough for me." Again, why in eliciting signs in the chest should it be said that "vocal fremitus" is increased or diminished, thus using an English and a Latin word in the same phrase? Or is it really to one's advantage to know that splenomedullary leukaemia is synonymous with myelocytic leukaemia? I well recall on a ward-round my chief reading out to us clerks the registrar's impressive differential blood count in which well over a dozen different types of cell were claimed to have been seen under the microscope. Among them was a group classed as "dictocyte." My chief, himself a blood expert, said blandly to us: "Dictocytes! What are they? Do they talk to you?" There is a tendency also to fix the incorrect proper name to certain things. In descriptions of lymphadenoma the giant cells are labelled Dorothy Reed or Sternberg cells, whereas they were first described by Sir Frederick Andrewes of Bart's and should be Andrewes cells. To give another example, Graves's disease was

first described by C. H. Parry, a West Country physician of repute.

Basic English has a lesson to teach us, I feel sure, in helping one to express oneself in a simple manner. Muddled thought leads to muddled action and has been responsible for not a little of the present international unrest, and for vague terminology in so many official documents, such as White Papers, that one meets nowadays. If everyone "called a spade a spade" the affairs of nations would soon sort themselves out in a reasonable manner.—I am, etc.,

Donibristle, Dunfermline.

J. B. GURNEY SMITH,
Surg. Lieut., R.N.V.R.

Obituary

CHALMERS WATSON, M.D., F.R.C.P.ED.

We regret to announce the death on April 6 at Fenton Barns, Drem, East Lothian, of Dr. Chalmers Watson, consulting physician to the Edinburgh Royal Infirmary, who had been well known for his work on nutrition and in later years devoted himself to rearing cattle for production of pure and safe milk.

Douglas Chalmers Watson, son of Walter Watson, M.D., of Midcalder, was born in 1870 and was educated at George Watson's College and at Edinburgh University, where he won the Wightman prize in clinical medicine on graduating M.B., C.M. in 1892. After serving as house-physician at the Royal Infirmary and at the Royal Hospital for Sick Children he was elected F.R.C.P.ED. in 1901 and proceeded to the M.D. in 1904. For a time he worked on nutritional problems in Sir Edward Sharpey-Schafer's laboratory, and for this research he was awarded the Alvarenga prize by the College of Physicians of Philadelphia. After his election to the visiting staff of the Edinburgh Royal Infirmary Chalmers Watson was active in promoting scientific methods in hospital practice; he exercised much influence upon students as a clinical teacher and became senior lecturer in clinical medicine in the university. He joined the B.M.A. in 1897 and was secretary of the Section of Pharmacology and Therapeutics at the Annual Meeting held in London in 1910. He was the original editor of the *Encyclopaedia Medica* published in fourteen volumes at the beginning of this century, of which a second edition appeared in 1915-25. His numerous published writings included *Food and Feeding in Health and Disease*, which reached a second edition in 1913, and a small volume, *Lectures on Medicine*, a handbook for nurses; also *The Book of Diet*. A clear and fluent writer, he was a strong advocate of reform in medical education and keenly interested in student activities, both athletic and social. At the Edinburgh University Rectorial Election in 1935 he ran Lord Allenby close.

His first wife, Alexandra Mary Geddes, C.B.E., M.D., sister of Lord Geddes, took a prominent part in Scottish public life and shared many of his tastes and activities. She had been physician to the Edinburgh Hospital for Women and Children, chief controller of the Women's Army Auxiliary Corps, and president of the Medical Women's Federation. She died in 1936, and he married secondly Miss Lily Brayton, widow of Oscar Ashe.

The following passages are quoted from a tribute paid to Dr. Chalmers Watson by a colleague writing in the *Scotsman*:

His originality of thought and dynamic spirit early created an impulse towards research. As a physician associated with the Royal Infirmary of Edinburgh throughout his active medical career he was a clinician of outstanding ability. He was equally loved for his humanity and respected for his sincerity and integrity of purpose. He inspired succeeding generations of students by his enthusiasm, his clarity of exposition, and his originality of thought. He had deep insight into human nature and an unusual capacity for imparting it to others. To his clinical work in hospital he brought his earlier scientific training and was responsible for founding the clinical laboratory of the Infirmary. In the sphere of social medicine his interest was equally wide and the effect of his endeavours equally impressive. Perceiving the lack of suitable institutional facilities for the treatment of those of moderate means he obtained the charter for the foundation of the Queen Mary Nursing Home in Edinburgh and led the way to numerous similar developments elsewhere. Faithful to his early instinct in nutrition as a basis of good health he was not only an ardent advocate of healthy food production, but, in later years, took a practical lead in dairy farming.

Dr. WILLIAM HERBERT SMAILES, who died on March 24 in the Brotherton Wing of the Leeds General Infirmary, was for many years an active worker in the British Medical Association. He had been chairman of the Huddersfield Division and president of the Yorkshire Branch; he served a year on the Central Council and nineteen years on the Insurance Acts Committee, and represented his Division at thirteen Annual Meetings of the Association. Born at Honley, near Huddersfield, on July 6, 1881, son of Thomas Smailes, M.D., he was educated at the Leys School, Cambridge, and at Manchester and Leeds Universities. He graduated M.B., Ch.B. of Leeds, and M.B., B.S. of London University in 1905, took the M.D.Lond. in 1910, and the D.P.H. of Sheffield in 1912. Dr. Smailes had been in practice at Honley for forty years. He was medical officer at the Deanhouse Institution, held many public appointments, and was for some time honorary pathologist at the Huddersfield Royal Infirmary. During part of the war of 1914-18 he worked as assistant surgeon at the Huddersfield War Hospital with the rank of captain, R.A.M.C.(T). He was a past president of the Huddersfield Medical Society and honorary secretary of the Panel Committee. Apart from his medical work, Dr. Smailes had many other activities. He was a J.P. for the West Riding of Yorkshire, a member (ex-chairman) of the Holmfirth Council, chairman of governors of the Holme Valley Grammar School, and a prominent Freemason. H. F. H. writes: His passing has removed from this district an outstanding figure. After nearly seven years of close association with him on the National Service Board at Huddersfield, I can, with knowledge, pay tribute to his worth. He was a fine clinician, of mature and balanced judgment, a most careful and courteous examiner, and a delightful colleague. No matter how busy he might be in his practice, he was invariably punctual in his attendances at the Medical Board, his work was never hurried, and he never lost his serenity. Always ready to help his colleagues, he had a smile and pleasant word for everyone, and was loved by us all. It is not to be wondered that his patients were devoted to him, his life being spent in their service. He was an example of the ideal family doctor, and his passing has left a void which it will be difficult to fill. To his widow and family we extend our deepest sympathy.

Dr. DUGALD CAMPBELL ORR, M.C., who died in hospital at East Kilbride on March 25, graduated M.B., Ch.B. at Glasgow University in 1926. A. B. S. writes: On learning of the death of Dr. Dugald Orr I felt keenly the loss of a great friend and a great physician. My association with him extended over a short nine months, when as a very green house-physician it was my happy lot to be under his masterly guidance. His knowledge of the management and treatment of pulmonary tuberculosis had an uncanny completeness and breadth. But his real mastery lay in his deep sympathy with and understanding of an afflicted human being rather than an afflicted lung. It was this ability to understand and analyse human reactions that made him a great physician. Despite an incapacitating illness he struggled on heroically—his first concern always being the care of his patients. Not only the medical world but also all those privileged to fall under his care will mourn the passing of this beloved physician.

Dr. LEWIS TURNER LANCASTER, of Clitheroe, Lancs, died on March 26 at his home, after a short illness, at the age of 80. He graduated M.B., C.M. at Edinburgh in 1890, and succeeded his father in 1893 in an extensive and scattered country practice in the Clitheroe district. He was in active practice for 40 years: 20 years with horses over long distances, and 20 years with motor cars doing N.H.I. work. He referred to the first 20 years as the good years, the harder years, when work was difficult, responsibilities heavy, hospital facilities scanty—the years when services were appreciated. He found it hard to adjust himself to the psychology of the N.H.I. patients who crowded his surgeries and wasted his time. He was a man of strong individual character, of artistic tastes, loyal, sincere, kind and genial, but hostile and impatient in the presence of humbug. In the pleasant atmosphere of his own home, with his wife and daughter, there was a cordial welcome to all friends who came to see him. He was well known to the older practitioners of N.E. Lancs and to a wide circle of friends in this district. He was a member of the B.M.A. for the last 50 years. The writer has worked with him as an assistant, as a partner, and succeeded him in his practice 15 years ago. Throughout these years he remained the same staunch friend and counsellor, sound and solid and true—qualities which his colleagues in practice respected throughout his active career. He loved a joke and could pass one on with relish. His reminiscences of his early days in practice were highly entertaining. He has gone from among us, but the memories of a vivid personality remain.—J. M.