

Nova et Vetera

THE LIBRARY OF CALEB HILLIER PARRY

Mr. Reginald W. M. Wright, city librarian of Bath, has lately published in the *Record-Bulletin* of the municipal library (1948, 1, 225) an account of the Bath Hospital Medical Library. The library has been under his care for many years, and has now been formally presented by the hospital to the city. Bath has been famous as a health resort since Roman times. It is therefore right that the city should own a medical library. But this library has the special value that it was formed by Caleb Hillier Parry, the great Bath physician who made valuable observations on the cause of angina pectoris and described the syndrome of exophthalmic goitre. At his death in 1822 Parry bequeathed to the Bath Hospital his collection of 555 medical books covering a remarkably wide range of history. His successor as physician to the hospital, Dr. John Soden, added a further 220 books when he died in 1863.

Parry's library contains many Renaissance books, both texts of the Greek and Arabic medical writers and original works of the sixteenth century. It is instructive to find that he owned works of English medical writers of the Tudor period, such as Elyot, Borde, Vicary, Peter Lowe, and William Clowes, who are generally thought to have been despised in Parry's time. The library is also broadly representative of European medicine of the seventeenth and eighteenth centuries.

Edward Jenner was one of Parry's intimate friends. He dedicated his *Inquiry into the Cow-pox* to Parry, and a copy of the original edition of 1798 is in the library. Twenty-four years later Jenner published *A Letter to Charles Henry Parry* (Caleb Parry's son); his presentation copy is also in the library. The elder Parry's own writings are fully represented; he was an agriculturist and geologist as well as a physician.

W. R. L.

Reports of Societies

FOOD-POISONING

A meeting of the Section of Epidemiology and State Medicine of the Royal Society of Medicine was held on Dec. 6, with Sir ALLEN DALEY, the president, in the chair.

Dr. E. T. CONYBEARE opened the discussion with a reference to the pioneers in this branch of preventive medicine, notably Ballard and Savage; the former considered that cleanliness in food handling would by itself eliminate these diseases, while the latter stressed the importance of the reservoirs of infection, especially of salmonella diseases. The recent increase of food-poisoning outbreaks in this country, which began about 1942 and has continued since, was doubtless attributable in large measure to increased consciousness on the part of doctors and patients of the importance of even mild or missed cases in causing spread and to better laboratory facilities for diagnosis, but there was reason to believe that there had been an actual increase, due to greater use of prepared foods and to storage of food in homes where there were no proper facilities. Although the current Ministry of Health memorandum was now obsolete and should be revised, it remained a moot point whether further progress might be expected to result from fresh legislation, which was most applicable to the control of large-scale food manufacture and catering. In relation to personal hygiene and to the smaller units engaged in food distribution, legal powers such as those available in the Food and Drugs Act, 1938, though useful, were less effective. It might well be that education in personal and domestic hygiene, as foreseen by Ballard sixty years ago, was the only real precaution against food-poisoning.

Dr. V. D. ALLISON outlined the different factors in the wartime increase of food-poisoning: the use of synthetic cream, cooked meats including sausages, shortages of hot water, soap, towels, and crockery, which too often was cracked, and the

employment of insufficiently trained kitchen staffs. Contamination with staphylococci was a not uncommon cause of food-poisoning. It was characterized by a short incubation period (one to seven hours, average three hours), acute onset with abdominal pain, nausea, vomiting, and often diarrhoea, lasting three to twenty-four hours, and this was followed by rapid recovery even in those cases in which there were symptoms of collapse. Recent surveys had shown that 50% of normal adults harboured such organisms in the nose, and in some 10-20% they were present on the skin of the hand. The current accepted criterion of actual or potential pathogenicity among staphylococci was the ability to produce plasma coagulase. The organisms could be identified by serological and bacteriophage techniques, but these methods were as yet inapplicable to routine laboratory and epidemiological investigation. Human volunteers and suitable workers were still necessary for proof of pathogenicity. When the organism had been destroyed by cooking or processing (leaving the toxin intact, as it resisted boiling even for thirty minutes) the difficulties were great, as the kitten test for enterotoxin was no longer accepted; in many cases the evidence was no more than circumstantial.

Dr. JOAN TAYLOR discussed the salmonella group and recent work on the identification of strains. These organisms were generally resistant to specific therapy and persisted in the gut longer than was formerly thought. An animated discussion followed in which current practice in food handling, including the routine inspection of meat, was severely criticized. The need for education in the school and by means of the Press, radio, and film was stressed.

DEEP PAIN SENSIBILITY

MANCHESTER MEDICAL SOCIETY

At a meeting of the Manchester Medical Society on Dec. 1, Dr. J. H. KELLGREN delivered an address on "Deep Pain Sensibility." He said that the phenomena of pain were usually described in terms of distribution, time, intensity, and relation to other phenomena such as movement and rest. Not all the differences between one pain and another could be described in these terms only, for there were three main types of pain that could be distinguished by their qualities: deep pain arising in muscles, bones, and joints, and cutaneous pain, which might be immediate or delayed. The delayed pain had an "itch" component which gave it a distinctive quality. These three types of pain sensibility could be dissociated in disease or by nerve blocks, so they were probably mediated by different types of nerve fibres.

The normal sensory gradation which accompanied a graded stimulus might be lost so that a threshold stimulus set up severe prolonged pain. This explosive exaggerated response affected all three types of pain, and such terms as "protopathic," "hyperpathic," and "peculiarly unpleasant" probably described this phenomenon rather than an alteration in quality.

The deep tissues varied in sensitivity to pain. In the less sensitive tissues pain-sensitive spots were infrequent; varying sensitivity of the tissues probably resulted from a varying density of innervation. Pain from deep tissues was also localized with varying accuracy. Thus, subcutaneous periosteum, ligaments, and fascia gave rise to local pain, while structures lying deeply within the trunk and limb girdle caused diffuse pain of segmental distribution. Intermediate structures gave rise to segmental pain more or less modified by a crude attempt at localization. The areas of cutaneous hyperalgesia occasionally found in visceral disease were entirely different phenomena from deep pain of segmental distribution; it was a misstatement of fact to say that pain was referred to this or that dermatome, because segmental deep pain was felt in the deep structures and not misinterpreted as arising from the skin. The possible mechanisms of pain localization and reference were then discussed.

Deep pain was accompanied by segmental muscle spasm. This spasm had been studied in decapitated cats and found to be produced by a spinal reflex. Electromyographic studies in diseases such as sciatica, rheumatoid arthritis, and fibrositis often revealed this type of muscle spasm. Its presence had been held to support the view that these diseases were primarily

neurogenic, but the only conclusion that could be drawn from these findings was that the subject's pain was deep, since cutaneous pain was not accompanied by this type of muscle spasm. Of more interest was the possibility that this continuous motor activity might lead to muscle fatigue and so to secondary sources of pain.

Effect of Cooling

Deep pain sensibility was peculiarly susceptible to cooling. Cooling tissues rapidly caused severe pain while the temperature was falling from 30° to 15° C., but with further cooling the pain faded away because deep analgesia developed, becoming complete at about 10° C. With slow cooling analgesia was effected without preceding pain, so that the usual climatic fluctuations of temperature gave rise to no pain in the normal individual. If deep hyperalgesia was present, even slow cooling of the affected part might cause prolonged and severe pain and the analgesia developed imperfectly. Pain produced by cooling and relieved by warmth was a feature of many conditions affecting the extremities, post-traumatic syndromes, painful nerve injuries, glomus tumours, and many forms of arthritis and rheumatism. In these cases the cold pain was mainly due to abnormal sensitivity of the deep pain nerves, though vascular disturbances might contribute to the symptoms by allowing abnormal cooling.

Dr. Kellgren concluded that deep pain sensibility had certain attributes, such as characteristic quality, frequent false localization, associated muscle spasm, and susceptibility to cooling, which distinguished it quite clearly from cutaneous pain. Deep and cutaneous pain sensibility might be dissociated, so they were probably mediated by different types of nerve fibres. Furthermore, the clinical syndromes produced by disturbances of deep and cutaneous pain sensibility might differ markedly, and what was true of cutaneous pain was not necessarily true of deep pain. It would therefore seem wise to distinguish between these two main types in all clinical and experimental work.

A brisk discussion followed in which Professor Schlapp, Professor Jefferson, Professor Morley, and Dr. Marshall took part.

FACIAL PALSY

A meeting of the Liverpool Medical Institution was held on Nov. 25, with the president, Professor T. P. McMURRAY, in the chair.

Mr. R. P. OSBORNE said that, whatever the cause of facial paralysis, if signs of recovery were not manifest within four months support to the paralysed side should be provided by means of fascia lata slings. The view that plastic surgery was only of value when the paralysis was deemed permanent was incorrect. Many of the results of other procedures—for example, nerve grafting—were spoilt by the stretching of the muscles which occurred during the long interval, possibly two years, before return of function. No matter what operation was contemplated on the nerve itself, the provision of a fascia lata sling at an early stage could do nothing but good. In cases in which operation on the nerve was not contemplated the insertion of fascia lata slings would not prevent full recovery where this was possible and would tide over the period of stretching which would otherwise follow. The difficulty was in finding some exact method to decide whether recovery was probable and whether it would be progressive. The ordinary faradic test was too crude for this purpose. Electromyography, while still in its infancy, showed signs of being a much more delicate and reliable means of obtaining the necessary information.

At the same meeting Mr. D. ANNIS read a short paper on experimental pancreatico-gastrostomy.

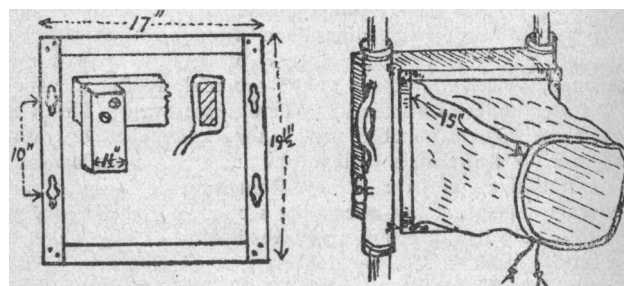
On Dec. 10 and 11 the Fever Hospitals' Medical Services Group of the Society of Medical Officers of Health held a week-end meeting at the North Eastern Hospital, St. Ann's Road, N.15. The president of the Group, Dr. E. C. BENN (Leeds), was in the chair. On Friday Dr. J. E. FRANCIS read a paper on palatal paralysis in children. Dr. F. O. MACCALLUM spoke on the laboratory diagnosis of some virus infections, and Dr. N. H. BRADLEY presented a film on poliomyelitis. In the afternoon Dr. M. B. ALEXANDER discussed infantile diarrhoea and vomiting, and Dr. JOAN TAYLOR read a paper on recent research on the aetiology of infantile enteritis. On

Saturday the subject for discussion was the role of the nasal carrier in the spread of infection. Dr. G. W. RONALDSON spoke on the carrier of diphtheria, Dr. R. CRUICKSHANK on the carrier of haemolytic streptococci, and Miss WINIFRED HALL on the treatment of the nasal carrier.

Preparations and Appliances

DAYLIGHT SCREENING AID FOR MASS RADIOGRAPHY

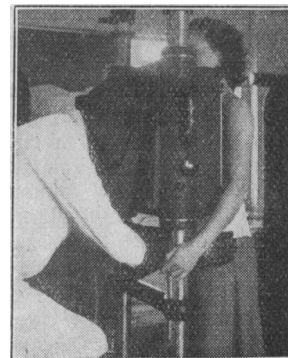
Dr. S. W. VIVIAN DAVIES, Assistant Medical Director, Mass Radiography Unit, Warwickshire and Coventry Joint Committee for Tuberculosis, writes: With the accommodation placed at the disposal of mass radiography units it is not always possible to get a satisfactory black-out for screening



purposes. The factories concerned are already subsidizing the running of the set at their premises, and anything which reduces the cost and also the difficulties of preparing accommodation is of advantage. Moreover, on public surveys large halls have often to be used where an adequate black-out is impossible. Further, it is necessary to have the staff working in as natural a light as possible.

I have therefore devised a simple radiology hood, which I have now used on several surveys and have found very satisfactory. The materials employed are four 18 by 1½ by ¼-in. (45 by 3.75 by 0.6 cm.) pieces of ebonite, 2 yards (1.8 m.) of thick black-out non-coupon material, and eight small nuts and bolts. The accompanying diagrams will give sufficient details for making one of these hoods. A frame is constructed to correspond with the camera tunnel, the slot-holes, etc., being made to measure. The hood material (black-out), in double thickness, can then be sewn round the frame with buttonholing to match the slots. To exclude light a drawstring is used in the skirt of the hood.

When using this device I have found that the patient being screened is less apprehensive and more co-operative, thus materially compensating for its defects.



A collection of over 300 surgical instruments given for use in Scottish hospitals during the war by the late Mr. J. Hogarth Pringle has been handed over by the Department of Health for Scotland to the Glasgow Royal Infirmary, where it will be housed to commemorate Mr. Pringle's services there and his patriotism in making the gift. Mr. Pringle presented his valuable collection to the Department in January, 1940, when Scottish hospitals were seriously short of surgical instruments, in response to an appeal made by the Rt. Hon. Thomas Johnston, then the Regional Commissioner for Scotland. It was arranged that the collection be permanently associated with his name and used at a Scottish emergency hospital, and the instruments were used at Gleneagles Hospital for some years. When the hospital was closed they were returned to the Department, and they have now been accepted by the Glasgow Royal Infirmary, where Mr. Pringle was in charge of the surgical wards for 27 years.