adrenaline on the blood pressure, of pituitrin on the uterus, of pilocarpine on the isolated loop of gut, and so on, and there he must stop short. The rest is handed over to the teacher of therapeutics, who is a clinician through and through. The subject of therapeutics, as taught in the final year of the curriculum at perhaps ten or twelve sessions, each lasting an hour, is expected to cover the entire field of materia medica. The teacher of therapeutics in most institutions in India is entitled to undertake this task on the strength of his clinical experience alone—an experience that has no scientific basis in pharmacology. This is at best empiricism. Clinical experience is as essential to a teacher of pharmacology as is scientific knowledge to a teacher of therapeutics.

I am altogether in agreement with your correspondent in his concluding observation that "the subject of pharmacology should be taught in the clinical period, and that therapeutics should be closely co-ordinated with it." The ideal is that pharmacology and therapeutics should be taught by the same teacher, who should be in charge of beds.—I am, etc.,

Department of Pharmacology, Medical College, Vizagapatam, Oct. 28. V. ISWARIAH.

Sulphanilamide in Gonococcal Infections

SIR,—A few weeks ago I was called in one night to see a case of acute gonorrhoeal urethritis. The patient, a male, told me that it was almost two weeks since the first appearance of the discharge. On examination I found that he had a temperature of 101° F., that he had a profuse discharge, and that there was a chain of enlarged glands in the groin on both sides so painful that he would hardly allow me to touch them. He had been having alkaline treatment for ten days. I put him on to prontosil album, 15 grains three times a day. The result was dramatic. In twenty-four hours the glands had diminished in size, the tenderness had disappeared, and they could be palpated with ease. On the third day the discharge had cleared up completely. Wash-outs with 1 in 8,000 solution of potassium permanganate were used in conjunction with the prontosil, but there can be little doubt, I think, that the speedy disappearance of the gross manifestations was brought about by the use of the latter. —I am, etc.,

Sedlescombe, Nov. 8. T. J. HOLLINS.

Inhalational Therapy

SIR,—The renewed publicity given to a so-called asthma cure which appeared in the Sunday papers a fortnight ago raises a number of interesting and important issues. They are important to the laity and the medical profession. One announcement is headed "Machine that Beats Harley Street." This is the sort of announcement beloved of the quack and frowned upon by the British Medical Association. One wonders what is the position of certain well-known medical men who allow their names to be associated with such articles, especially as it is boldly stated that treatment is carried out by *secret* machines, and that "air [is] being sucked over twelve medicaments which are picked up in invisible form." This particular article tells how an ex-service man has been cured of asthma by the treatment, and as a result letters have been received from many other sufferers.

The last campaign on behalf of this "American nephew of a Canadian chemist" used the name of a prominent film star in its propaganda, and claimed him as being cured. This name has been dropped for the very good reason that he was recently reported as having relapsed. A few weeks ago a letter was published in the *British Medical Journal* from a doctor whose patient had commenced this particular treatment without his knowledge, and died shortly afterwards from acute bronchitis, brought about more or less as the direct result of the treatment, which, the letter said, took the finish off the furniture.

The purpose of this letter is not so much a criticism of a particular nostrum, but rather to query the wisdom of those doctors who associate themselves with any secret treatment which is given the tremendous publicity that this treatment has had. The same point would arise in view of the present ethical laws however efficacious the remedy may be.—I am, etc.,

London, W.1, Nov. 8. F. T. HARRINGTON.

"A Plain X-Ray"

SIR,—I should like to make peace between Dr. John Roth (*Journal*, October 23, p. 829) and Dr. R. Hermon (November 6, p. 940) in regard to the use of the terms "plain," "straight," or "direct" *x*-ray. Is it not more rational to cut out such adjectives entirely? The matter is apparently trivial, but the fact that it is discussed at all is psychologically interesting. In these days a radiologist should surely be asked to carry out an examination, and not to "take an *x*-ray," either plain or fancy. Not only is it unnecessary but actually it may be dangerous for a clinician to indicate what particular technical process should be utilized by the radiologist in his investigation. Therefore the adjectival *x*-ray has no rational meaning, except possibly between radiologists and technicians. How often has one seen the request for a "straight *x*-ray of kidneys" followed by the report "no radiological abnormality." It is obvious that a patient whose condition necessitates this expenditure of radiological time and material may not be helped by such an examination; whereas, given a well-reasoned assessment of clinical signs and symptoms, an invitation to the radiologist to "do his damnedest" would be most likely to produce the necessary elucidation. The same applies to examinations of the gall-bladder region, and others in which the so-called "straight *x*-ray" is often worse than useless until it becomes an essential part of a complete examination.

Reasonable collaboration between clinician and radiologist should not be an ideal at all difficult to attain, and if the radiologist is informed, however briefly, what is in the mind of his colleague, his knowledge of medical, surgical, and pathological principles is, or should be, quite sufficient to enable him to carry out whatever examination is necessary, with or without the aid of a surgical colleague. Therefore it would appear that the only adjectives properly applicable to *x*-ray examinations are "complete" or "inadequate."—I am, etc.,

Scarborough, Nov. 9. C. BELLAMY.

Technique of Cataract Extraction during Narcosis

SIR,—May I reply to letters written as the outcome of my article in the *Journal* of August 14 (p. 319)? Space did not allow of my discussing then various points which I shall deal with in a communication I am preparing for publication elsewhere. The condensed title of the article failed to clarify the fact that it mainly described (*a*) a method of holding the eye in cataract extraction delicately and so as to abolish any need for co-operative control by the patient, who may therefore be asleep, and (*b*) a method of firmly closing the eye incision by a satisfactory suture independently, if desired, of any question of narcosis.

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Professor Emile de Grósz (September 11, p. 551), referring to 5,000 cases in a condensed generalization of fifteen lines, is describing a very different method of cataract extraction—the intracapsular, which is not generally adopted in England—and he also performs an iridectomy. The method of using a stitch as I have described is partly (there are other reasons) based on my desire to leave the iris intact and yet to obviate the risk of its prolapse afterwards. The omission of an iridectomy and the use of the stitch as described are not dependent upon the fact that the patient is operated on while asleep; some operators might adopt narcosis, yet prefer to do the customary iridectomy and not to use any stitch, provided that the narcosis is not in a form apt to be followed by vomiting.

To Mr. D. V. Giri (October 2, p. 681) may I point out that the administration of a narcotic before operation has been practised for many years, but the aim hitherto has always been to avoid giving the patients such a dose as would abolish their co-operative control of the eye because, with the customary technique of "fixing" the eye, difficulties arise if this occurs. To permit of narcosis (complete unconsciousness) the eye must be held in a manner such as I have described; having employed both methods, I prefer on the whole to have patients put fully to sleep for cataract operations and to have them remain so for some hours afterwards. Surgeons generally do not fully appreciate the profound psychological effects that operations can have on elderly persons. Anaesthetic risks are overt, surgical risks to the eye in cataract operations are virtually occult, and the general risks are relatively so. In the last six years I have been told of three cases of a fatal termination of urinary retention in men after ordinary simple cataract extraction. In this complication the functional "nervous" element plays a very strong part, and I am inclined to think that it is less, or abolished, following narcosis.

Mr. Giri brings in the question of the nurse's attention to the feeding and to the evacuation of the bowels and bladder of the patients sleeping after operation. Sleeping patients are not fed; they occasionally wake to ask for a drink of water and go to sleep again. I have never known a cataract patient who has been suitably "prepared" before operation need evacuation of the bowels within twelve hours or so; this is all too often a matter of days. I have similarly known of no difficulty in passing urine in the ensuing seven to fourteen hours of sleep; none may be passed, or patients may quietly wake up and ask to pass it and then go to sleep again. As to the drugs and doses, I have relied on the opinion of experienced anaesthetists, though I have not often administered, per rectum, more than 6 drachms of paraldehyde, and have never exceeded 8 drachms of paraldehyde, or 1/3 grain of omnopon. It is desirable to give an injection of 1/4 grain or 1/6 grain of omnopon two nights before operation, both as a "test" with reference to vomiting and other idiosyncrasies, and as a sedative. On sitting a patient out of bed the next day Mr. Giri does not state whether his patients have had an iridectomy or not; in any case, I should not like them to sit out so soon unless the incision in the eye had been closed by an appropriate stitch such as I have described.

Mr. J. J. Laws (October 16, p. 778) specifies that "co-operation is retained" in his mental hospital patients. There is much to be said in favour of the 2-drachm doses of paraldehyde which he mentions. Mr. S. Tibbles (October 23, p. 827) writes: "Since the whole operation is completed in about a couple of minutes." It is still common for the "gallery," in complete and inevitable ignorance of what is happening inside the eye, to adjudge the competence of an eye surgeon by his "speed"—a view which Mr. Tibbles epitomizes—and fail to look upon cataract operation as the work of refined "craftsmanship" which it is, and over which the operator should take as long as he likes.—I am, etc.,

London, W.1, Nov. 12. BASIL GRAVES.

Obituary

FREDERICK MILNES BLUMER, M.B., C.M.

Consulting Surgeon, Staffordshire General Infirmary

We regret to announce the death on October 16 of Mr. Frederick Milnes Blumer of Stafford, at the age of 78 years. He was a native of Sunderland and a son of the late Dr. Luke Blumer. He received part of his early education in Germany and studied arts at Durham University, graduating B.A. in 1879, and afterwards studied medicine at Edinburgh University, where he graduated M.B., C.M. in 1884. He was then appointed assistant house-surgeon at Cumberland Infirmary, Carlisle, and became house-surgeon to the Staffordshire General Infirmary in 1885. In the following year he began practice in Stafford and was elected medical officer of health to the borough. In the latter capacity he became a pioneer in better housing for the working classes, and effected a good deal of slum clearance. Through his efforts some of the first model houses for workmen in this country were established. His tenure of office was also characterized by his persistent endeavour to secure the services of qualified midwives for the poor. He was elected to the staff of the Staffordshire General Infirmary in 1887, first as physician and afterwards as surgeon, and served on the honorary staff until 1927, his services to this institution being so valuable that he was requested to remain on the staff for three years after he had attained the age limit. On his retirement his services were recognized by the presentation of an illuminated address and election as consulting surgeon.

Mr. Blumer took a wide interest in public life. He was a member of the Guild of Social Health since its formation, and took an active part in its development into the present Guild of Social Welfare. During the late war he served on the Stafford Borough Tribunal and on the Mid-Staffordshire War Emergency Committee. In February, 1918, he became justice of the peace, and in the following year, shortly after he had resigned his position as medical officer of health, he was elected mayor of Stafford, though not a member of the town council. In 1932 he was unanimously elected the first president of the Mid-Staffordshire Medical Society and was a regular attendant, notwithstanding pressure of work and failing health. Before the war he had been president of the Staffordshire Branch of the British Medical Association and chairman of the Mid-Staffordshire Division. He is survived by his widow and three sons, one of whom, Mr. C. E. M. Blumer, is now senior surgeon of the Staffordshire General Infirmary.

A colleague writes: By the death of Mr. Blumer the medical profession in Mid-Staffordshire has lost a delightful colleague. He was a brilliant orator and possessed a keen sense of humour. His speeches and commentaries added greatly to the enjoyment of the meetings of the Medical Society, and we all feel that his passing from our midst has left a vacancy which cannot be filled.

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