Dr. Burrell, I made an incision about 4 in. long parallel to and about 2 in. above Poupart's ligament. The peritoneum was tense and bulged forward into the opening, and on being divided the caecum presented hard and distended. I explored with my finger for the appendix, and on lifting the caecum to the left a gush of foul faecal pus escaped from a large abscess cavity beneath, in the right iliac region. The appendix was found with difficulty adhering tightly to the under surface of the caecum, with a meso-appendix of about two-thirds its length, which was 4 in. The end was bulbous. After freeing the appendix from adhesions and tying the meso-appendix, I found at about 1 in. from its caecal end a gangrenous perforation, with a faecal concretion the size of an orange pip lying loose externally. I ligatured the appendix close up to the caecum with silkworm gut, divided it, and touched the stump with pure carbolic. The abscess cavity was well flushed out with hot sterilized water and drained with rubber tubing and iodoform gauze. The peritoneum was approximated as well as its tense condition would allow and the sides of the wound closed; $\frac{1}{30}$ grain of strychnine was given, as patient was suffering from shock.

Result.—The temperature fell after the operation to 99.2°, and fluctuated for the next three days between 100° and 99°. The pulse slowed down from 100 to 68. Fortunately no sickness or vomiting occurred after the anaesthetic or at any time afterwards. Catheterism was required for three days. The patient was fed per rectum entirely for three days, saline enemata given to relieve thirst, and soap enemata caused daily action of the bowels; the motions were liquid and offensive for the first few days, and contained mucus; no pus present. Liquid food was gradually increased by mouth after third day. The wound discharged a copious amount of foul-smelling pus until some dirty-looking sloughs were passed on May 4th. The cavity was plugged with iodoform gauze soaked in glycerine and iodoform, and drained by aid of rubber tubing. Lysol 1 in 100 was used as a douche. Solid food was commenced on temperature remaining normal after May 4th. Motions were formed on May 9th, and bowels acted regularly. Except for a small tracking sinus along course of sutures, which healed rapidly on plugging with gauze to the bottom, the wound healed soundly by May 16th. The patient was discharged in good health, wearing an abdominal belt, on May 31st.

Remarks.—The above case, though one of a disease of frequent occurrence nowadays, presents some features of interest to the general practitioner. The onset, probably caused by a severe chill in an otherwise healthy person, with no previous history of constipation or appendicitis, the self-administration of a strong aperient, and the duration of the subacute symptoms for a week, ending in a fulminating crisis—warn us that appendicitis, however mild to begin with, requires constant supervision, and may terminate acutely and call for immediate surgical treatment. The tension from pressure beneath was so great that rupture must have taken place either into the intestine or general peritoneal cavity, unless relieved.

I am indebted to Dr. Moxham for his assistance and to the matron, Miss Bird, for her careful preparation and constant attention during the after-treatment of the case.

British Medical Association.

CLINICAL AND SCIENTIFIC PROCEEDINGS.

ULSTER BRANCH.

Professor Symington, F.R.S., President, in the Chair.

Belfast, June 29th, 1907.

President's Address.—The President gave an address on some recent observations on cranio-cerebral topography, with demonstrations of a new method, illustrated by specimens, photographs, and diagrams.

Typhoid Fever with Unusual Complications.—Dr. Calwell gave an account of a case of typhoid fever with unusual complications, probably due to the presence of *Bacillus coli* in the urine.

Splenomegalic Polycythaemia.—Dr. W. B. McQuitty read notes of a case. He said the condition known as splenomegalic polycythaemia was first described by Vaquez in 1892, and ten years later by Russell of Birmingham. Subsequently Parkes Weber and Watson, Professor Osler, Robert Hutchison and Miller, Begg and Bullmore, as well as a number of Continental observers, including Senator, Köster, and Reckzeh, had recorded cases with, in a few instances, the *post-mortem* findings. The cardinal signs were three in number: (1) *Increased number of red corpuscles.* This was constant, although the number may vary within fairly wide limits, and might even in pyrexia sink to the normal. (2) *Enlargement of the spleen*, which might be slight or considerable. This was almost constant. Several cases had been described with spleen of normal size. (3) *Cyanosis.* This was usually present. The earliest subjective symptoms were throbbing headache, debility and lassitude, gastro-intestinal disturbance and attacks of vertigo. Sometimes there was epistaxis or other haemorrhages with temporary alleviation of symptoms. The blood pressure was usually above normal; the viscosity and the specific gravity of the blood were increased. There was often a polymorphonuclear leucocytosis of a moderate grade. The patients were, generally speaking, of middle age, and both sexes were equally affected. It was probable that the triad of polycythaemia, enlarged spleen, and cyanosis constituted a definite clinical entity, and that its pathological explanation was an increased activity of the erythroblastic tissue of the bone marrow. The occasional presence of myelocytes in the blood was in favour of this view, which was first suggested by Türk, afterwards by Parkes Weber, and still later by Hutchison and Miller. The prognosis was unfavourable but the progress was, as a rule, slow and might extend over years. Remissions might occur just as is the case in pernicious anaemia. Treatment was unfortunately of little avail, but on theoretical grounds it would be advisable to limit the amount of animal food, to encourage the patient to take whatever gentle exercise his strength would permit, and to avoid haematinic drugs such as iron and arsenic. With the object of diminishing the viscosity of the blood, citric acid in doses of grains xx three times a day might be given.

The following were the notes of a case which recently came under the observation of the author:

Mrs. —, aged 68, consulted him (at the request of Dr. George M. Thompson, Bellaghy) on November 19th last for weakness and loss of flesh.

Family history showed a tendency towards arterial degeneration.

Personal History.—Ten or twelve years ago patient suffered from typhoid fever and two years later from slight congestion of the liver. Otherwise her health had been good prior to the onset of present illness.

Present Illness.—Began in June, 1905, when she took ill with diarrhoea, followed in two or three days by severe pain in the upper part of the abdomen, which was not specially localized in one or other side, and for which she was poulticed. The pain did not last more than a day, and there was some rise of temperature. In a fortnight she was better again, but felt weak. At this stage she came under the care of Dr. Thompson, who found her very much thinner than when in her ordinary health. There was some unusual resistance on palpation in the region of the gall bladder, and there was a slightly yellowish tinge in the skin. The spleen was enlarged; the urine free from albumen and sugar. There were occasional attacks of diarrhoea, sometimes once a week, sometimes once a fortnight, in consequence of which she had to be carefully dieted for some months. By degrees she was able to eat most ordinary digestible articles of food with comparative safety. At the beginning of November, 1906, her condition was better than it had been since the onset of her illness, but her most prominent symptom was that she was very easily tired. It should be mentioned that in June, 1906, she had a severe pain, lasting a few hours, in the left side of the chest in front, for which she was treated by Dr. Spence.

Present Condition.—Patient looks well coloured—the cheeks are red; sclerotics slightly yellow; tongue very red, somewhat cracked, with smooth mucous membrane between the fissures and discrete red spots here and there. (In her ordinary health she had a "geographical tongue.") Thyroid gland a little larger than normal. Weight, 9 st. 5 lb. (two years ago, 12 st.; six months ago, 9 st. 2 lb. or 3 lb.). Pulse 120 at beginning of examination, 108 at the end. Arterial tension a little above the average; artery not thick. Temperature, 97.6°.

Heart.—Apex beat in fifth interspace one finger-breadth outside nipple line, rather forcible; cardiac dullness not increased in any other direction. No murmurs and no accentuation of the aortic second sound.

Lungs.—*Nil.*

Abdomen.—Four inches of liver dullness in the nipple line; the liver comes down one finger-breadth below costal margin at the end of inspiration. The spleen can be easily felt and comes down three finger-breadths at the end of inspiration. The lower third of right kidney can be palpated. The muscles in the right hypochondriac region were on guard at first, but relaxed towards the close of the examination.

Rectum.—*Nil.*

Urine.—Clear, acid, specific gravity 1018; albumen negative by nitric acid test, but a minute trace is shown by the boiling test; sugar, *nil.*

Having regard to the high colour of the face and mucous membrane of the lips and mouth together with the en-

largement of the spleen, it occurred to Dr. McQuitty that this might be a case of splenomegalic polycythaemia, and accordingly he sent the patient to Dr. Thomas Houston who kindly made the following blood-count:

Red corpuscles=9,500 000 per c.mm.
White ,, =13,000 ,,
Haemoglobin =116 per cent.

Differential count:

Polymorphonuclear cells	=46 per cent.
Small lymphocytes	= 22 ,,
Large lymphocytes	= 27 ,,
Transitional cells	= 5 ,,
Eosinophile cells	= 0 ,,

The red corpuscles were well formed and there were no nucleated red corpuscles. The blood was more viscous than normal. The differential count shows a large increase of the large lymphocytes and a relative decrease of polymorphonuclear cells. The diagnosis of splenomegalic polycythaemia was therefore established. At Dr. Houston's suggestion the patient was put on citric acid grains xx t d. Dr. McQuitty did not see the patient again, but Dr. Thompson told him her general condition remained much the same until about January 12th, when she began to suffer from attacks of giddiness, which kept up for a fortnight and were relieved by pot. bromidi grains xx t.d. These attacks were not accompanied by deafness or noises in the ears. On March 13th she was seized with pain in the left side of the chest in the front and the temperature rose. A good deal of crepitation developed at both bases, and there was marked delirium on the second day. The breathing was quiet, and the temperature ranged between 101° and 103°. The patient gradually sank and died on the fourth day. For the last three or four weeks the palms of both hands were bright red, especially on the thenar and hypothenar eminences. Dr. McQuitty pointed out that the points of interest in the case were: (1) The absence of cyanosis; (2) the marked loss of flesh and strength; (3) the decrease in the polymorphonuclear cells, and the large increase of large lymphocytes (large mononuclears); (4) the low colour index. He wished, in conclusion, to express his indebtedness to Dr. George M. Thompson for the history of the case and of its subsequent progress, and to Dr. Thomas Houston for the blood examination, which was essential to the diagnosis.

Excision of Rectum for Carcinoma.—Mr. FULLERTON showed a case in which carcinoma of the rectum had been removed three years previously. The patient was a woman, aged 65 years at the date of operation. The growth was a columnar-celled carcinoma, and almost surrounded the interior of the rectum about a finger's length from the anus. The operation was performed by making a posterior incision, and after removing the coccyx the tumour, with the greater part of the rectum proper and the glands in the hollow of the sacrum, was incised. The upper portion of the bowel was brought out at the anus and sutured to the everted anal canal. A Paul's tube was inserted before the bowels acted to protect the line of junction. Fistulae formed at this line in front and behind, but these soon healed up. The patient had now full sphincteric control, is free from stricture, and is in excellent health.

Gastro-enterostomy for Ruptured Duodenal Ulcer.—Mr. FULLERTON also showed a case of ruptured duodenal ulcer treated by suture and gastro-enterostomy at the same operation. The patient, a woman aged 40, was admitted to the Royal Victoria Hospital for fractured olecranon, which was wired. Sixteen days later, while lying in bed, she was seized with violent abdominal pain and vomiting of bloody material. The abdomen soon became rigid in the upper part. No food had been taken for ten hours previously. Operation was performed four hours after the onset of symptoms. A large dilated stomach, full of grumous material, was found, and in the duodenum at the upper margin a large ulcer had perforated. The edges of the ulcer were hard, thick, and friable. The perforation was treated by infolding and suture with linen thread. A posterior gastro-enterostomy was then performed, and the escaped fluid, of which there was a fair amount, was mopped up by dry sponging with gauze. The abdomen was closed without drainage. No attempt was made to wash out the stomach or irrigate the peritoneal cavity. The patient left hospital on the twentieth day after the rupture quite well. She was now in better health than she had been in for years, and her stomach was much reduced in size. She could take ordinary food without discomfort.

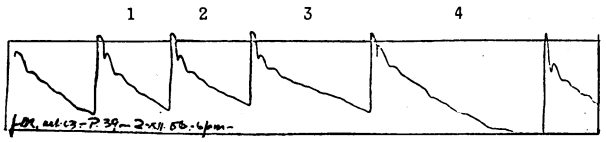
These cases were discussed by Drs. CALWELL and DARLING.

Retroperitoneal Lipoma.—Mr. R. J. JOHNSTONE read a paper on a case of recurrent retroperitoneal lipoma.

Coccygeal Cyst.—Dr. DEMPSEY read notes of a case of coccygeal cyst operated on by him, and Dr. DARLING described a similar case which he had just seen.

Hysterectomy for Ruptured Uterus.—Dr. DARLING read notes of a case of ruptured uterus, with hysterectomy and recovery.

A Case of Heart-block.—Dr. J. L. RENTOUL related this case: J. M., aged 60, came to him in June, 1904, complaining of "weak turns." He described these as faintings preceded by dizziness. On examination he found the man had a systolic murmur in the mitral and a diastolic murmur in the aortic area. The latter was the more pronounced and serious of the two. The pulse was full and strong; rate 80. In June, 1906, Dr. Rentoul was sent for, as his weak turns were more numerous and lasted longer. On this occasion the heart sounds were as two years previously. The pulse was regular if high; tension rate 24. The ventricular rate was also 24. The pulsations in the jugular veins were about three or four times faster than the radial. He put the patient on strychnine. His pulse-rate rose to 39 and kept so till September, when it again fell to 24 and the same phenomenon of fast jugular pulsations with slow radial associated with "weak turns" In December, 1906, the patient was much worse, and remained much longer unconscious. The pulse was peculiar in that twice per minute for four beats the individual beats became slower and longer till the fourth, when they resumed the usual 39 rate. The pulse tracing



shows this well. He then put the patient on tr. belladonnae and liq. trinitrini, on which he did well, the pulse going at the rate of 60. The belladonna and trinitrin was stopped and the pulse remained at 60 for three days; it then fell to 40. Vomiting set in, which lasted ten hours, after which the patient died of exhaustion. The only explanation Dr. Rentoul could think of for the peculiarity in the pulse referred to above was that the "block" was most effective at certain times, so causing a longer period between the ventricular beats. It might be that some one had met with a similar condition and would be able to give an explanation. Dr. MCQUITTY discussed the case, agreeing in the diagnosis.

Cases.—Dr. CECIL SHAW showed two patients, one a man of 43 suffering from a tumour of the larynx, the diagnosis between syphilis and malignant disease being doubtful; the other a girl of 5 operated on by him three months ago for papilloma of the larynx. Mr. H. H. CUNNINGHAM showed a patient, a child, suffering from tuberculous periostitis in the orbit.

SOUTH-EASTERN BRANCH: BRIGHTON DIVISION.

W. A. HOLLIS, M.D., in the Chair.

Brighton, June 12th, 1907.

A Case of (?) Achondroplasia.—Dr. HOBHOUSE showed this case:

Beatrice L., aged 5½, was sent from a London hospital where she was being treated for rickets. Family history *nil*, previous history not fully known. The child had some of the rickety stigmata, but she showed in addition some peculiar features. The femora were bowed and very short, the femur being 7¾ in., the tibia 6¼ in. in length. The body was of about normal length. When the child stood up the lordosis was very marked. The bones of the hands and fingers seemed to be almost non-existent, the fingers being movable in any direction; the arms were short as compared with the body, but the bones were not deformed. The child was very bright and quite intelligent.

Dr. Hobhouse did not feel certain that this was a case of achondroplasia, but he thought that it was extremely probable, as it was unlike rickets in many respects. Of course, there was rickets too, but he thought there was something more, namely, that the rickets was superadded on an achondroplasic condition. The latter, which was also called chondrodystrophia fetalis or fetal cretinism, consisted essentially in a dwarfing of the bones which were ossified from cartilage before birth, whereas rickets was marked by a hyperproliferation of the cartilage cells at the epiphyseal junction. The intelligence was not affected in achondroplasia, and there were no nervous symptoms as in rickets. It was not an uncommon disease; many of the dwarfs seen in the streets were achondroplasic, but in the early stage it was hard to be certain of the diagnosis.

Cerebral Diplegia.—Dr. Hobhouse also showed this case:

W. G., aged 2½ years, was a very typical case of cerebral diplegia; he was one of triplets, the others having died. It was very probable, therefore, that delivery was difficult. The child had never had any use in the arms or legs, he could not sit up or turn himself, had no control of sphincters, and had had a squint from birth. No history of convulsions.

The condition was that of a birth palsy due practically in all cases to meningeal haemorrhage, the secondary lesions resulting from which were (1) meningo-encephalitis, (2) atrophy and sclerosis of cortex, cysts, and secondary degeneration of cord; to the latter is due the rigidity and scissor position of the legs, which is seen in this case. The cases varied indefinitely in severity, but there was usually some degree of mental impairment with ocular paralysis, and sometimes more or less optic atrophy. No treatment or improvement was possible.

Sarcoma.—Mr. Hutchison showed microscopical specimens of sarcoma, and read notes of the three cases. (1) A boy, aged 14 years, suffering from osteo-sarcoma of both superior maxillae; (2) a woman suffering from disease of the middle and internal ear (left). In both these cases there was great prominence of superior maxillae.

In the boy the protuberances were almost symmetrical, but rather more marked on the right than on the left side. The swelling extended from the root of the nose and below the eyes over the front of the face down to the alveolar margin of the maxilla. In the alveolus the swelling was most pronounced on the outer surface, less on the palatal surface, from the first molar tooth on the right side to about the same position on the left. The teeth were not much displaced; there was a little irregularity of the incisors, and the permanent canines were erupting through the gum above and in front of the milk canines, which were *in situ*. The nose was almost completely obstructed, the outer wall bulging into the nasal fossa and pressing on the septum, but it was possible to pass a fine probe along the middle meatus on each side. The nasal ducts were obstructed, and he suffered from lacrymation and epiphora. Radiographs showed the teeth quite clearly, and showed nothing abnormal about the roots—no dentigerous cyst, etc. On transillumination the cheek was quite dark, no infraorbital crescent of light, no fundus reflex, and no subjective sensation of light.

History.—Nothing special in the family history. About two years ago some obstruction of the nose was noticed, but passed off under the use of a nasal douche. Nothing further was remarked until about three or four months ago, when the swelling in the face was first noticed. Since then the swelling had increased steadily. There was no pain, and the general health was apparently not much affected.

Diagnosis.—No definite diagnosis could be made without an exploratory opening of one or both maxillary antra. Puncture through the inferior meatus with trocar and cannula was impossible, no point could be found where the trocar would penetrate. The muco-periosteum was therefore raised from the right canine fossa—or rather from the bone where the fossa ought to be—and an opening made into the protuberance. No antrum could be found. The swelling consisted of soft bone, easily drilled into and easily cut with chisel or gouge. Some of this was cut out and sent to Dr. Bushnell, who reported the specimen to be a spindle-celled osteo-sarcoma.

The second patient came under treatment in December, 1905, on account of pain and discharge from the left ear. A very peculiar condition was found, namely, (1) some granulation tissue sprouting through Shrapnell's membrane; and (2) a complete ring at the inner end of the meatus quite denuded of epithelium. This bled readily on touching with a probe, but no bare bone could be found. This raw surface extended from the margin of the membrana tympani outwards to about the junction of the bony with the cartilaginous meatus. After trying a variety of local applications without any effect, the patient was anaesthetized, the auricle turned forward, and all the diseased tissue removed. This operation in March, 1906, gave some relief, but did not stop the progress of the disease. In November, 1906, a further operation was performed, practically the whole of the mastoid being removed. The large operation cavity was partly filled up with new bony tissue, and the hard swelling spread over the skull back almost to the middle line, upwards to beyond the level of the attachment of auricle and downwards to a limit that could not be made out. Paralysis of the left side of the tongue followed, then difficulty in swallowing, then paralysis of the left side of the face, and the patient died in April, 1907.

(3) Mrs. B., aged 43, first seen in June, 1904. History of nasal polypi for ten or more years. When first seen the nose was completely blocked on both sides by a firm rather fleshy mass beyond which it was impossible to pass a probe. A piece was removed from the left side with a snare and profuse haemorrhage followed, necessitating firm packing of the nose which had to be kept up for four days. Under an anaesthetic the finger was passed well behind the palate, and on pressure the tumour ruptured, and a large quantity of pus escaped, followed by profuse haemorrhage. The finger then passed into an immense cavity, so that practically all the sinuses at the back of the nose had been broken down into one large cavity. The whole of the bony septum had been destroyed. With a large spoon passed through the nose and guided by the finger behind the palate, the cavity was scraped out as well as possible. The cavity was packed with two long strips of gauze. The patient made a good recovery, and was in perfect health two years after the operation.

A microscopical examination of some of the tissue removed showed it to be of a sarcomatous nature.

North Lancashire and South Westmorland Branch.—At the annual meeting held at Furness Abbey on Wednesday, June 26th, A. J. Cross, M.D., President, who was in the chair, delivered an address on the Medical Aspect of Elementary Schools. He dealt with (1) the insanitary condition of such schools; and (2) the effects produced from this condition on the children attending such schools. He said the *cloak rooms* were a breeding ground for lice and the germs of tinea tonsurans and impetigo, due to want of numbering and allocating to each child a peg for its own use. He referred to the want of provision for drying clothes whilst children were in school. The *ventilation* was generally bad, and even if fairly good was unable to carry away foul smells due to emanations from lungs and bodies of children. The bad ventilation was in many cases due to tinkering with the original system, and also to putting up glass screens to form class rooms, and so totally altering the original system; the latter was often inadequate in summer and not properly used in winter, owing to the temperature required by code not being produced without closing means of ventilation. The interstices between the flooring boards were full of dust permeated with germs, and were stirred up by children marching into and out of school, and again at night by cleaners; some form of impermeable flooring that might be flushed at least once a week was required. Schools were thoroughly scrubbed out twice only a year except after epidemic disease. Children should not be admitted until 5 years of age, being more susceptible at that time to measles and whooping-cough; the greater percentage of deaths under 5 years were of children affected with these and other zymotic diseases; while physical deterioration was favoured by insanitary condition of babies' class rooms, and restraint for considerable periods of time. *Epidemic disease* was more frequent than in former years. This was due (1) to the stirring up of dust impregnated with germs; (2) to the admission of children under 5 years; (3) to the mildness of disease preventing it being diagnosed by parents, and children suffering attending school; (4) to the return of children to school too soon after infection; (5) to the want of frequent medical inspection of children attending school during epidemic, and also when schools were reopened after closing for epidemic; (6) to the indiscriminate use of reading books and writing materials. *Long desks* were now being replaced by *dual desks*. Each child should now have reading books and writing materials for its own particular use which could be at once destroyed after it was found that they had been used by infected children. On dual desks also provision might be made for hanging cloaks and hats. Dr. Cross then discussed the general question of medical inspection (1) of children before being allowed to attend school; (2) of badly nourished children to see if properly fed; (3) the inspection of skins and throats during and after epidemics of measles, scarlet fever, and diphtheria; (4) the inspection of girls on reaching age of puberty before leaving school;

and (5) the special inspection of teeth, eyes, etc.—Dr. A. F. RUTHERFORD showed a baby with symmetrical maldevelopment of the upper extremities, with absence of radii. It was also born with an imperforate anus. Dr. Rutherford read notes of a case of embolism of the superior mesenteric artery following an injury to an aneurysm of the abdominal aorta.—Dr. W. H. COUPLAND exhibited numerous dissections and diagrams illustrating the auriculo-ventricular band of His.—Dr. G. BLAIR demonstrated under the microscope: (1) Spirochaete of African tic fever; (2) larva of tunicate; (3) section of amphyoxus; (4) Purkinje's fibres in heart of sheep; (5) striated muscle of frog and rabbit.—The following specimens were also shown: Dr. A. F. RUTHERFORD: (*a*) Twin ovum in ectopic gestation; (*b*) melanotic cancer of penis. Mr. J. H. IRVIN: Large lipoma of mamma. Dr. F. E. DANIEL: Modification of stem pessary. Mr. A. S. BARLING: (*a*) Myoma of uterus; (*b*) renal calculus.

REPORTS OF SOCIETIES.

EDINBURGH MEDICO-CHIRURGICAL SOCIETY.

J. O. AFFLECK, M.D., President, in the Chair.

Wednesday, July 3rd, 1907.

BACTERIOLOGICAL TREATMENT OF GENERAL PARALYSIS.

DRS. W. FORD ROBERTSON AND DOUGLAS MCRAE, in a paper on The Treatment of General Paralysis and Tabes Dorsalis by Vaccines and Antiserums, said that the two types of diphtheroid bacilli used by them both showed marked virulence to mice, and produced in rats a disease resembling general paralysis. Probably there were several different but closely allied species of diphtheroid bacilli which were capable of producing the same effect. They had treated by vaccines 8 cases of general paralysis and 1 of tabes, in most of which there was a distinct improvement in the patients' physical and mental condition, followed by relapse after several weeks. In one case of general paralysis the improvement persisted for a year, when the patient was removed from the asylum. Their antiserum they obtained from sheep, administering it hypodermically or by the mouth in doses of 20 c.cm. A temperature reaction followed, and in their opinion this was diagnostic. It consisted in a rise to 100° F., when the serum was given hypodermically. The rise occurred within twelve hours, and had passed away in twenty-four hours. Out of 12 cases of general paralysis thus treated for over a period of three months, 10 had shown marked improvement. Two cases of tabes which had been similarly treated showed progress, the severity of the lightning pains had diminished, and the length of the periods of remission had increased. Nine control cases had been subjected to the antiserums and in none did any specific reaction occur. Several cases of general paralysis had also been subjected to treatment with the serum of normal sheep and also with antistreptococcic serum, and in no case were the injections followed by any reaction similar to that which ensued upon injection of the antiparalytic serum.

Dr. G. M. ROBERTSON read a paper on the presence of a bacillus (Muirhead's diphtheroid) in the blood of persons suffering from general paralysis, adding observations on the *Bacillus paralyticus*. The bacteriological researches on which the paper was based had been carried out by the staff of the Stirling District Asylum, their object being to test the conclusions of Dr. Ford Robertson. The primary observations were restricted to cultures made from the blood and cerebro-spinal fluid of living general paralytics. The mucous surfaces were avoided owing to the recognized occurrence of diphtheroids in those regions in other conditions, and *post-mortem* results were treated as of secondary importance owing to the tendency to *ante mortem* invasion by micro-organisms, and the rapid putrescence of those dying from general paralysis. The positive result of those researches was the finding in the blood of a bacillus of the *xerosis* group of diphtheroids differing from the *Bacillus paralyticans* of Dr. Ford Robertson. Cultures of this bacillus had been grown on suitable media.

Dr. CLOUSTON said he had been very much impressed by the diagnostic value of Drs. Ford Robertson's and McRae's antiserum, and by the marked improvement which followed in the condition of the patients who had been subjected to its administration.

Dr. BRUCE (Murthly Asylum) thought that the rise of temperature following the administration of the antiserum might be a coincidence, since it was well known that the temperatures of general paralytics were subject to considerable variation. He had not succeeded in isolating any organism from the blood or cerebro-spinal fluid of general paralytics.

Dr. LAWSON considered that the treatment of cases of general paralysis by serum was unsatisfactory in its present state. The serum was not standardized, and the method of administration was empyrical. Furthermore, no experiments had been made as to whether a reaction followed injection of the antiserum into healthy persons.

SOCIETY OF TROPICAL MEDICINE AND HYGIENE.

Sir PATRICK MANSON, K.C.M.G., M.D., President, in the Chair.

Wednesday, June 26th, 1907.

INAUGURAL ADDRESS.

THE first meeting of this newly-formed Society was held at 20, Hanover Square, W.

The PRESIDENT delivered an inaugural address in the presence of over one hundred Fellows and guests. He took as a subject the enormous strides that tropical medicine had made in the last ten years, and compared existing knowledge of the subject to-day with that contained in Davidson's book on *Hygiene and Diseases of Warm Climates*, which was published some fifteen years ago. Almost every subject contained in that work, he pointed out, had had to be entirely rewritten to-day, and whereas the word "mosquito" did not occur in the chapter on malaria there, hundreds of pages had had to be devoted to it and other insects in the volume on Tropical Diseases in the new Allbutt and Rolleston's *System of Medicine*. Similarly, with Malta fever, sleeping sickness, and other diseases, the same story could be told. In the old days, when a man came home from abroad, anxious to keep abreast of the times and to obtain information in the special branches in which he was interested, he had no place to go or no one to turn to. Now what a difference existed! Tropical schools and post graduate schools abounded, in which the newly-returned doctor could revel in work and discoveries to his heart's content and meet and converse with many of his compatriots. Still, there must always be a class of men passing through town and only having a little time to spare, to whom such institutions did not appeal, and to those such a Society as now had been founded would prove of the greatest value. Some exception had been taken to the original founding of the tropical schools, and the same feeling might creep in with regard to this Society, but as success had followed the former so also would it follow the latter.

LANTERN DEMONSTRATION.

At the conclusion of the address Dr. DANIELS gave a lantern demonstration of some of the commoner parasites that cause so many of the tropical ailments, and also exhibited some very interesting photographs of Central Africa, showing the home and breeding grounds of the malarial mosquitos.

VOTE OF THANKS.

The proceedings then concluded with a vote of thanks to the President.

DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND.—This Society held its final meeting on June 26th before amalgamating with the Royal Society of Medicine, Dr. LESLIE ROBERTS, President, in the chair. The following were among the exhibits:—Dr. A. EDDOWES: (1) A case of *Chronic pruriginous eczema* of long duration in a girl of 16. (2) A woman aged 56, with a *Scarring eruption* upon the left temple, resembling clinically a rodent ulcer, but it was probably syphilitic. (3) Photographs of a case of *Malignant syphilis* in which great destruction of the nose had occurred. Mr. T. J. P. HARTIGAN: (1) A man with *Lupus erythematosus* of the scalp of the atrophic type; the disease had lasted for forty years, and had not affected the general health at all. (2) The daughter of this patient with an acute eczematous eruption of the scalp and a history of having been bald