

## THE STANDARDISED BABY.

To the Editor of THE LANCET.

SIR,—Your annotation on p. 542 of THE LANCET of April 13th, which refers to the teaching of the Royal New Zealand Society for the Health of Women and Children (of which I am general president) as somewhat dogmatic in its tendencies with regard to the artificial feeding of babies, is based, I think, on a misconception. It was necessary in a small book on infant hygiene, for popular use, to confine oneself to a few simple, definite recipes and to be so far dogmatic. It would have been merely puzzling and confusing to the mothers to give more than the formulæ included and the indications for varying these.

Perhaps it is the recommendation to "humanise" cow's milk and to use sugar of milk in preference to cane sugar that suggests the idea of dogmatism, but I think we are all agreed that, other things being equal, milk sugar should be recommended for use in the feeding of normal babies if feasible. I cannot agree that there is scientific or clinical warranty for saying that cane sugar, or even malt sugar, should be regarded as equally safe and suitable in the feeding of normal infants, though malt sugar is, of course, preferable in certain pathological conditions. Whether the better term would be "humanising" or "modifying" cow's milk is an open question. All recipes given for modifying milk so as to make it approximate the composition of human milk are, of course, instructions for humanising. While preferring fresh milk to dried milk, a formula for the use of the latter is given in the appendix.

The main purpose of the society's book was to emphasise the importance of paying careful attention to all the main hygienic factors included under the following headings: Air, Water, Food, Clothing, Bathing, Exercise, Warmth, Regularity, Cleanliness, Mothering, Management, Rest, and Sleep. The foremost place is given to the transcendent importance of breast-feeding, and, failing this, to approaching nature as nearly as possible in preparing an artificial substitute. This is not standardising the baby, but doing our best to approximate the composition of the baby's food to the standard set for us by nature. I am not suggesting for a moment that the recipes given in "The Feeding and Care of Baby" afford the best and closest approximation feasible, but they were the best I could arrive at, and they have proved satisfactory in practice, without alteration, over a long period of time. I am, Sir, yours faithfully,

April 24th, 1918.

F. TRUBY KING.

## AURICULAR FLUTTER AND PAROXYSMAL TACHYCARDIA.

To the Editor of THE LANCET.

SIR,—The studies in cardiac pathology by Dr. Frederick W. Price, published in THE LANCET of April 6th and 13th, give clearly and in few words much information on two disorders of cardiac motion of great clinical interest. The essential nature of these cannot yet be said to be positively determined, however one may interpret the registrable phenomena.

I think I am correct in stating that the first clinical case of what is now usually termed auricular flutter was noted by myself in 1903, and polygraphic tracings from it were published in THE LANCET of Jan. 9th, 1909, in the course of an article on cardiac motion as revealed by the vivisection of disease. In that case there was a persistent 2:1 rhythm with an auricular rate of 240. A very clearly observable feature of the case, and one to which I called the attention at the time of my then colleague at the Great Northern Central Hospital, Dr. Clifford Beale, was that the accelerated auricular action was not only visible to the eye when registered by the polygraph, and indeed to the naked eye in the veins of the neck, but was also audible to the ear as distinct tic-tac sounds resembling a rapidly beating foetal heart. These sounds were audible over the jugular bulb, on which account I described the condition as a "jugular embryocardia" in a communication to the Æsculapian Society. This auscultation sign of auricular tachycardia I have looked for in subsequent cases without finding it, and my friend, Dr. W. T. Ritchie, of Edinburgh, now on foreign service, also informed me that he failed to note it in auricular flutter. When, however, the sign does occur it is so unmistakable as to be diagnostic and should always be

looked for. Its presence is probably due to a certain force of systole in an hypertrophied chamber, together with the existence of well-developed jugular valves above the bulb.

When Dr. Price states that "the commencement and termination of auricular flutter are sudden and abrupt" they certainly are so, if the condition termed flutter be regarded as synonymous with paroxysmal tachycardia, which is the subject of his second study; but I think it is questionable that this is so. True flutter, as I regard the condition, persists when the ventricular rate is reduced, and it is not a common consequence of the paroxysmal state. Such a case as that of which Dr. Price gives a polygraphic tracing on p. 491 (Fig. 1) I should regard as indistinguishable from paroxysmal tachycardia. He deals with a point of interest in his article on the latter subject (p. 521). I agree with him in his description of this mode of cardiac motion, but while I am aware that he gives the usual explanation of the phenomenon urged by most myogenists—namely, that it is the expression of ectopic stimulus in the auricle, the topus being the sinu-auricular node—and attributes the return to normal rhythm to cessation of the ectopic and reassertion of the topic stimulus, I confess that I prefer to regard the aberrant phenomenon as due to disturbance of the neural control of the sinu-auricular node and auricle, and the return to normal to a reassertion of such control.

I think I am correct in stating that I was the first to publish and illustrate an account of the complete innervation of the so-called "pacemaker," sinu-auricular, or Keith-Flack, node in the *Journal of Anatomy and Physiology* for July, 1912, and it is generally admitted that the excitatory system of the heart, once regarded as independent of neural control, is now known not to be so.

While in these details of scientific interpretation I may differ from Dr. Price, I regard his articles as valuable, and in their practical portion should only question the desirability of employing the very large doses of digitalis which he suggests as at times necessary in a condition which, when not fatal (as it unfortunately may be), is suddenly and automatically terminable. As in all exaggerated visceral actions, there is use in the employment in these cases of opium in various doses, although even with this drug (to which Dr. Price does not specially refer) it is difficult to be certain that the *post* and *propter remedium* are closely related, even when an apparently happy result has been secured.

I am, Sir, yours faithfully,

ALEXANDER MORISON.

Upper Berkeley-street, W., April 15th, 1918.

## Obituary.

JOHN MICHELL CLARKE, M.D. CANTAB.,  
F.R.C.P. LOND., LL.D.,

PRO-VICE-CHANCELLOR OF THE UNIVERSITY OF BRISTOL.

As we announced last week, the death of Professor Michell Clarke took place on April 21st at Headland House Hotel, Looe, Cornwall, in his fifty-ninth year.

John Michell Clarke was the son of the late Mr. W. Michell Clarke, a well-known surgeon at Bristol, and was educated at Clifton College, Caius College, Cambridge, and St. Thomas's Hospital Medical School. At Cambridge he graduated in honours in the Natural Science Tripos of 1882, in which year he became demonstrator of anatomy at the medical school. Three years later he graduated in medicine at Cambridge and served as house physician at St. Thomas's Hospital. Clarke's intellectual and practical gifts were already well appreciated by his seniors, and it was probably his intention to remain in London, but the death of his father led to his return to Clifton. He was appointed almost immediately lecturer on practical physiology in University College, Bristol, became later professor of pathology and of medicine, and held these offices till 1909, when he became professor of medicine in the University of Bristol. In 1887 he took the M.R.C.P. Lond. and was appointed assistant physician to the Bristol General Hospital; six years later he became full physician, taking the M.D. Camb. in 1892 and being elected F.R.C.P. Lond. in 1896.

At Bristol Clarke succeeded without dissentient voice to many academic and official posts. He had been at different times secretary and president of the Bath and Bristol Branch