A Lecture ON CONDITIONS WHICH SIMULATE DYSPEPSIA.

DELIVERED AT THE LONDON POLYCLINIC,

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I HAVE had some difficulty in selecting a suitable title for this lecture. I have called it "Conditions which Simulate Dyspepsia," but perhaps it would have been better had I said "Conditions which simulate primary disorder of the stomach." What I mean is that many patients are believed to be suffering from disease of the stomach in whom there is either no real stomach trouble at all, or in whom the primary disease is so overshadowed by secondary gastric symptoms that it is apt to be overlooked, with the result that a correct diagnosis is not made. This will become clearer as we proceed.

It need not surprise one that such mistakes as I have indicated are common. Two of the chief symptoms of gastric disorder are pain and vomiting, and both of them are deceptive. In such a region as the abdomen, in which several organs are closely packed together, many of them with a common nerve supply, it is not to be wondered at that pain which has its seat of origin in one organ should often be referred to another. Vomiting, again, is a symptom which may arise in a great many different diseases and disorders, owing to the very widespread peripheral connexions of the vomiting centre. This, however, is apt to be forgotten, and the vomiting is put down to disease of the stomach, when its real cause is perhaps situated quite remotely from that organ.

In the present lecture I propose to discuss some of the mistakes in diagnosis which most commonly occur, and I shall deal with (1) cases in which vomiting is wrongly attributed to primary disorder of the stomach, and (2) cases in which pain is attributed to disease in the stomach when it is really due to something else.

THE VOMITING OF PREGNANCY.

A fairly common cause of vomiting which is frequently misdiagnosed is the vomiting of pregnancy. I suppose we have all of us sooner or later in practice fallen into the mistake of regarding a case of the vomiting of pregnancy as if it were a case of primary stomach trouble. I had a lesson in regard to it early. I remember some years ago having under my care a young woman who was anaemic and had gastric pain and a great deal of vomiting, so much so that she had in the course of it some haematemesis. At all events, her symptoms were so urgent as to make it necessary to call in a surgeon. To my disgust the surgeon, on examining the abdomen, was able just to make out the top of the uterus coming up above the brim of the pelvis. He said at once, "Three months pregnancy," and I looked rather foolish.

Cases in which a mistake is more excusable are such as the following. I was consulted by a lady who was suffering from nausea, gastric discomfort, and a certain amount of sickness, especially in the morning. She had had two children and had not missed a period, and I confess I did not think of the vomiting of pregnancy at all. She had been sick in her first pregnancy and it had not even occurred to herself that that was what was the matter with her. She was treated for some weeks with little success. Suddenly she had an attack of acute pelvic pain. It was found that an extrauterine gestation had ruptured, and we had therefore been dealing all the time with stomach symptoms which were the result of pregnancy. If one has in mind the possibility of such an error one ought to be able to avoid it. If one remembers always, in the case of young women, the possibility that gastric symptoms may be the result of early pregnancy, I do not think one is likely to fall often into a mistake of that sort.

URÆMIC AND PHTHISICAL VOMITING.

The second group of cases that I shall mention illustrate two morbid states which may be classed together, as they

present certain points of resemblance and are both apt to be regarded as cases of primary gastric disease. I refer to the vomiting which occurs in the course of uraemia and of phthisis. I fully admit that in both of those conditions there is probably gastric trouble present. They are both, I think, to be regarded as conditions in which one gets what is called secondary gastric catarrh. But what I do mean to say is that although the gastric condition is entirely secondary, the stomach symptoms may be so prominent that the main disease is overlooked; in proof of which I may mention that not long ago I saw a patient suffering from nephritis, in whom gastro-enterostomy had been performed under the belief that his symptoms were due to a gastric ulcer.

Uræmic vomiting may arise as the first symptom of anything being wrong with the kidney. I refer especially to cases of chronic interstitial nephritis which occur in men of late or middle life, in whom the first symptom of renal disease may be the occurrence of sickness, and along with that, as in all cases of gastritis, loss of appetite and nausea, but no pain. The gastric disease that such cases are apt to simulate is carcinoma. I can recall more than one case where a patient has been admitted to hospital with a diagnosis of carcinoma, but who, on further examination, has been proved to be the subject of secondary gastritis associated with renal trouble. The diagnosis in those cases is rendered more difficult by the undoubted fact that there may be at the stage of the case when it comes under observation no albuminuria, but merely urine of low gravity. I believe that the absence of albumen sometimes causes the true nature of those cases to be overlooked. One should, therefore, remember that it may be possible for kidney disease to go on so far as to lead to secondary symptoms, such as gastritis, and yet for albuminuria to be absent.

The other disease which I have bracketed with uraemia is phthisis, because it also may cause in its early stage a form of dyspepsia, probably due to gastric catarrh, the symptoms of which may be so pronounced that the phthisis itself quite escapes the observation both of doctor and patient. I remember, for instance, a lad being brought to me by his father for "dyspepsia," the complaint being that he was constantly sick, had no appetite, and had lost a certain amount of flesh. He had been treated outside the hospital for some time as a case of gastric disorder, and without any suspicion having arisen that there was anything wrong with the lungs. On examination of the chest, it was found that there was advanced phthisis in one lung, and it came quite as a shock to his father to be told that it was not really a case of mere stomach disorder, but one of serious organic disease elsewhere. Such a mistake, I think, is particularly apt to occur in young women. In an anaemic young woman the phthisis may often be comparatively latent, and the gastric symptoms unusually prominent. The patient goes to the doctor complaining entirely of the stomach, and very possibly, without the lung being examined, the patient is treated as a case of dyspepsia.

"URO-KINETIC" DYSPEPSIA.

I pass on now to a rarer group of cases, in which mistakes are very apt to occur, and I think I may say quite excusably. I refer to cases in which the gastric symptoms are secondary to disease in the bladder or urethra. These cases are not, I think, very well known. They have been described by Rosenberg¹ under the title "uro-kinetic dyspepsia," which means that the dyspeptic symptoms are due to something wrong with the motor apparatus of the urinary tract. Examples have been published by Dr. Herschell² in this country. The patients are often elderly men who suffer from enlargement of the prostate, and in whom the gastric symptoms which are present are relieved only when the prostatic trouble is dealt with. Here, again, it is very possible that we have to deal with a secondary gastritis set up by retention of urine. But whether that be so or not, there can be no doubt that in some patients with enlarged prostate or weakness of the bladder we find loss of appetite, nausea, and possibly a certain amount of vomiting, and frequently, also, some looseness of the bowels—symptoms due not to primary gastric disease, but secondary to the genito-urinary disorder.

To make the nature of these cases clearer I propose to describe briefly a very remarkable example which I had under my observation only a short time ago.

A man, aged 37, complained of abdominal pain and vomiting, which had been present, off and on, for six years, but had been much worse for the two years before his admission to hospital. He stated that he had a good deal of sickness and pain in the morning, but as the day went on he "pulled himself together," as he put it, and the symptoms became less. The pain was situated both in the epigastrium and above the left groin, and it came on a quarter of an hour after food; it was relieved by pressure. He had been treated at a hospital out-patient department for some considerable time under the belief that he was the subject of gastric ulcer—a mistake which no one could be much blamed for making, because of the epigastric pain and vomiting. He did not get any better, and was admitted as an in-patient. On examination it was found that the bladder became greatly distended at times, reaching up to the umbilicus, and forming a prominent tumour in the lower part of the abdomen. It was further found that it was only when the bladder was distended that he had his bad attacks of sickness and retching. In one of these attacks he became absolutely collapsed, and as the symptoms were extremely urgent the bladder was punctured above the pubes and 44 ounces of urine drawn off, with immediate relief to all his symptoms. It was subsequently found that he had a stricture of the urethra, which was dilated, and as long as the urethra remained patent his gastric symptoms did not recur.

I regard this as a typical example of uro-kinetic dyspepsia, although the patient was younger than is the rule in such cases. Certainly in elderly men who complain of gastric symptoms one should always examine for distension of the bladder, for any tumour in the lower part of the abdomen, and for the presence of residual urine, for if there be any obstruction present one can only relieve the gastric symptoms by attending to the state of the urinary apparatus.

CHRONIC OBSTRUCTION IN THE COLON.

Much commoner than the above are cases in which gastric symptoms are due to chronic obstruction somewhere in the large bowel. Here, again, it is vomiting which is the symptom that leads one astray. As every one knows, chronic obstruction in the large bowel from the growth of a cancer may proceed very insidiously, so insidiously, indeed, that the patient is not actually aware of having any real obstruction of the bowels at all, although he may admit, perhaps, to some degree of constipation. Such an one may come complaining of some abdominal discomfort and vomiting; it is only on careful examination that it is found that these apparently gastric symptoms are secondary to disease much lower down in the alimentary canal. The following is a case in illustration:

A woman, aged 50, had been ill for two months with abdominal discomfort and frequent attacks of vomiting. She had always suffered a good deal from constipation, and this had certainly been more pronounced of late. She became so weak from constant vomiting that she had taken to bed a month before I saw her, and since that time she had had every few days violent fits of vomiting, which had further reduced her strength.

On examination it was found that the abdomen was generally distended, and that there was visible peristalsis in the colon. The conclusion was that she was suffering from some obstruction in the sigmoid, probably malignant, and that the vomiting was entirely a secondary phenomenon. Subsequently she submitted to an operation, and a growth was found in the sigmoid. Fortunately it was capable of being removed, and she has done well.

In younger people vomiting may result from mere accumulation in the colon in consequence of prolonged constipation. I have seen more than one such case in which the gastric symptoms entirely disappeared after some large enemata had been given. Such cases, again, are very apt to be mistaken for primary gastric disease.

VOMITING FROM DISEASE OF THE NERVOUS SYSTEM.

The last group of cases which I would mention in which vomiting is a deceptive symptom are those in which the gastric symptoms are really due to disease of the nervous system. I state this in general terms because there are several diseases of the nervous system that are deceptive in this way.

Cerebral Tumour.

First, of course, one should mention cerebral tumour, which is sometimes, although not often, mistaken for gastric disease, especially in children, in whom cerebral tumour is relatively common. Such an error may occur. It is well to remember, however, that children do not

often suffer from chronic vomiting of gastric origin. The supervention of paralysis, optic neuritis, and other signs quickly make the diagnosis clear.

Gastric Crises of Tabes.

More apt to be overlooked is disease of the spinal cord such as tabes. The gastric crises of tabes may be very deceptive, particularly when they occur, as they sometimes do, quite early in the course of the disease, and before there are any pupil signs or loss of knee-jerks. The vomiting in such a case may be so urgent and recur so frequently, that one is naturally tempted to suppose that one is dealing with primary gastric disease. The resemblance, indeed, may be so close, that I have heard of no less than four cases in which gastro-enterostomy was performed on the subjects of tabes under the belief that the vomiting was due to gastric ulcer.

I have seen several cases in which the gastric crises of tabes led to error.

I remember, for instance, one in a man aged 26, a very early age to have tabes. He suffered from attacks of vomiting lasting for three or four days at a time, for which he was sent to hospital. On examination it was found that he had no knee-jerks and his pupils were very sluggish. There was no doubt that he was a case of tabes with gastric crises, and not one of gastric ulcer as had been supposed.

I saw another case not long ago, in a man aged 39, who had been ill for six days with severe vomiting, which was specially deceptive in that it had begun immediately after a dinner consisting of beefsteak pudding. He continued to vomit everything for five days until he became collapsed, and in that state was brought to hospital. He had also shooting pains in the legs and back which had started on the same day as the vomiting. He had had a similar but slighter attack three years before. The knee-jerks were absent, the pupils sluggish, and there was paralysis of the bladder. There could be no question that this was a case of well-marked tabes, and that the vomiting was purely a symptom of that disease.

It has been pointed out by some as of diagnostic value that during a gastric crisis the blood pressure is raised, whereas in all other cases of acute vomiting it is greatly lowered. I have not had an opportunity of verifying that statement myself, because one does not often happen to see the patient when the vomiting is actually going on, but it may be worth bearing in mind in a doubtful case.

Nervous or Hysterical Vomiting.

Lastly, I should mention cases of purely nervous or hysterical vomiting—cases that are certainly very misleading. I have seen several in Jewish women in the London Hospital. One of the latest is the following:

A woman, aged 36, who was said to have been ill for twelve months with constant vomiting and some pain in the stomach, aggravated by the taking of food. It was also said that she suffered greatly from flatulence. She had never vomited any blood, but the case was believed to be so bad that she had been kept in bed for two months. Like most of these patients, she suffered from obstinate constipation.

On examination she appeared well nourished, and of course no one is likely to suffer from continuous vomiting, due to organic disease, for the best part of a year and yet remain perfectly plump and well-looking in appearance. I was therefore extremely suspicious that one was dealing with a case of hysterical or nervous vomiting, and not with gastric ulcer as had been supposed. She was carefully watched, and was found to be constantly bringing up watery fluid, but rarely any food. There was some general tenderness over the abdomen, but never anything else abnormal to be made out. A stomach tube was passed with the view of impressing the patient, and she was told that the vomiting would now cease. This immediately happened, and she went out of the hospital after two weeks, a stone heavier than when she came in.

This was evidently a case of purely nervous or hysterical vomiting, and yet it had been so pronounced and so urgent in its symptoms that the patient had been thought to be suffering from some organic disease of the stomach. I think there is no actual rule for diagnosing these cases. They can be diagnosed only by the process of exclusion, but there is often something in the general aspect or behaviour of the patient that will put one on the right track.

GALL STONES SIMULATING DYSPEPSIA.

I shall now turn to those cases in which pain is the symptom which is misinterpreted—pain arising in some other organ being ascribed to the stomach and leading to mistakes. Perhaps the commonest, certainly one of the most important groups of cases in which the true origin of pain is apt to be mistaken, are those in which it arises in the gall bladder—cases of gall-stone disease,

I think we owe a debt of gratitude to the surgeons, and particularly in this country to Mr. Mayo Robson and Mr. Moynihan, for directing attention forcibly to the fact that the symptoms of gall stones may be for a long time purely gastric, and that the underlying cause is therefore apt to be overlooked. Now there is no doubt that this mistake has arisen in part from the very inadequate description of gall-stone disease which is given in our textbooks. The usual description deals only with the classic form of the disease, in which a stone passes down the cystic into the common duct and produces the typical paroxysm of pain that we know as biliary colic. But these cases are really a minority; in the great majority the stone does not pass down the common duct, but remains in the gall bladder and produces quite different symptoms. Again, I find that what is being constantly cast up to one in practice, if one makes a diagnosis of gall stones, is this: "But the patient has had no jaundice!" Undue prominence has been given to jaundice in the classical or textbook description of the disease. It cannot be too often repeated that a patient may have gall stones for years and never be jaundiced at all.

The pain in gall-stone cases is extremely deceptive, and may absolutely simulate the pain of gastric disease, for it may come on directly in relation to the taking of food, or even after the taking of a certain kind of food. Yesterday, for instance, I saw a patient operated on, and from whom a gall stone was removed. She said she could take fluids, but never solids. Others, again, can take certain kinds of solids only.

In yet other cases the pain may be a typical hunger pain and suggest duodenal ulcer. I was once consulted by a doctor, who thought he had duodenal ulcer because of such a pain. I did not think he had an ulcer, but he insisted on being operated upon, and it was then found that he had a gall stone. There is really no way, I think, of certainly distinguishing, from the patient's description, between the pain due to gall stones in the gall bladder and that of gastric disease. Cases may be rendered still more like gastric trouble from the fact that gall-stone patients often suffer from flatulence. A great many women who in the out-patient department complain of flatulence and "the spasms" are certainly the subjects of gall stones, and not of primary gastric disease. So that one must admit quite frankly that the distinction between cases of gall stone and dyspepsia is in many instances a matter of the very greatest difficulty. If there be definite tenderness on palpation over the gall bladder the difficulties are less, but no physical signs at all may be found. In many cases it is only by watching the case, and seeing that it does not improve under ordinary treatment, and perhaps by the pain beginning to radiate towards the right shoulder, that one can arrive at a correct conclusion. At all events, I am sure it is wise in cases of flatulent dyspepsia attended with a good deal of pain—in middle-aged women particularly—to keep always prominently before the mind the possibility that one may be dealing with gall-stone disease and not with gastric trouble at all.

ANGINA PECTORIS.

A condition of more seriousness which is not infrequently mistaken for dyspepsia—I have seen two cases within the last fortnight—is angina pectoris. Not long ago a gentleman was sent to me said to be suffering from dyspepsia. He certainly had some symptoms which at first sight suggested dyspepsia. He complained of eructations of wind, which came on particularly on exertion after a meal. He lived in one of the suburbs, and when hastening to catch his morning train after breakfast he would be very apt to have an attack of flatulence, attended by some pain in the "chest." It was certainly suspicious that the pain came on with exertion, and that if he sat still after a meal he did not have it. He had also a very high blood pressure, and I obtained a history that his grandfather and father had both died of angina pectoris. A month later I read of his sudden death in the newspapers. I have no doubt at all that, like his grandfather and father, this patient was the subject of angina pectoris, which had simulated dyspepsia and had been treated for some time as a stomach disorder. I saw only yesterday another man, about 65 years of age, who had a similar history of flatulence coming on after a meal, and attended by pain which he thought was due to the wind. He came

to be treated for his stomach. But here again it was found on examination that he had an exceedingly irregular heart and a blood pressure of 175. In this case also the pain came on only when he exerted himself. I therefore concluded that one was dealing with the minor form of angina, where flatulence, as it often is, was a marked feature of the attack. It is the flatulence, I believe, which causes these patients to be regarded as cases of gastric disease, and time is lost when the cardio-vascular condition might be amenable to treatment.

ABDOMINAL ANGINA.

A form of angina which is not so well recognized as ordinary angina pectoris, and which may simulate dyspepsia even more closely, is what is called "abdominal angina," which is due to arterio-sclerosis of the abdominal vessels. The symptoms in such a case may be entirely gastric, the patient getting attacks of gastric pain, which usually, however, come on only after exertion, particularly after a full meal, and are associated with flatulence, the pain being relieved for a time by the belching up of wind. Some of these cases are even attended by haematemesis. In abdominal angina the pain is certainly more severe than it is in ordinary gastric flatulence, and it tends also to radiate upwards into the chest, and possibly down the arms. During the attack there may be a good deal of tenesmus. These cases are not so easy to diagnose as ordinary angina, but here again it will usually be found that the patient is the subject of high blood pressure and thickening of the peripheral arteries, and he will respond to treatment directed to the vascular system, and particularly to the administration of diuretin.

COLITIS SIMULATING DYSPEPSIA.

Passing again to abdominal conditions, you will find that a number of cases of colitis, particularly muco-membranous colitis, with a tendency to spasm of the bowel, simulate dyspepsia very closely. If a patient gets a cramping pain in the transverse colon, you can easily understand that he may refer the pain to the stomach, particularly as the pain is apt to come on when food enters the stomach, owing to the stimulation of peristalsis which this induces. It is a feature of such pain, however, that it tends to be relieved by pressure, whereas gastric pain is aggravated by pressure.

I remember a young girl of 21 being brought to me by her doctor with a history of pain of this sort. She used to get, not long after eating, violent pain across the upper part of the abdomen, and it was therefore suggested that she might be the subject of gastric ulcer. On questioning her about the pain, there could be no doubt about its severity, and she further said that she used to get something hard and press it as tightly as she could into the epigastrium, and that this always gave her some relief, which was very suggestive. It subsequently proved that there was a good deal of membrane and mucus in the motions, and under treatment directed to the colon she lost her symptoms.

These cases of colon pain are rendered still more deceptive by the fact that the transverse colon may be dilated, and give a splash on abdominal palpation, and the combination of pain in that region along with the presence of a splash is apt to lead to an incorrect diagnosis of dilated stomach, and I have seen at least one case in which this conjunction of symptoms and signs nearly led to the performance of an unnecessary operation.

CHRONIC APPENDICITIS SIMULATING DYSPEPSIA.

Akin to these cases are those in which chronic disease of the appendix simulates gastric disorder. It must be remembered that chronic disease of the appendix may produce pain only in the epigastrium, and not in the region of the iliac fossa at all. It may produce also pain which is felt only when the stomach tends to get empty, and which is of the nature of hunger pain.

I remember seeing a man 38 years of age who had some acute abdominal trouble for which, before he first came under my observation, he had already been kept in bed for some time. He had suffered a good deal from pain—indeed it was almost constant—and he lost weight. The pain was felt in the lower right abdomen and also in the epigastrium. He found even liquids increase the pain, and he practically could not take solid food at all. He made no complaint of vomiting and his bowels were regular. There was very little to be made out on the abdominal examination except some slight tenderness in the right iliac region and some thickening and gurgling in the region of the caecum. He was advised to submit to abdominal

exploration. It was found that he had an appendix which was thickened, kinked, and bound down, and after it was removed he lost his pain.

Here, then, was a case in which one was apt to think that one was dealing with gastric trouble owing to the aggravation of the pain by the taking of solids.

EXTRA-ABDOMINAL PAIN SIMULATING DYSPEPSIA.

Of extra-abdominal causes of pain which may simulate dyspepsia, mention should be made of spinal caries and pleurisy. Both of these mistakes are more apt to arise in children. In spinal caries the child sometimes refers the pain to the epigastrium, which is apt to make one think that the case is one of dyspepsia. Pleurisy also, particularly left-sided pleurisy, may easily deceive. Not long ago I saw in one week two patients who believed themselves to be suffering from dyspepsia, but who on examination were found to have malignant disease of the pleura. In both cases it was secondary to mammary carcinoma. The wasting, and weakness, and misinterpreted pain had led the patients to think they were the subjects of indigestion.

ERUCTATIO NERVOSA.

Finally, I should mention a group of cases in which one common symptom of gastric disorder—namely, flatulence—is a course of error in diagnosis. I refer to cases of eructatio nervosa or “aerophagia.” These cases are almost always diagnosed as dyspepsia, when really they have nothing to do with dyspepsia at all.

About two hours before I came here I saw a perfectly healthy-looking man, aged about 40, who has suffered for years from what he spoke of as “violent belching up of wind” both day and night. He had consulted about ten different physicians in various parts of the world for this flatulence, and had taken all sorts of diets and stomach mixtures without any benefit. I found that it was a case of air swallowing, or “aerophagia.” I saw him for the first time three days ago, and he reported himself again to-day. Since the nature of his case was explained to him he has entirely lost his symptoms by day, and has almost lost them even at night, and I have no doubt that he will soon be quite well.

There are two points by which these cases can be distinguished from gastric disease. First, the flatulence is much worse when the stomach is empty. True gastric flatulence tends to come on after meals. Secondly, the patient can eructate to order. If a patient comes into your room complaining greatly of flatulence, and you say to him, “Have you any wind in your stomach? Let me hear you bring it up,” and if he straightway begins to eructate, you can be absolutely certain that he is an air swallower or an air-sucker, and not an example of true dyspepsia. The curious thing is that this is a neurosis which, in my experience at least, is really commoner in men than in women, and it may occur in otherwise perfectly healthy men, such as the patient I have just mentioned. It is usually sufficient in the treatment of these cases merely to explain to the patient what he is doing—that he is unconsciously sucking down air, and that, instead of making violent efforts to bring it up, when the attack comes on he should keep his mouth open, for then he cannot suck down any more air, and this will certainly bring the attack to a termination. It is very striking how, when the true nature of the case is pointed out, the symptoms tend to disappear. Bromides are also useful. They will do the patient far more good than stomach mixtures and diets. So far, indeed, from being strictly dieted, many of them, like most nervous patients, need to be fed up.

It will be apparent to you now what I meant by the title of this lecture. It is an attempt to describe some cases in which the patients are believed to be suffering from gastric disorder when they are either not so at all or only secondarily, the gastric symptoms being due to some other disease. The moral of the whole matter is that when a patient comes before you complaining of gastric symptoms you must not be content with merely examining his abdomen, but you must also investigate all the other organs, for if you do this you are not likely to fall into any of the mistakes that it has been my object to point out to you to-day.

REFERENCES.

¹ *Deut. med. Woch.*, August 17th, 24th, and 31st, 1899. ² *Medical Press and Circular*, May 31st, 1905.

An Address

ON THE

MEDICAL TREATMENT OF THE POOR.

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It will be observed that the title of this lecture,¹ as arranged with the committee, is “The Medical Treatment of the Poor,” and not merely the medical treatment of paupers. But my consideration of the subject was approached through investigation, made on behalf of the Royal Commission, into outdoor and indoor Poor Law medical relief in various rural and urban districts in England and Wales. It will therefore be convenient to follow the same line now, and to state briefly the impressions which I formed in the course of my inquiry. The facts can best be grouped according to the period of life of the paupers.

ADULTS.

1. *The Aged.*

A very large number of the cases, both outdoor and indoor, under medical treatment, were aged persons, and relief or palliation rather than cure could be the only object in most of them. Chronic bronchitis, chronic heart disease, chronic Bright's disease, chronic rheumatism, paralysis, cancer, varicose veins, ulcers, and the various debilities of advanced life, were the commoner affections. In the management of such patients, qualities of heart as much as of intellect are required. A little kindly medical attention, a bottle of cough mixture, a pot of ointment, a liniment or plaster, are among the principal needs of such patients, and such needs were being reasonably met, though the supply of surgical dressings, and especially of lint, was often insufficient, and resulted in much discomfort in some instances.

The greatest defect in the management of these old persons referred not to medical treatment but to nursing. This was more notable among the outdoor than among the indoor paupers. Nursing associations are by no means universal throughout England, and they are frequently wanting in rural districts. Skilled attention by professional nurses trained in great medical and surgical hospitals is not usually needed. Housekeeping—the daily routine of cooking and cleansing and bedmaking—is much oftener required, and I was surprised to find that a nurse of this sort is not always easily obtained even where the guardians are quite willing to make reasonable payment.

This question of nursing links itself on to that of compulsory removal of persons who cannot be looked after at home. Not infrequently I found old men and women living in conditions of the utmost filth and wretchedness, but at the same time utterly opposed to going into the workhouse. In country districts that institution is nothing less than abhorred, while outdoor relief, medical and otherwise, is apt to be regarded as a matter of course. Where old people are a danger to themselves and a cause of nuisance and anxiety to their neighbours, there ought to be powers of compulsory removal to a proper institution, not necessarily a workhouse of the present standard type, but something in the nature of an almshouse in which the inmates could be kept clean and comfortable at a reasonable cost. The ill behaved and undeserving should be placed where they could be properly controlled, so that there would be no opportunity for vicious indulgence.

In the sick wards of workhouses and in Poor Law infirmaries, though the nursing is no doubt much better than formerly, there still remains ample room for criticism, and this may be referred to here, though it applies to the nursing of indoor patients of all ages. The staff was in very many cases inadequate. In the country many of the institutions were too small for economical nursing. The number of patients varied greatly from time to time, and a nurse who might have far too much work at one time might be idle at another. The remedy for this defect is enlargement of administrative areas, so that hospitals of a size sufficient for good administration may be provided, say, by the transformation here and there of an existing workhouse.

¹ Delivered before a combined meeting of Societies in Sheffield February 21st, 1910.