On April 21st 41 oz. were passed containing 34.5 grains of sugar to the ounce.* The skin was moist, and there was no increase of appetite or unusual thirst. Under a modified diet the amount of sugar diminished, the lowest quantity before the operation being found on May 1st, when 40 oz. of urine were passed containing 28.2 grains of sugar to the ounce. In other respects the patient's health was good.

If there had been no glycosuria the case was one in which the uterus and tumours should be removed without hesitation, because the patient's health was seriously deteriorated by the repeated and profuse losses of blood, which there was no prospect of arresting, and because surgical treatment when the uterus is freely movable is almost without danger. At the time of writing there has been only one death in my last 61 cases of hysterectomy for fibromyoma, and I have never lost a patient from this operation when the conditions were at all near being so favourable as in the case under consideration.

Obviously, it was important to know whether the causes of the condition of the urine would have an ill-effect upon surgical treatment. In the opinion of some, and I think these constitute the majority, a persistent glycosuria is a very dangerous complication of any major operation. Others attach less importance to it, and we know that an operation for diabetic gangrene is not necessarily fatal. Moreover, in cases of obstruction of the pancreatic duct by gall stones or by inflammation of the ducts associated with glycosuria, the latter has been cured by removal of the stones and drainage of the gall bladder, which allowed pathological changes in the pancreas to subside.¹

The opinion I have formed is that, if the conditions are otherwise suitable for surgical treatment, a patient should not be denied its advantages because of the presence of sugar in the urine. I understand, however, that cases of this kind have been known to collapse suddenly during or soon after an operation, and it seems to me that septic infection may be unusually difficult to eliminate in a glycosuric patient and may prove rapidly fatal before characteristic symptoms of microbic action have time to develop. In deciding whether to operate or not, it must be taken into account that the causes of the glycosuria may lead to a fatal issue within a few years in young and middle-aged people.

The uncertainties of the position were explained as fully as possible to the patient, who is an intelligent woman, and she expressed a strong desire to have the tumours removed. As I thought her decision justified by the circumstances, I performed panhysterectomy on May 3rd, 1907.

Operation and After-History.

A mixture of one part of chloroform with two parts of ether was selected as the anæsthetic, and the operation was delayed twice by respiratory difficulties, which were alarming in view of the reputed danger of anæsthetics in the cases under consideration, but on both occasions artificial respiration with traction upon the tongue quickly restored the patient to a condition of safety.

In all other respects the operation and convalescence were uncomplicated from a surgical point of view, the highest temperature being 99.8° F., and the highest pulse-rate being 100 to the minute. Strength with an appearance of perfect health was quickly regained, and the patient's weight rose 8 lb. to 9 st. 9 lb. during the first four weeks after she left the hospital. In December her weight was 10 st. 1½ lb., the bowels acted well, there had been little pain of any kind, flushings were hardly noticed and there was complete freedom from headaches, which had caused much suffering before the operation.

Immediately after the tumours were removed, the patient was placed on a diet consisting chiefly of beef-tea and broths, and the quantity of sugar in the urine rapidly diminished until on the fourth day there was only a trace, but it did not disappear. When the patient showed every sign of doing well, a mixed diet was given, and the amount of sugar excreted varied with the kind of food. After a time a fairly strict diabetic diet was arranged, and in the last twenty-four hours of the patient's stay in hospital she passed 44 oz. of urine, which had a specific gravity of 1.013, and contained only 1.8 grains of sugar to the ounce. At a seaside convalescent home she was put on ordinary diet, or nearly so, and afterwards at her own house she seldom passed less than 3 pints of urine in twenty-four hours. On July 2nd this quantity contained 24 grains of sugar to the ounce. Under Dr. Beattie's care and under restricted diet, the amount went down to 2 grains to the ounce. In October the eating of one pear seemed to have a permanent unfavourable effect on the glycosuria. Dr. Beattie informs me that in January an attack of bronchitis almost proved fatal from cardiac weakness. The diet regulations were relaxed, and

* Whilst the patient was in hospital the amount of sugar was estimated at the Laboratories of Public Health. Later it was estimated at 1 grain per ounce for every point lowered in the specific gravity by fermentation.

the patient recovered. When convalescent, on January 24th, she passed 70 oz. of urine with a specific gravity of 1.036 and containing 30 grains of sugar to the ounce. On February 15th, the patient being again on restricted diet, 60 oz. of urine were passed, containing 28 grains of sugar to the ounce. The patient had recovered from the bronchitis. Recently the administration of codeina in ½ grain doses three times daily was followed by a reduction of the urine to 50 oz. in 24 hours, containing 10 grains of sugar to the ounce, but the improvement was not maintained, and on March 14th 75 oz. were passed containing 16 grains of sugar to the ounce. The patient now says she never felt better in health.

The evidence is strong that, on ordinary diet, there is a tendency in this case to a persistent increase of the quantity of urine and of the sugar in it, but from a surgical point of view it is hardly possible that the result of the operation could have been more satisfactory. It would be unwise to lay too much stress upon a single observation, but patients with a large amount of sugar in the urine requiring major operations are not very common, and this case would encourage the undertaking of surgical treatment in others if the circumstances seemed to demand it.

REFERENCE.

¹ W. Alfred Nash, *Lancet*, November 1st, 1902, p. 1192; C. W. Mansell Moullin, *Lancet*, June 15th, 1907, p. 1645; Mayo Robson, *Lancet*, June 29th, 1907, and the *Montreal Medical Journal*, November, 1904.

SOME REMARKS ON THE IRISH POOR-LAW MEDICAL SERVICE.*

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ALMOST the first who called attention to the unfortunate position of the Irish Poor-law Service in a practical way was Sir William Thomson, C.B., who has laid its members under a deep and lasting obligation by the amount of time and trouble he so ungrudgingly devoted to their cause. Before him, however, the Branch had taken up the subject, and with the Royal Colleges, the Irish Medical Association, the Irish Graduates' Association, etc., formed deputations to chief secretaries and the Local Government Board where the view held by the former bodies was fully stated. Since then at least three presidents of our Branch have devoted their addresses to bringing forward the hardships of the dispensary medical officers and ably advocating the claims made on their behalf.

I think the actions of these representative members and bodies prove, if indeed proof is required, the need of a reform not only of the Poor-law Medical Service, but of the system as a whole, though it is only the medical department we have time briefly to consider.

DUTIES.

The Poor-law medical officers are so many—almost half the profession in Ireland—that anything affecting them affects the profession as a whole; and a feeling of discontent with their lot and dissatisfaction with the conditions under which their duties are carried out exists. The chief hardships seem to me to be (1) inadequacy of salary, and (2) want of superannuation.

What are a medical officer's duties, and how is he paid for performing them?

He attends his dispensary to afford medical relief to all "poor persons" coming there and presenting the "black ticket." When he gets the "red ticket" he must attend at the patient's house, and continue his visits until termination of the case. When necessary he orders medicines and medical and surgical requirements; each must be ordered on separate requisition forms, each made out in duplicate. He checks the supplies, cares for the instruments, and, unless he is fortunate enough to have the services of one of the 47 compounders allowed for the 1,197 dispensaries of Ireland, makes up all his own prescriptions.

He sends at least three samples of drugs for examination every quarter. He returns all empties, and is even expected to pack them himself.

He keeps a register of every patient attended, and sends the book monthly to guardians for inspection. He reports the hours and duration of his stay in each dispensary.

*An address delivered on February 29th at the annual meeting of the Leinster Branch.

He must send half-yearly to the Local Government Board a form giving the number of tickets, and dealing with zymotic diseases, lunatics, and vaccination; he must answer queries concerning dispensary arrangements, vaccine, drugs, births, and give his opinion on the capabilities of the midwife and the sanitary inspector, and also answer many questions concerning the public health. He must make two copies of his report, one for the guardians, the other to be kept for future reference. He sends quarterly to guardians the name and address of every child in the district over 3 months old who does not appear to have been vaccinated.

The Public Health Act makes the medical officer, medical officer of health of his district. His duties as such, if their value to the country as a protection against disease were duly appreciated, would be among his most important functions, as in this capacity he is responsible for the detection and destruction as far as is possible of every source of disease, and is responsible for advising the people as to the preservation of domestic and personal health, and where necessary enforcing or at least recommending protective measures. The public health is a national asset, and so the importance of preventive medicine is freely acknowledged; but in Ireland, outside the cities at least, it exists largely on paper. The medical officer of health receives a pittance of from £10 to £25 a year, salaries insufficient to offer any inducement to commence sanitary work, particularly in the face of strong opposition, frequently coming from members of the sanitary authority, so strong that it is little wonder that sanitation has remained a dead letter in many parts of Ireland, a country so wanting in sanitary improvements.

REMUNERATION.

Most of the country districts are extremely large, many of them having over 100 square miles, and often very difficult to work. The toll is very heavy; single journeys to see a patient sometimes take four or five hours. One man told Sir William Thomson: "A canoe is built of ribs of wood covered over with tarred canvas, and night and day, summer and winter, I have to turn out in it to do my red tickets." In another "district 100 square miles, very hard to work. There are roads where a horse is barely able to climb up, and lots of places where you could not take a conveyance at all."

The allowance for locomotion is *nil*—not one penny-piece; be the district 100 square miles or more, he must get over it by day or night, in fair weather or foul, as best he can at his own expense.

One does not know which to wonder at most—the audacity of the proposal or the softness of its acceptance. The officers of the Royal Irish Constabulary are allowed £50 a year for a horse, £45 for a servant, and draw salaries rising from £125 to £450, with an allowance for house rent.

Can any one dispute the right and justice of similar terms as regards travelling to those medical officers, and they are a large majority, who have, from the size of their districts, to keep one or more horses? The able Special Commissioner sent by the BRITISH MEDICAL JOURNAL to this country to report on this condition, writes:

It is evident in all phases of the medical, sanitary, dispensing, and midwifery duties of the medical officers of the Irish Poor-law Service, that had they been drawing splendid salaries, with the smallest possible districts, and leading lives of utter idleness, no more stringent, thorough-going, and carefully-worded orders could be issued than are now issued to them by the Local Government Board. Had these unfortunate officers been entirely public servants, relieved of the demands of private practice, no more stringent orders could be issued, and I say this with full knowledge of the official routine of the other national services.

The salaries vary from something under to something over £100 per annum; £145 is probably a fair average of the total official income of the Irish dispensary doctors. Out of this he must spend £100 for locomotion; many have to spend more. The balance provides him with house, food, fuel, clothes, household expenses, support and education of children if he have any. Truly he must be an economist of the first water. But, then, it may be said he has private practice. He has, it is true; but listen to an epitome of the answers received by Sir William Thomson in reply to questions on this subject.

The great majority reply that private practice is poor, a

few say that it is good. In the poor districts two return it at £10 a year, and then there are many who return it at £25, £40, £50, some at from £100 to £200, one at £500, one at "nothing," while another is glad to get an "occasional tourist." The causes assigned are chiefly the desertion of the country by many of the landed gentry, diminution of population and the abuse of the dispensary ticket system. In Ireland to a greater extent probably than in any other civilized country, the care of the sick devolves on State-supported officials. In England, for instance, none but those actually destitute are entitled to share, or do share, in the relief afforded by the Poor Law, and therefore the artisan, the small farmer and petty shopkeeper, etc., all provide for themselves in sickness by such agencies as "clubs," or by resort to cheap practitioners. In this country, on the contrary, all such citizens look as a matter of course to the dispensary medical officer, and though never so intended their claim on his services is tacitly admitted, and, indeed, we might say intentionally provided for by a studied vagueness in the wording of the Poor-law Regulations. The consequence is that every year thousands of persons receive medical treatment at the expense of the doctor, the ratepayer, and the country, who are well able to pay for it and who would at the same time be greatly affronted at the bare suggestion that they were receiving out-door relief. Seldom a day passes in which the medical officer does not feel that he is being "done." Looking at it from another point of view, it may well be doubted that such a condition of dependence on State help in time of illness is beneficial to the community, or is not rather pernicious because of the want of self-reliance and forethought which it inculcates.

SUPERANNUATION.

Almost the greatest grievance of the service, to my mind, are the conditions at present existing as regards superannuation. The law only permits a pension to be given; the guardians have the power to determine the amount, and also whether it shall be given at all, but the worst feature is the cruel and tyrannical rule that no medical officer can have his application for superannuation even considered until after he has resigned his appointment. He must then place himself at the mercy of his Board, when, if the vote is against him, he loses both his office and the expected pension. The wonder is how such an unfair and unjust rule can have existed so long; but in the face of it there is no wonder that there are many men broken down by long years of hard work, by old age and infirmity, quite unfit for efficient work, still in the ranks, simply because they are afraid to resign. Did time permit, many pitiful stories could be told of individuals who have suffered from this defective system. The argument that has been used against giving a pension to a medical man as he is not a "full time" officer is indeed a weak one. A civil servant works not more than forty hours a week, his evenings and all his Sundays are free, he knows nothing of the night bell or dislocation of his meal hours. The medical man is ever on duty, and if hours of work were totted up they would exceed those of any civil servant. In risk, wear and tear, anxiety, and exposure there can be no fair comparison made. The pension should be, as in the case of army medical officers, automatically given for efficient service. The State should contribute its full share as it does to salaries, for undoubtedly the difficulty of obtaining a pension is increased by the introduction into the permissive Superannuation Bill of 1869 of the fatal provision "that no contribution be made thereto out of any moneys voted by Parliament." Naturally enough the guardians are the less willing to grant a pension the whole cost of which must be borne locally, so that the pension may cost them more than the salary.

A NATIONAL MEDICAL SERVICE.

Any proposal to reform the dispensary system must go further than any scheme having as its object increase of of salary and right to a pension only.

I am convinced that there should be a National Medical Service, entrance into which should be by competitive examination.

There could be local bodies to assist in administration of relief, but the Government should defray the whole cost, instead of half as at present.

The salary should be £200, rising to £300, with allowances for house and horse at Royal Irish Constabulary rates, and retirement at the age of 65 with a pension on Civil Service scale.

Medical inspectors to be chosen by competitive examination from dispensary and workhouse medical officers of over ten years' service who have a diploma in public health.

A post-graduate course about the tenth year of service should be attended by each medical officer, with full pay and free lectures. Every medical officer should be entitled to yearly vacation of one month.

Each county or group of counties should have a medical officer of health, a "whole-time" official, with adequate salary.

This is merely an outline, leaving many important matters of detail to be filled in; but it is on some such lines, I submit, that the much-needed reform in this system must be brought about.

The reformation is almost entirely in the hands of the profession itself. The service at present is hard and unattractive, and offers but little inducement to the young man starting in life. If this could be brought home to him, the unflinching law of supply and demand will bring the remedy, as it has, for instance, in our Army Medical Service, for which there is now keen competition among the best of our students.

We must remember that it is not only on professional grounds that reform is needed; the claims of the poor of Ireland should also be considered. It was for them the system was established. It is plainly the duty of the State to provide them with a service thoroughly efficient and up to date, and it is a reproach to successive Governments to have allowed the present conditions to have continued so long.

THE ATTENDANCE PRIZE SYSTEM;

ITS RELATION TO THE SPREAD OF DISEASE IN
ELEMENTARY SCHOOLS

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PRIZES for regular and punctual attendance are given in nearly all the elementary schools of this country. Some few education authorities give prizes for efficiency and progress, but a high percentage of attendance is also required, and absence on account of illness, infectious or otherwise, is not taken into account, and therefore disqualifies. The giving of bronze and silver medals for consecutive perfect attendance during such periods as four and six years is also a common practice. The advantages and disadvantages of the system may be briefly summed up.

ADVANTAGES.

1. The Government grant is earned by means of attendance. Thus money spent in prizes is looked on as well invested, and likely to return great increase in larger grant obtained.
2. The children are trained in regular and punctual habits.
3. If children are absent there is a loss of sequence in their education.

DISADVANTAGES.

1. The wrong children often get the prizes. The child who tries and the brilliant child may have temporary illness, and therefore receive no reward; whilst the dull and backward and the idle child may win yearly.
2. In many cases the parents are most keen, they really deserve the reward. The child with neglectful parents has little chance, as it is kept away from school for trivial causes, and is thus not successful.
3. In the more enlightened cities, where absence on account of infectious disease is allowed, the prize is a farce as a prize for regular attendance, as a child may be absent for months with ringworm or scarlatina, and yet receive a first-class reward for, perhaps, a month's attendance in the year.
4. The giving of prizes for attendance demanded by law, when by the child's absence parents are liable to be fined, is also an argument against the system, although a very trivial one compared with
 - (a) The risk to individual health.
 - (b) The risk to the public health.

THE RISK TO INDIVIDUAL HEALTH.

Children are sent to school with bilious attacks; they have to be kept recumbent, and even then vomit on the floor. The teachers allow them to remain simply to prevent their losing an attendance.

Again, in the case of children suffering from various physical defects, I often receive answers to my letters requesting the parents to obtain medical attention to the effect that the child will be attended to in the holidays, so as not to miss its special prize, and promises are very poor things compared with deeds. I know children have lost special rewards owing to one half-day's absence spent at the hospital for the removal of adenoids. No doubt many parents are over-anxious about their children, and keep them away from school for the slightest ailment; but if done in good faith this is much better than sending the child to school, well or ill, in order to obtain a first-class reward.

THE RISK TO THE PUBLIC HEALTH.

Children sent to school with the early symptoms of scarlatina, measles, etc., sit close to healthy children, and thus disease is spread.

In one case a mother brought a little boy to school, and begged the teacher to allow him to stay, although he was obviously far from well, so that he "might not miss his prize." This was on a Tuesday morning; on Thursday he died of scarlatina. In another case a child was kept at school all one day and till noon the next. During the afternoon she was delirious, and, on the family doctor being called in, she was sent to the fever hospital suffering from scarlatina. Another child was seen sitting by the fire on account of a sore throat. This child had diphtheria, and her reason for being in school was that absence would deprive her of a prize. In all these instances grave risk had been run of infecting other children.

In visiting schools when measles is prevalent in the district, how often colds in the head and red eyes are noted and excluded! Supposing these symptoms occur in the last fortnight of a child's six years' perfect attendance, with a silver medal fall in sight, ignorant parents can scarcely be blamed for sending the child, although even to the unprofessional eye it ought to be in bed rather than at school.

I think all interested in the problem of health at school will agree that the weight of evidence is against the attendance prize system, and that some effort should be made to remedy it.

In Sheffield the system has been completely altered. The prizes in the future are to be given for progress and efficiency based on the class teacher's recommendation and the head teacher's examination. A high percentage of attendance will be required, but illness, both infectious and otherwise, will be allowed for, so that the child who is ill during the term will have as good a chance of a prize as the one who is ill in the holidays.

It is to be hoped that, in the near future, other education authorities will alter their prize system to one on the Sheffield plan, and thus a good deal of unnecessary misery be spared the children for whom they are responsible.

MEMORANDA: MEDICAL, SURGICAL, OBSTETRICAL.

PAROTITIS AS A SEQUELA OF PNEUMONIA.

THE patient in the following case, a man aged 42, was attacked by acute pneumonia on December 26th, 1907, the left lung being involved. Crisis occurred with five attacks of vomiting on the seventh day of the disease.

After-Progress.—On the following day the temperature and pulse ran up again, and what should have been the third day of convalescence was marked by the onset of tenderness and great swelling behind the right ramus of the lower jaw, below the lobule of the ear. Next day, owing to extension of swelling and symptoms of toxæmia, an incision was made over the inflammatory tumour, but no pus was evacuated. After the lapse of a further forty-eight hours, and the employment of boracic fomentations, beads of pus appeared in the incision. As drainage was evidently deficient, and the whole parotid gland, superficially and deep, was suppurating freely, further extensive incisions were employed, and a thorough vent given to the loculated collections of pus, which welled up from deep tracks, reaching to the digastric fossa behind, the glenoid fossa and interpterygoid muscular area anteriorly, as also through Stensen's duct into the mouth.

Thirty-one days after the onset of the parotitis sinuses were healed, and induration and swelling remained, giving rise to slight limitation of movement of lower jaw.