responsibility for carrying out the necessary measures to prevent the spread of the disease; but medical men and nurses can materially assist the authorities in this respect, and prevent the disease from spreading in the family or infecting themselves. For this purpose, until the local authorities can take action, or if the circumstances of the patient do not permit of removal, the patient should be strictly isolated in the most secluded and best ventilated room in the house. An acid solution of perchloride of mercury, of the strength of 1 in 500, should be obtained at once. Sputum, urine, and excreta should be received in vessels containing perchloride of mercury of this strength, while a solution of half this strength may be used in vessels for soaking soiled clothes, disinfecting cups and spoons, etc., or washing the doctors' and nurses' hands after handling the patient.

Nothing from the patient should be discharged down the drain without being thoroughly mixed with an abundant quantity of this disinfectant, otherwise rats in the sewers may become infected and carry the disease elsewhere. In the event of death a sheet soaked in the strong perchloride solution should be wrapped around the body and carbolised sawdust should be put into the coffin. Nurses, doctor, and the inmates of the house should be inoculated with Haffkine's prophylactic. Under ordinary hygienic condition and with ordinary precautions there is no danger to a doctor or nurse attending a plague patient. I have not entered into the precautions which the local authority are likely to take, for these do not come within the scope of this paper.

MOSQUITOS IN RELATION TO MALARIA.

By IAN MACDONALD, M.D.,
Assistant Medical Officer, Rio Tinto Company, Spain.

THE most recent advances in our knowledge of the parasite of malaria prove clearly that part of its life-circle can be passed in the body of certain mosquitos of the genus *Anopheles*. It becomes, then, of immense importance to investigate whether in fever-stricken localities the distribution of this mosquito is associated with the presence of fever.

Working under the direction of Dr. Thin I have begun an inquiry with reference to the presence or absence of mosquitos in certain localities. The district, as a whole, over which my observations extend embraces an area of 60 miles, reaching from the southern part of the Spanish Sierra to the Atlantic. I have examined, in all, twelve districts; of these nine have endemic malaria, the remaining three may be considered free from fever. Isolated cases do occur in two of them, but I have always been able to trace the infection to a night or more passed in the fever zone beyond them. The remaining one on the sea coast is quite free from malaria.

The subjoined table shows the mosquitos I have identified up to the present, and their distribution in the different localities:

Three Healthy Districts.	
<i>Culex elegans</i>	From larvæ and found as adults.
<i>Culex phytophagus</i>	
<i>Culex pipiens</i>	
<i>Culex spathipalpis</i>	
<i>Culex penicillaris</i> ...	Adult specimen only. Sea coast (pines).

Nine Malarial Localities.

The first four already mentioned; with also
Anopheles claviger in all nine, *Anopheles pictus* in three; and
Anopheles bifurcatus in one (one adult).

Most of the malarial villages are situated on the face of a hill, with small ravines or partially dried up streams at its foot. In small pools in these ravines I have always found *Anopheles* larvæ without difficulty, and in one district notoriously malarial the larvæ of *Anopheles pictus* were present in great abundance. It will be seen that here, as in Italy, up to the present *Anopheles claviger* is the predominating *Anopheles*.

I could cite circumstances where apparently the use of curtains has warded off fever, but I shall only mention two. During four years' residence in a fever-stricken locality, the only Englishman who has avoided fever has invariably slept under curtains. Further, he has always made it a custom, in order to avoid being bitten, when sitting outside his house in the evening to cover his feet with towels, protecting his

hands with gloves, and his neck with a muffler. His servant has suffered severely from fever. The only mosquito present in his house is *Anopheles claviger*. They are found in numbers in the rooms of the house and adjoining shed.

The healthiest area, as I mentioned, is on the coast, where the company has its sanatorium on a sandy shore. Malaria does not occur there. Mosquitos exist, but are hardly noticeable. I have found *Culex penicillaris* biting sometimes at night, and have obtained here *Culex spathipalpis* from larvæ. Six miles further along the coast I visited a fishing colony of 100 people, all of whom were suffering from fever at the time of my visit, for those who were not actually ill said they awaited their attack next day. Three deaths had occurred amongst them in a week from pernicious attacks. The only difference between those two coast areas consists in the latter having behind it a small lagoon, some stagnant pools, and disused surface wells. In all those places I found *Anopheles* larvæ. The people said they were bitten furiously at night by a large mosquito. Their "patron" alone slept under curtains and had not had fever. Adult specimens sent me from their huts were *A. claviger* and one *A. bifurcatus*.

Can it be said that these facts are only coincidences? That might be possible, but looked at in connection with recent researches on the life cycle of the parasite in *Anopheles*, it will be probably considered that they have a direct bearing on the all-important problem of malarial infection.

In conclusion I thank Mr. C. E. Rowcroft, M.P.S., for much help in the search for, and collection of, the different larvæ.

SIXTY-SEVENTH ANNUAL MEETING

OF THE

BRITISH MEDICAL ASSOCIATION.

Held at PORTSMOUTH, August 1st, 2nd, 3rd, and 4th, 1899.

PROCEEDINGS OF SECTIONS.

SECTION OF PSYCHOLOGY.

DAVID NICOLSON, C.B., M.D., President.

CAN THE REPROACHFUL DIFFERENCES OF MEDICAL OPINION IN LUNACY CASES BE OBTIATED?

By DAVID NICOLSON, C.B., M.D.,
Lord Chancellor's Visitor in Lunacy.

ONE of the first cases that I had to deal with in my present appointment was that of a lady, a native of the Principality, who had been left some money. A question arose as to her capacity for managing her affairs. Two medical men swore in their affidavits to the effect that the lady was perfectly sane and capable of managing herself and her affairs; while two other medical men swore to the effect that she was an absolute imbecile, and had been so from birth, and that she was totally unfit to look after her affairs. The Lord Justice before whom the case was being argued, finding himself unable to arrive at a decision upon these affidavits, called for a special report from the Chancery Visitors' Department; and, as the case happened to be in my district at the time, I had to go and inquire into the state of her mind. This was a duty for which I was not specially well qualified, as the lady could not talk a word of English, and I could not speak a word of Welsh. However, with the aid of an interpreter, I was able to arrive at the only possible conclusion in the case, and to find that all the doctors were wrong, and that truth lay, as it so often does, somewhere between the two extremes.

This incident will form a fitting text for the few remarks I propose to make on the question: "Can the reproachful differences of medical opinion in lunacy cases be obviated?"—a question which deeply concerns us and which is of considerable public interest.

In ordinary plain-sailing cases of insanity the adult lay mind, by reason of its common sense and experience, has no