Air Service and serving for two years as a pilot employed with the Zeppelin patrols at Eastchurch and at Dunkirk. He was wounded during action in the Ypres salient, and afterwards resumed his medical studies. In 1919 he was appointed assistant to the late Professor Starling in the physiological department of University College, London, and in 1920 was awarded the Beit Memorial Fellowship. From 1923 to 1927 he acted as lecturer in experimental physiology in the Welsh National School of Medicine at Cardiff, and in 1927 was appointed professor of physiology in the University of Birmingham. Professor Daly has carried out much work on experimental physiology, especially on questions concerning the circulatory and respiratory systems, and his work has been recorded in such papers as "Influence of Mechanical Conditions of the Circulation on the Electrocardiogram" (*Proceedings of the Royal Society*, 1923), "Peripheral Resistance and Capacity of the Circulation" (1926), "A Closed Circuit Heart Lung Preparation" (*Journal of Physiology*, 1925), and "Negative Pressure Pulmonary Ventilation in a Heart Lung Preparation" (1927). Sir Edward Sharpey-Schafer, whom he succeeds, was appointed to the chair of physiology at Edinburgh in 1899.

Edinburgh University General Council

At the half-yearly meeting of the General Council of the Universiy of Edinburgh on May 3rd, when Principal Sir Thomas Holland presided, it was announced that the arrangements for the celebration of the 250th anniversary of the founding of the university on October 27th and 28th, were in progress, and that groups of graduates in various parts of the world would hold local gatherings on October 28th. Sir Thomas Holland said that there were 731 graduates in India who had arranged for a meeting in Bengal and 148 in Canada who had arranged a meeting at Alberta. Graduates in Australia numbered 333, in New Zealand 240, in the Cape Province of South Africa 356, and in the Transvaal 211, and these also would probably arrange meetings. It was also intimated that a history of the university, continuing "The Story of the University of Edinburgh" by the late Principal Sir Alexander Grant, was in preparation. Sir Alexander Grant's work carried the history up to the tercentenary in 1884, and the present volume would deal with the progress of the University in the last fifty years. The celebrations, in which both the city of Edinburgh and the university will take part, will include a reception by the Lord Provost and magistrates on October 27th, a ceremony for the conferment of honorary degrees on October 28th, at which two short addresses will be given by honorary graduates, and a commemoration service in St. Giles' Cathedral, when Principal Sir George Adam Smith of Aberdeen University, who graduated at Edinburgh in 1875, will preach.

Edinburgh Royal Maternity Hospital

At the annual meeting of the Edinburgh Royal Maternity and Simpson Memorial Hospital, Bailie Adams, who presided, spoke of the close co-operation that existed between the hospital and the corporation of Edinburgh, and to the prospect in the near future of the hospital being taken over by the Royal Infirmary. The report showed that the number of cases treated in the hospital during 1932 was the highest yet recorded for the institution: it exceeded the figure for 1931 by sixty-nine. The number of patients who had attended the ante-natal and other clinics was also higher than it had ever been before, the figure for 1932 being 16,028, an increase of 1,541 on the figure for the previous year. Owing to this great increase, extra accommodation had to be obtained in the municipal hospital at Craigleith. The total number of patients dealt with by the hospital, including those attended at their own homes, was equivalent to 45.4 per cent. of the total births in Edinburgh. The report also stated that during the past five years the number of maternal deaths in the hospital had steadily decreased. In 1928 the rate per 1,000 cases admitted was 20.96: in 1932 this figure had fallen to 8.68.

CORRESPONDENCE

Maternity and Child Welfare Services

SIR,—Dr. Donald Paterson suggests in his article on maternity and child welfare services in their relation to public health in your issue of April 29th that his remarks are intended to offer criticism and provocative observations on the present state of affairs. Naturally the principles and teaching of medical officers in regard to maternity and child welfare must vary somewhat. Naturally, also, conditions vary in different areas. Middlesbrough is a purely industrial town where unemployment is rife. The percentage of notified births attending welfare centres was fifty-six in 1932. Given a knowledge of economic food values, given a uniformity in teaching by medical officers and their health visiting staffs, given a confidence in such teaching by the mothers, much can be effected. The same headings are followed in my remarks as Dr. Paterson gave in his.

Tonsils and Adenoids.—I am struck at what seems to me to be a terribly high figure for tonsils and adenoids in comparison with the figures for other diseases quoted. For 1931 the number of cases of tonsils and adenoids admitted to the Great Ormond Street Hospital was ninety-two under 2 years and 3,927 over 2 years, while the number of cases of rickets, for example, was only eighteen under 2 years and eighty-nine over 2 years. It may well be that the decline in the incidence of rickets is one of the triumphs of the welfare baby clinics, in the same way as the decline in the incidence of eclampsia is one of the triumphs of the ante-natal clinics. These two conditions are easily preventable and are infinitely less frequent and severe than they were. It would serve no useful purpose to quote figures in respect of rickets, as one medical officer might only give those cases with bony rickety deformities, while another might include earlier cases before bony deformities are evident. Practically every mother attending a baby clinic receives teaching as to the prevention of rickets, either in respect of her own diet as a nursing mother or in respect of the feeding of a bottle-fed baby, and in the diet of breast-fed or bottle-fed babies after the first twenty-eight weeks of its life. I recognize that Dr. Paterson's patients over 2 years may include children up to 14 or 16, whereas 5 is the maximum age of children in a welfare baby clinic. Attention in a baby clinic is at once given to a mouth breather. A mother is shown how to encourage nose breathing during both day and night. Manipulation of the pillow whereby a child's head can be kept flexed if the child is not a restless sleeper is sometimes successful. A flexed head implies a closed mouth. Unless a child's health is threatened operative treatment is not encouraged until after 2 years of age—in other words, until the child has got his twenty temporary teeth. Operations referred to include those for tonsils and adenoids, for umbilical and inguinal hernia, naevi, imperforate hymen, etc.

Schools.—Unfortunately neither imperial nor local moneys are available for the equipment and upkeep of nursery schools. In the North it is not a matter of the authorities insisting on a child having reached his fifth birthday before he is allowed to attend school: it is a matter of there not being room for children under 5. Many child welfare centres have a toddlers' nursery, where the toddlers can spend one afternoon in the week off their feet, frequently on a rocking-horse. Dr. Paterson suggests that a child's health improves when he begins to attend school, as he spends a good part of his

Br Med J: first published as 10.1136/bmj.1.3775.843 on 13 May 1933. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.

school hours sitting. Perchance there are factors other than simply being kept off his legs which improve a child's health when he goes to school. There is the irritable child to whom his parents pay too much attention ; there is the child who feeds at all hours, or the child who for some reason or other is not quite tranquil in his home surroundings. The school child has his pleasant routine of breakfast, school, dinner, school, tea.

Feeding.—Advice given to a mother in respect of feeding is based in the first instance on the weight chart. Unreliable weighing is misleading. At each weighing it must be the same machine, the same weigher, the same time of day. If the weighing this week is just after a feed and next week just before a feed, a fallacy occurs. By the weight chart one can say if a healthy baby is underfed or overfed. If a baby is on the breast the mother is advised as to her diet. If the baby is bottle-fed advice in respect of iron and vitamins is given. The most reputable of the dried milks have now iron as an added constituent. Fortunately for the unemployed, fruit juice to supply the infant's needs need cost nothing either. A mother need only run a teaspoon over the cut surface of a raw turnip, carrot, or apple when she is preparing the family dinner. Fortunately also for the toddlers vegetables are cheap and can be given in soups and stews. It may be that babies are kept on milk and milk only for too long. At the twenty-eighth week a baby can have two or three teaspoonfuls of a vegetable soup, especially if cabbage and carrot are used. At most baby clinics extra vitamin D can be had as ostelin at a penny a week. Artificial sunlight is even more important here in the North than it is in the South, as the real sunshine is less. A puny or ailing bottle-fed baby quickly responds to light treatment, even though it is only a ten-minutes' exposure twice a week from a carbon arc lamp. Some results are spectacular. In the case of a breast-fed baby a mother feeds it during the exposure. The children over 7 months are given a piece of apple to suck at or to eat, according to their age, during the exposure.

Fevers, Tuberculosis, and other Diseases.—Most of us will have experienced the satisfaction of finding Koplik's spots two days before a measles rash appears and giving advice accordingly. That and an early diagnosis of diphtheria from a positive throat swab are the chances a medical officer gets in baby clinics. The incidence of infantile diarrhoea is infinitely less here since the dried milks have taken the place of dairy milk. Cases of paralysis are quite often seen in baby clinics, due to poliomyelitis missed in the acute stage or to a missed slight diphtheria. As to tuberculosis prevention by the C.G. serum, our hopes were raised some years ago, only to be dashed again. Frequently all we can do when there is a case of pulmonary tuberculosis in a household where there are small children is to reiterate each time the mother is seen the methods she can use to help the patient to keep his infection from spreading to the other members of the family, particularly to children.

Co-ordination.—In the case of a baby with a temperature or of a baby who looks too sick to be brought to a clinic the mother is advised to call in her own doctor. When a child reaches the age of 5 the baby card is sent to the school medical officer when there is any abnormality. When hospital treatment is required arrangements are made for a child to be admitted. Use is also made of the tuberculosis and venereal diseases dispensaries, and of the bacteriologist.

It is evident, then, that the uses of child welfare centres are the preservation of health, the prevention of disease, the treatment of such deficiency diseases as rickets, and the sending for treatment of other diseases either to the patient's own doctor or to hospital. Many general medical practitioners make use of the centres for their poorer patients, knowing often that a pound packet of a dried milk or of cocoa is more indicated than is a bottle of medicine. Since the passing of the Local Government Act the onus of giving "extra nourishment" for children under 5, formerly borne by the Poor Law Department, is now borne by the Maternity and Child Welfare Department.—I am, etc.,

GRACE H. GIFFEN DUNDAS, F.R.C.S.I., D.P.H.

Middlesbrough, May 3rd.

Nomenclature of the Involuntary Nervous System

SIR,—The article by Professors E. D. Telford and J. B. Stopford on lumbar sympathectomy, in the *Journal* of February 4th (p. 173), brings into prominence the nomenclature of the abdominal and pelvic portions of the involuntary nervous system. Such terms as "intermesenteric plexus" and the so-called "middle root of the pre-sacral nerves," for what Langley and Gaskell in animals have called respectively the "inferior mesenteric ganglion" and the "hypogastric nerve," are only confusing, and not even widely recognized.

Hugh Trumble, in the *Medical Journal of Australia*, October 3rd, 1931, writes:

> "Turning now to consider the arrangement in human beings it is at once apparent that there is a close agreement with that in animals. . . . It would seem to be eminently desirable that someone with authority in the realms of anatomy should undertake a review of the nomenclature, and he could scarcely do better than to adopt that used by those very devoted and painstaking physiological workers Langley and Gaskell."

Telford and Stopford surmise that because there is no deleterious effect of their operation a sympathetic supply remains to the pelvic organs. Trumble has shown that total destruction of the sympathetic supply to the bladder, prostate, etc., "has apparently no very ill effects either in animals or in man. Incontinence of urine does not follow, nor is bladder or rectal sensation abolished."—I am, etc.,

A. S. FURNESS, M.B.

Toowoomba, Queensland, March 16th.

First Operations

SIR,—To claim priority or novelty in these days of a superabundant medical literature is admittedly difficult, and requires, if one is not prepared to undertake a very considerable and oft-times tedious search, a redoubtable audacity. For this reason we should extend our sympathy to those who, in the best of faith, advance a claim for originality which further acquaintance with the subject proves to have been anticipated, perhaps on several occasions.

The *Journal* of May 6th provides two instances where such anticipation has occurred. Mr. Alex. Wells, in his article (p. 778) on high gastric ulcer, proposes partial gastrectomy below the level of the ulcer as "a new operation for this type of ulcer" ; but I would refer him to an article of my own on the later results of partial gastrectomy (*Lancet*, August, 1928), in which, after a discussion of the *modus operandi* of the operation in the treatment of ulceration, the following appears:

> "Ulcers of the cardiac end of the stomach are not so uncommon as is sometimes thought. Where the ulcer is capable of local excision without danger this should be done, combined immediately or subsequently with partial gastrectomy. Where the ulcer cannot be excised removal of the pyloric end is nevertheless indicated. This method of treatment has been adopted in several cases with complete relief of symptoms and definite radiographic evidence of cure of the ulcer."

I make, of course, no claim to originality in this statement, since the publication of this letter will doubtless bring forth others from surgeons with still earlier experience of the method.

The second and perhaps more marked instance is Mr. Watson Jones's description of "a new operation for the repair of defects in the vault of the skull by a pedicle bone graft." The description is that of the classical Müller König operation, of which a complete account will be found in Binnie's *Operative Surgery* (1916, p. 12),

Br Med J: first published as 10.1136/bmj.1.3775.843 on 13 May 1933. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.