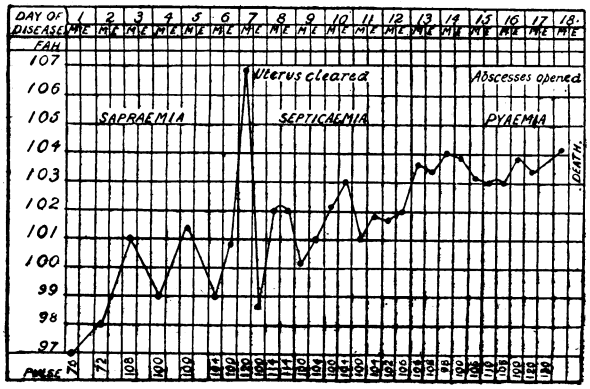
Some few months ago I was casually asked to see a case by midwife, on the fifth day, owing to a slight rise of temperature (101°). I was informed that the patient had influenza (of which there was a case in the house) and required no examination, but just the proverbial "bottle of doctor's medicine." The midwife stated that the placenta was perfect and the confinement quite



normal. Therefore I agreed, but the next day the temperature rose to 106.8°, and I removed with my fingers a piece of putrid placenta as large as my hand—the temperature then falling to normal (see chart). The woman died on the seventeenth day with secondary abscesses and sepsis. I feel sure that could I have removed this source and cause of infection early the woman would have lived.

I have seen this kind of case so often, and, as a rule, the marked recovery after evacuation and thorough cleansing of the uterus is astounding. Every practitioner knows this to be so, especially in incomplete abortions. As students we were shown a temperature chart as an example of a fall by crisis in sapraemia where retained placenta had been removed. Probably Professor Watson has forgotten this chart. My case shows the same thing.

Professor Watson discards the old classification of sapraemia and septicaemia, but Professor Munro Kerr states they do exist clinically as two distinct forms—the one condition being early and due to retained products, whilst the other occurs later on when the infection becomes generalized. He also states that saprophytic organisms lower local and general resistance and permit pyogenic organisms to multiply and gain entrance to the uterine tissues. He advises the removal of débris and repeated intrauterine douches (Fairbairn, p. 592). Bacteriologically organic tissues aid the growth of some organisms—for instance, testis for spirochaetes. Why should not placental tissue act in the same way, helping to form a septic factory?

One of my cows recently calved, appeared to be very ill, and my man informed me that she had not "cleaned" properly. Therefore I encouraged him to try and clear her, which he did with a wisp of straw and a cleansing douche. The immediate recovery of the cow followed. I do not understand why a portion of the after-birth so often gets trapped in man and beast alike.

I quite agree that to scrape the whole of the uterus out with a sharp curette is wrong, and opens up fresh surfaces for infection. But as a rule one's fingers and a gauze swab are sufficient, although a soft blunt flushing curette, a warm douche, or an application of iodized phenol will help in cleansing and purifying the source and culture bed of the bacteriaemia. Professor Watson does not agree, and states that retained placenta does not predispose to bacterial infection. But I think no woman can be well with a portion of decomposing placenta inside the uterus, and will often die if left alone. Small bits of membrane do not matter, but placental tissue should always be extracted at once. If retained placenta is left it will provide plenty of work for gynaecologists later on.

I must apologize for writing contrary to the teaching of such an eminent authority; but most practitioners have their own views and practical methods for treating such cases, and Professor Watson invites discussion.—I am, etc.,

Lowestoft, April 4th. DUDLEY W. BOSWELL, M.D., D.P.H.

CONGENITAL HYPERTROPHY OF THE PYLORUS.

SIR,—After reading Dr. Still's paper published in your columns on April 7th it seems worth while to record the after-history of the case which I reported in the *Lancet*, January 10th, 1903. This was, I believe, the first case ever recorded as having recovered with simple feeding alone, without operation or lavage.

It was an absolutely typical case fulfilling all the diagnostic requirements. The patient is now an Oxford undergraduate; he has just taken second-class honours in Mods., and rows in the Torpids. He never suffers from indigestion in any way, and is well grown, strong, and healthy.—I am, etc.,

Shrewsbury, April 18th. H. WILLOUGHBY GARDNER.

PHTHISIS: COMPLETE AND PERMANENT RECOVERY.

SIR,—Fifty years ago this month Dr. Andrew, of St. Bartholomew's Hospital, told me I had phthisis, both lungs were affected, and I must leave the hospital at once, and on his certificate the College allowed the session.

I went to the country, got well, returned to Bart's in October, but relapsed at the end of the session. Intending to winter at Davos I went to Paris, attended the Hôtel-Dieu, and determined to observe carefully the conditions under which I was worse or better, to avoid or counteract the former and live under the latter. By this means I got well in 1876—chest girth increased nearly five inches and vital capacity over 200 cubic inches—and have remained well.

The investigation was continued, and I laid the results before the British Association in 1886–87, and I demonstrated the practicability of the work in 1890–1915 by giving the measurements of 100 cases of chest and lung development, and the results of scientific treatment in 100 cases of phthisis—complete recovery in early cases, recoveries and arrests in cases more advanced, and great relief and some temporary arrest for months or years in cases still further advanced.

This experience is unique in the history of phthisis, and I venture to think it should be placed on record.—I am, etc.,

London, S.W. GODFREY W. HAMBLETON, L.K.Q.C.P.I.

THE TRAINING OF NURSES IN SMALLER AND COTTAGE HOSPITALS.

SIR,—With reference to Dr. Flemming's letter (April 21st, p. 699) the committee of our small hospital considered the regulations of the General Nursing Council for training unsatisfactory, and in consequence some months ago made a reasoned statement to the Ministry of Health upon the subject. But that infant prodigy, the General Nursing Council, appears to have been born with a swollen head and also to suffer from defects of hearing and of vision.—I am, etc.,

St. Albans, April 23rd. SIDNEY CLARKE.

"HICCUP."

SIR,—The note in the BRITISH MEDICAL JOURNAL of April 7th (p. 603) on epidemic hiccup surprises me much. During all the years I have been in general practice I have had several cases of intractable hiccup and I am firmly of the opinion that the diaphragmatic spasm is due to rheumatism; for many years I have never failed in curing the most obstinate case within a very short time by exhibiting a few doses of antirheumatic medicine such as 15-grain doses of sodium salicylate without the addition of any sedative. I have never had a case of encephalitis lethargica, but firmly believe that it has the same etiology and would respond to intensive antirheumatic treatment. Of course—as stated in your article—morphine preparations will relieve any spasms, but there is great satisfaction in relieving symptoms by treating the disease causing them.—I am, etc.,

Manchester, April 22nd. MARTIN J. CHEVERS.

Universities and Colleges.

UNIVERSITY OF CAMBRIDGE.

THE following candidates have now satisfied the examiners in both parts of the examination for the Diploma in Public Health:

D. Basu, L. S. Chatterji, †A. J. Copeland, N. D. Dunscombe, Elizabeth J. Findlay, A. T. Gailleton, C. H. Gunasekara, †J. C. L. Hingston, *S. Hunt, Florence S. Kirk, Hilda L. Laidlaw, F. Lobo, Barbara R. A. Morton, L. K. Ray, Annabella A. Reid, Mary Russell, Beatrice M. Sellar, Y. Sen, Annie E. Somerford,

* Distinguished in the principles of Hygiene.
† Distinguished in the application of Sanitary Science.

The following candidates have satisfied the examiners for the Diploma in Medical Radiology and Electrology:

Part I (Physics and Electrotechnics): M. A. Afifi, N. M. Bodas, J. E. Bowen, B. L. W. Clarke, L. R. G. de Glanville, M. Frizell, N. Grellier,