GENERAL SECRETARY: The N.E.C. have not drafted any definite scheme. Miss Wiese brought the matter to our notice, and asked us to permit the Conference to vote on it, and we put it on the agenda on the understanding that if you passed it the N.E.C. would draft a scheme, which they would submit to you in due course. All the points raised are of very great importance, and I can see many difficulties in the way. We should, of course, have severely to limit the number of scholarships, and to do so would mean setting up some authority to make a choice from amongst the applicants, but the N.E.C. would not proceed with any scheme without first coming to this Conference for approval. [*Vide: N.A.-W.U. Magazine*, August, 1928.] **[Carried.**

GENERAL PARALYSIS SUB-COMMITTEE.

POINTS FOR A DISCUSSION ON THE DIAGNOSIS, PATHOLOGY AND TREATMENT OF GENERAL PARALYSIS.

The Diagnosis.

1. Is the diagnosis of general paralysis justified on laboratory findings only, *i.e.*, without the support of (*a*) mental, (*b*) physical, or (*c*) both mental and physical signs? If not, then what physical and mental symptoms are necessary to support laboratory findings in order to justify a diagnosis of general paralysis?
2. Are cases now being diagnosed and treated as general paralysis in virtue of certain common laboratory findings, and which otherwise would not have been diagnosed as such? If so, do these cases represent an altered type of general paralysis, or are they merely the cases which were formerly classed as cerebral syphilis and treated as such with a reasonable prospect of improvement or cure?
3. Can cases of acute cerebral syphilis be distinguished from general paralysis clinically or serologically? If so, how?
4. To what extent is there unanimity of opinion as to the laboratory findings which justfiy or support the diagnosisof general paralysis? [This question arises because of the necessity for a complete standard correlation between the mental and physical signs and the serological changes in such cases.]

The Pathology.

1. Is there a special neurotropic strain of spirochæte in general paralysis?
2. Should cases of acute cerebral syphilis (infection *vid* blood-vessels and not lymphatics) be regarded as suffering from general paralysis?
3. Is general paralysis due to a pure or mixed infection?
4. Are the pathological findings in general paralysis pathognomonic or are they merely those found in all cases of dementia?

Treatment.

1. The application of malaria and tryparsamide therapy to cases of early syphilis showing pathological changes in the cerebro-spinal fluid.
2. The cause of the variation of the results of malaria and tryparsamide therapy in general paralysis claimed by different observers.
3. Should malaria therapy be supplemented by other anti-syphilitic measures?

It is hoped that members will take every opportunity of discussing these points at Quarterly, Divisional and Divisional Clinical Meetings during the year 1928–29, and forward notes of their remarks to the Hon. Secretary, Dr. W. D. NICOL, *Horton Mental Hospital, Epsom.*

PATHOLOGICAL, BACTERIOLOGICAL AND BIOCHEMICAL SUB-COMMITTEE.

SCHEMES OF RESEARCH.

[*May* 8, 1928.]

Subject:

(1) The Histology of the Basal Ganglia.

Leader: Dr. G. A. WATSON, Pathologist, Lancashire Mental Hospitals.

https://doi.org/10.1192/bjp.74.307.901-a Published online by Cambridge University Press

(2) Pellagra and Allied Conditions.
  (*a*) Symptomatology.
  (*b*) Endocrinology.
  (*c*) Pathology.
  (*d*) Bacteriology.
    Leader: Dr. G. A. WATSON.

(3) The Accessory Sinuses. The Study of their Pathology, Bacteriology and Ætiological Relationship to Mental Disorder.
    Leader: Dr. F. A. PICKWORTH, Director of the Joint Board of Research, City and University of Birmingham.

(4) Biochemical Research into Liver Function.
    Leader: Dr. R. L. MACKENZIE WALLIS.

(5) The Bacteriology of the Intestine.
  (*a*) Aerobic Methods, in Particular the Study of the Coliform Group and their Relation to Insanity.
    Leader: Dr. F. H. STEWART, Pathologist and Bacteriologist to Staffordshire Mental Hospital, Cheddleton.
  (*b*) Anaerobic Methods, especially the Study of the Diphtheroid and Leptothrix Group and their Relationship to Mental Disorders.
    Leader: Dr. W. M. FORD-ROBERTSON, Pathologist and Bacteriologist to St. Andrew's Hospital, Northampton.

Members desiring to take part in these researches should communicate with the Honorary Secretary, Dr. W. M. FORD-ROBERTSON, *St. Andrew's Hospital, Northampton.*

APPOINTMENTS.

HANCOCK, ALLEN COULTER, *M.C.*, M.B., B.S., M.R.C.S., L.R.C.P.Lond., D.P.H., D.P.M., to be Medical Superintendent, Kent County Mental Hospital, Barming Heath, Maidstone.

NICOL, WILLIAM DREW, M.B., B.S., M.R.C.S., L.R.C.P.Lond., D.P.M., to be Deputy Medical Superintendent, Horton Mental Hospital, Epsom.

LORD, JOHN ROBERT, *C.B.E.*, M.D., F.R.C.P.E., to be Lecturer on Clinical Psychiatry, London (Royal Free Hospital) School of Medicine for Women (University of London).

OBITUARY.

RICHARD BLACKWELL MITCHELL, M.D.Edin.,

Ordinary Member 1881–1914.

Dr. R. B. Mitchell died on June 18, 1928, at Edinburgh, where he had lived since his retirement from active work. Dr. Mitchell was a native of Orkney where he was born about seventy-three years ago. He studied medicine at the University of Edinburgh, and graduated M.B., C.M. in 1879. He obtained the M.D. degree with honours in 1885.

After leaving College in 1879 he spent some time as a ship's surgeon, visiting various foreign countries—a broadening experience particularly congenial to an Orcadian. He commenced his life's work as Assistant Physician in the Fife and Kinross District Asylum, from which he was promoted to a similar position in the Royal Asylum, Morningside, Edinburgh, under the late Sir Thomas Clouston.

In 1885 he was appointed Medical Superintendent of the Midlothian and Peebles Asylum, a post which he retained until his retirement nearly thirty years later. During this long period the institution was completely reorganized and largely rebuilt, and the land attached to it was extended from a few acres to an arable farm of several hundred acres. Similar changes are represented in the normal development of most Scottish mental hospitals, and it is not always easy to estimate the exact share taken by an individual superintendent in their promotion. It is certain, however, that without his active co-operation they could not have been successfully carried out.

https://doi.org/10.1192/bjp.74.307.901-a Published online by Cambridge University Press