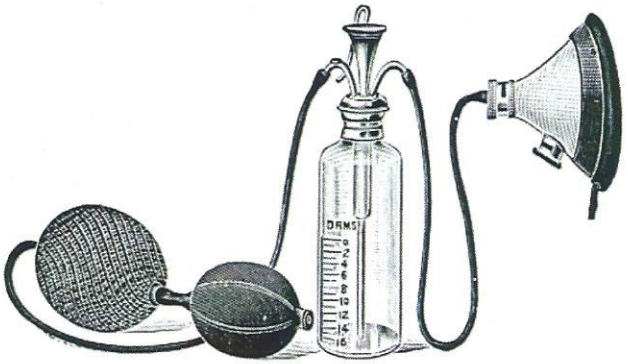
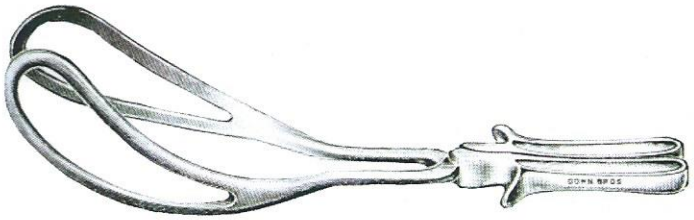


# The Historical Medical Equipment Society




BULLETIN NO. 32 ISSN 1366 - 4719 SEPTEMBER 2017

## EXECUTIVE COMMITTEE



## CONTENTS



## FUTURE MEETINGS

NEXT MEETING: THACKRAY MUSEUM , LEEDS SAT 14th APRIL 2018

# EDITORIAL

Seventeen members, guests and speakers attended the HMES meeting on Friday 21st April at the Royal College of Physicians, London (RCP). We owe thanks to the RCP staff including Sian Morgan (meeting organizer), Julie Beckwith & Natalie Craven (curators) and Katie Birkwood (archivist & tour guide). The RCP has a long and ancient history dating from its foundation in 1518 by Henry VIII. The College moved to its present Grade 1 listed building near Regents Park in 1964. It was designed by architect Sir Denis Lasdun (1914-2001) and houses the College's treasures, portraits and collections and adjacent Medicinal Gardens.

The top floor is home to four remarkable large 'anatomical tables' dating from 1650s Padua. They display, the vascular and nervous system splayed out on boards and were prepared from the dissected bodies of executed criminals. The first floor is devoted to an exhibition about Sir Thomas Browne MD FRCP (1605-82), physician, writer, collector and polymath. The Dorchester Library collection dates from 1680 and includes over 3000 rare volumes. The Treasures Room on the ground floor houses the College's silver and the beautiful display of antique medical equipment and surgical instruments collected by Dr. Cecil Symons FRCP (1921-87). On the corridor is a further magnificent display of 202 Delftware apothecary drug jars collected by Professor Allan Hoffbrand FRCP and recently catalogued by Alan Humphries. A further small exhibition is devoted to the College architecture and the Censors' Room is lined with 17th century Spanish oak transferred from the previous College building. The herbal and Medicinal Gardens are located on various sites around the College grounds and looked after by team of 'Garden Fellows' including Dr. Noel Snell FRCP, a new member to the HMES.

John Prosser introduced the meeting and gave an insightful paper on the history of pap boats based on his collection, which nicely complemented the display of similar ones in the Symons Collection. His paper discussed their role in infant feeding, the changes in fashion for breast feeding and their relationship to infant mortality. Tim Smith provided a lucid account of the developments of anesthetic equipment during World War II. The introduction of new equipment and drugs set the pace. Difference in British and American practice was sometimes problematic – especially confusion over the colour-coding of gas cylinders! Adrian Thomas gave a helpful paper on the early history and technical development of X-ray tubes and brought several types to illustrate his talk. He highlighted the problems of cooling and radiation protection and how engineer William Coolidge (1873-1975) overcame some of these problems. Jonathan Goddard related a nice story about 'Mr. Mogg's Resectoscope', which he had bought on E-bay. His detailed research revealed an interesting history ending up in the Seamen's Hospital in Cardiff! The paper about the 'Witch-Doctor's Bones' described the use of African divination dice and how they linked together three Fellows of the RCP – two of them Presidents of the College. The final paper by Alan Humphries provided a well-illustrated account of the Hoffbrand apothecary jar collection and discussion about their manufacture, decoration and use. The meeting was followed by a lively guided tour of the College by the Library archivist, Katie Birkwood.

John Prosser chaired a short HMES business meeting and Adrian Padfield gave a financial report. The problem of declining membership and meeting attendance was discussed again. It was proposed to reactivate the website and try the use of a HMES flyer/leaflet again. The next meeting will be at the Thackray Museum, in Leeds, April 2018.

Peter Mohr, Honorary Secretary

# PAP, PAPBOATS AND INFANT FEEDING

JOHN PROSSER

*Fig.1 Examples from the author's papboat collection*

'Papboats', made of ceramics, silver or other material, form an interesting subject for collecting and study (fig.1). As their name suggests they are an open boat-shaped vessel, similar to a gravy-boat and once used to feed babies. 'Pap' can be simply defined as 'infant food' and the word is derived from an old name for 'a nipple of a woman's breast'.

There are various ways to prepare the pap. It is a soft or semi-liquid slurry of bread, meal or flour in water or milk for feeding infants or invalids. The basic pap mixture might be 'beefed-up' with sugar, beer, wine, meat broth or raw meat juices. Sometimes morphine was added to pacify troublesome infants – a practice increasingly used by 'baby-minders' during the nineteenth century.

The papboat technique was used both for feeding new-born infants when breastfeeding was not available and for older infants before weaning. Not surprisingly, in the past artificial feeding has been associated with a high infant mortality particularly in summer with diarrhoea which could rapidly dehydrate and kill infants. The addition of any morphine as a sedative compounded the dehydration and malnutrition.

**Infant feeding and mortality over the ages**

In medieval times breast feeding predominated with weaning at one to three years, nevertheless, infant mortality was high at this time, caused by many epidemic diseases and environmental pollution. During the 16th and 17th centuries early weaning was favoured, often with disastrous consequences – 12% of infants died in their first year. Later, in the 18th century, breast feeding became unfashionable and weaning, often as early as two months, was popular which resulted in a further increase in infant mortality -- in London 50% of infants died in their first year, though mortality was lower in the country areas. During the 19th century 20% of live born infants died in their first year and even during the early 20th century this mortality was still 16%.

**Improvements in infant feeding**

During the 20th century the infant welfare movement; a better understanding of childhood nutrit-

ion, and the development of industrially produced infant foods all helped towards the rapid decline in the infant mortality rate.

Feeding vessels, many and varied, were often very difficult to keep clean. Vessels of cow-horn, pottery, tin, pewter, silver, gold, and glass have been used. Glass bottles proved better and were more hygienic, but some early designs were not easy to clean. Modern baby feeding bottles are much easier to clean and proper sterilizing techniques have dramatically reduced infections and feeding problems.

Papboats can be made of made of pottery, wood, pewter, Sheffield plate, silver or even gold (the Royal College of Physicians has one fashioned from a large shell.) Their open design makes them fairly easy to clean and enabled ample quantities of food to be shovelled into the child! Their use decreased towards the end of the 19th century as commercially prepared foods became available.

**A note on the Foundling Hospital**

Opened in1741 at the instigation of Thomas Coram (1668-1751), a retired Sea Captain, who was horrified at the sight of babies left to die in the streets of London. The mortality of the abandoned was very high: from 1750, of the 15,000 infants admitted 10,000 died. Later, the infants were put out to wet nurses in the countryside until they were 4 or 5 years old, then returned to the Charity for school and training for future employment.

**References:**

[1] Oxford English Dictionary

[2] L Payne, 'Health in England (16th-18th C) in children & youth in history', http://chnm.gmu.edu/cyh/primary-sources/166 2017

[3] https://en.wikipedia.org/wiki/Foundling_Hospital

# THE DEVELOPMENT OF ANAESTHETIC EQUIPMENT DURING THE SECOND WORLD WAR

TIM SMITH

Anaesthesia had emerged as a distinct specialty during the First World War. Simple mask anaesthesia had been superseded by more complex techniques using equipment such as the Boyles machine. Resuscitation with intravenous fluids and blood and the use of oxygen had become more widely accepted. Immediately after the War endotracheal intubation became an invaluable additional anaesthetic technique.

At the start of the Second World War the Boyle machine was the standard piece of anaesthetic equipment used by the armed forces. Considerably modified over the years (fig.1) it continued to be widely used in civilian and military hospitals

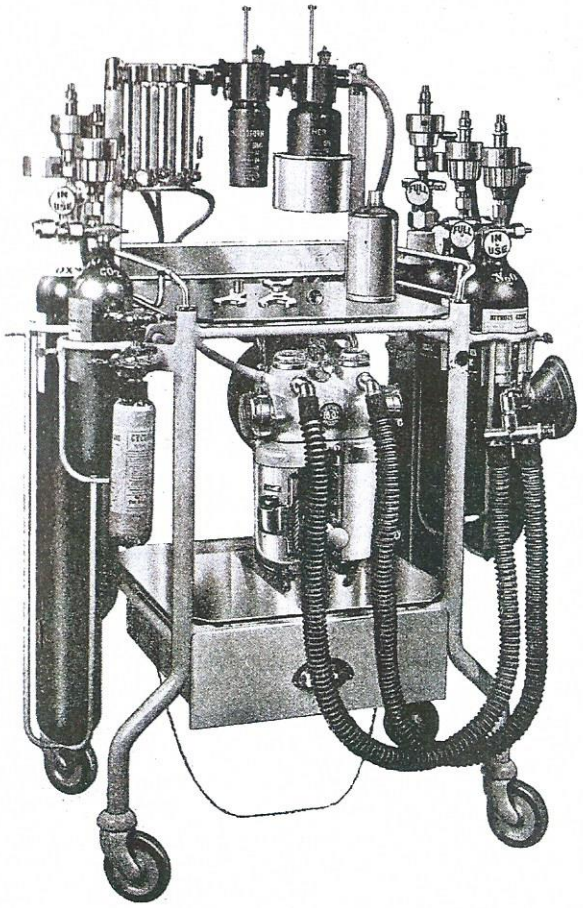


*Fig.1 The Emergency Medical Service Boyle machine of 1941. It had $N_2O$, $O_2$, $CO_2$ and cyclopropane cylinders and simple ether and chloroform vapourisers. It also incorporated a Mapleson-Mushin circle system for absorption of $CO_2$*

in the UK throughout the war (and well beyond). But it was bulky, needing two men to carry it. It also relied on heavy gas cylinders. It became clear that it was not appropriate for the rapidly moving type of warfare that emerged in WW2. Indeed a large part of the army's stock was left behind at Dunkirk. What was needed was a port-

*Fig.2 Oxford Vapouriser 1942*

able, robust and accurate machine that did not rely on cylinders. Such a machine, the Oxford Vapouriser (fig.2), was developed in 1942 by Robert Macintosh (1897-1989) and colleagues at Oxford. It delivered a known and accurate concentration of ether in air and was widely used for the rest of the war.

Another anaesthetic device, the ESO (Epstein, Suffolk, Oxford) was developed specifically for the air-born landings at Arnhem. It delivered chloroform in air, rather than highly inflammable ether which was unsuitable to be carried in aircraft. A less complex design was that of Rex Marrett (1915-2003) (fig.3). He produced a simple draw-over device which delivered trichloethylene (Trilene) in air. It provided useful analgesia but was not widely adopted. He later developed the Marrett Head which became the standard machine used by the military immediately after the war.

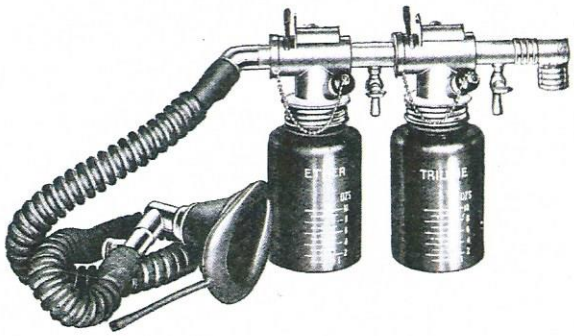


*Fig.3 Marrett's ether/Trilene/air draw-over apparatus 1944*

The Japanese attack on Pearl Harbour precipitated the entry of the USA into the war and also indirectly influenced the development of anaesthesia. The author and other anaesthetists of his generation were told that 'anaesthesia killed more Americans at Pearl Harbour than the Japanese'. While statisically false there was an element of truth in the story. There were no professional anesthetists at Pearl Harbour and nurse-anesthetists were employed who gave relatively large doses of intravenous thiopentone to shocked patients with a higher mortality than would have been expected from inhalation techniques. The use of thiopentone by the United States virtually ceased for the rest of the war but its use by the UK continued where it was considered a useful agent if given carefully by specialist anaesthetists.

After 1942 increasing numbers of anesthetists from the United States came to the UK for higher training. The US forces set up their own hospitals and brought their own anaesthetic equipment with them. One unforeseen problem was the colour coding of gas cylinders. US oxygen cylinders were (and still are) green whereas in the UK at that time green was the colour code for carbon dioxide. One hundred US oxygen cylinders were refilled at UK depots with carbon dioxide. Fortunately there was only one fatality before the error was discovered.

As the war developed it became increasingly clear that the use of experienced anaesthetists as near the front line as possible was highly desirable. For the seriously wounded rapid evacuation and resuscitation with saline, plasma and blood were vital in improving outcome. The widespread use of penicillin by 1944 further reduced mortality.

In addition to those anaesthetists working with the armed forces and in civilian hospitals there were those engaged in wartime research. Edgar Pask (1912-1966), an anaesthetist then working at Oxford and Farnborough, has been described as 'the bravest man in the RAF who never flew an aircraft'. At great personal risk he undertook a number of experiments to help improve the survival of air-crew who had to bale out of damaged aircraft. These trials included personal simulation of the hypoxic conditions at 40,000ft and the testing of flotation jackets while fully anaesthetised (fig.4).

*Fig.4 Pask floating head-down in a swimming-pool fully anaesthetised connected to a co-axial breathing circuit*

Realisation of the part played by anaesthetists during the war led to an improved status for the specialty and was probably a factor in determining that consultant anaesthetists had parity with consultants in other disciplines at the inception of the National Health Service in 1948.

# A BRIEF HISTORY OF X-RAY TUBES

ADRIAN THOMAS

In the 19th Century there was increasing interest in passing electrical discharges across evacuated glass bulbs. Sir William Crookes (1832-1919) investigated these phenomena extensively with a series of experiments in 1879. In these early Crookes-Hittorf tubes the anode and cathode were simple electrodes projecting into the bulb, and it was using one of these tubes that Wilhelm Röntgen (1845-1923) made his famous discovery.

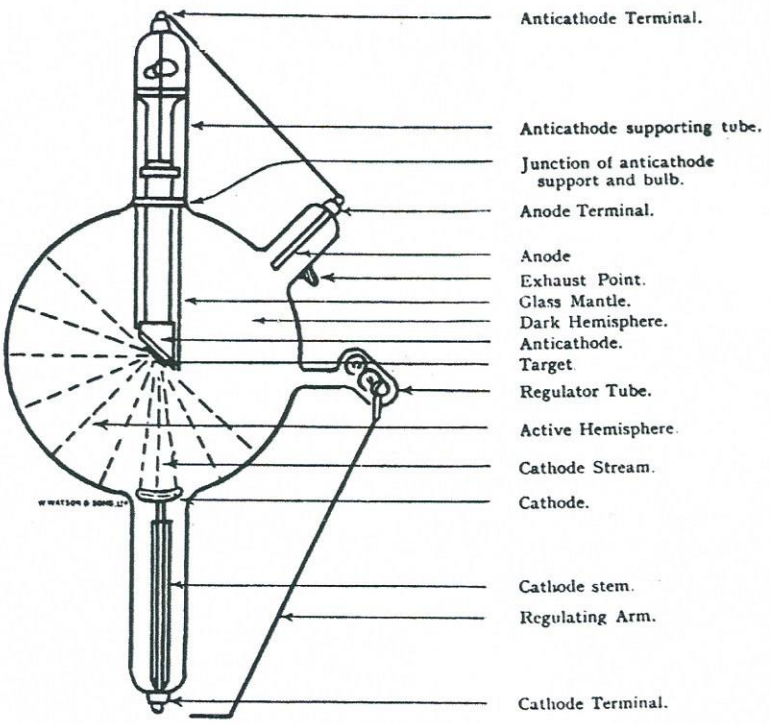



*Fig.2 Diagram of gas or ion X-ray tube.*

There was a rapid development in the technology of X-ray tubes. Herbert Jackson (1863-1936), of Kings College London, showed that the best results were obtained with the anode in the form of a platinum plate fixed at an angle of 40° to the cathode stream and placed in the "focus" of a concave cathode. Hence the term 'focus tube' (fig 1).

These early X-ray tubes contained a small quantity of gas (and were called gas or ion tubes) (fig 2). The passage of the cathode rays (electrons) from anode to cathode) depended on ionisation of the gas. As the tubes were used the vacuum increased (hardening) and it became increasingly difficult to pass a current through the tube. Current might then pass around the tube. A device was attached to the tube to produce gas and the tube was then useable. If there was too much gas in the tube there would be fluorescence of the gas and the tube was useless for producing x-rays.

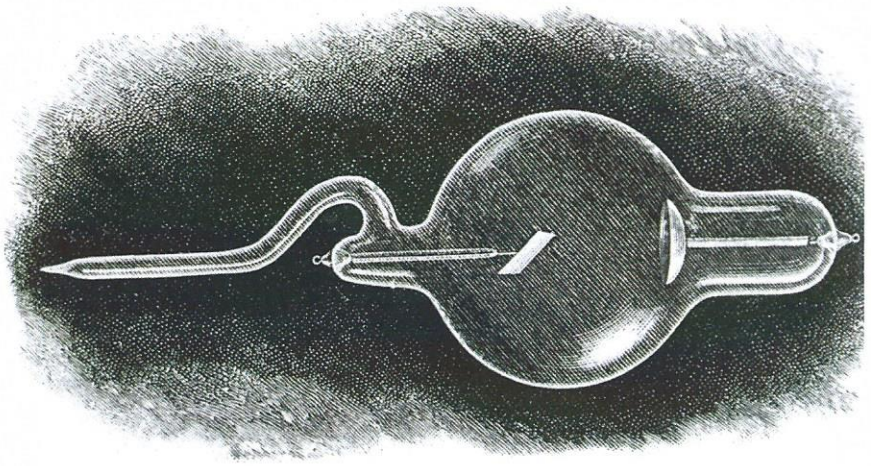


*Fig.1 The Jackson 'focus' tube.*

William Coolidge (1873-1975) produced a major improvement. He replaced the cathode with a heated spiral tungsten filament and molybdenum-focussing bowl. The filament could be heated and a current would pass through the tube even with a very low vacuum (fig 3). The anode of the standard Coolidge tube was set at 45°. All modern X-ray tubes are variants of the Coolidge tube. With the Coolidge tube, the X-

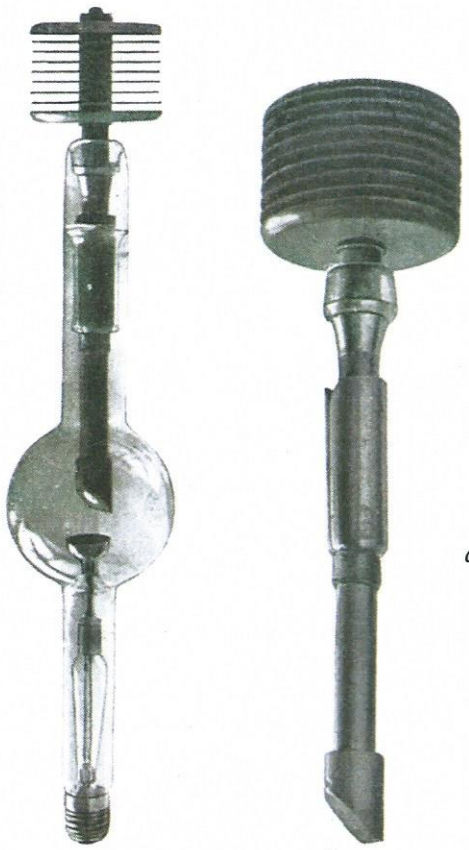


*Fig.3*

*The Coolidge tube. The fins are for cooling the anode.*

ray output of the tube was exactly predictable.

Albert Bouwers (1893-1972) of Philips designed the Metalix tube in 1924. This self-protecting tube was a major improvement and enabled truly shockproof and portable apparatus to be produced. The Metalix tube incorporated the principle of line focus, the anode face being set at an angle of 19° to the cathode. This reduced the apparent size of the focal spot and increased image resolution.

Finally, the rotating anode tube was developed. It was designed by Bouwers and was marketed in 1929 by Philips as the 'Rotalix' (fig.4). Siemens introduced a rotating anode X-ray tube with a tungsten anode disc in 1934. In the classic rotating anode tube the anode target is a heavy tungsten disc that spins so that the focal spot of the cathode rays is changing and the heat is dissipated. Contemporary tubes are variations on the theme of these earlier tubes. Modern tubes have to bear very high tube loading and this is particularly the case for tubes used for CT scanning and angiography.

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Honorary Secretary, The International Society for the History of Radiology

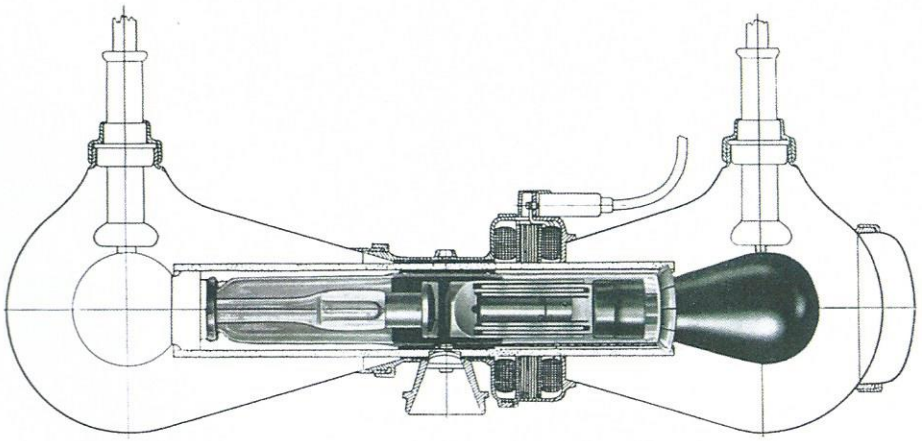


*Fig 4 The Rotalix tube. This tube has a rotating anode, is shielded for radiation protection, and is shockproof.*

# MR. MOGG'S RESECTOSCOPE

JONATHAN CHARLES GODDARD

Mr Mogg's resectoscope was acquired from eBay in September 2016 (fig.1). An old label

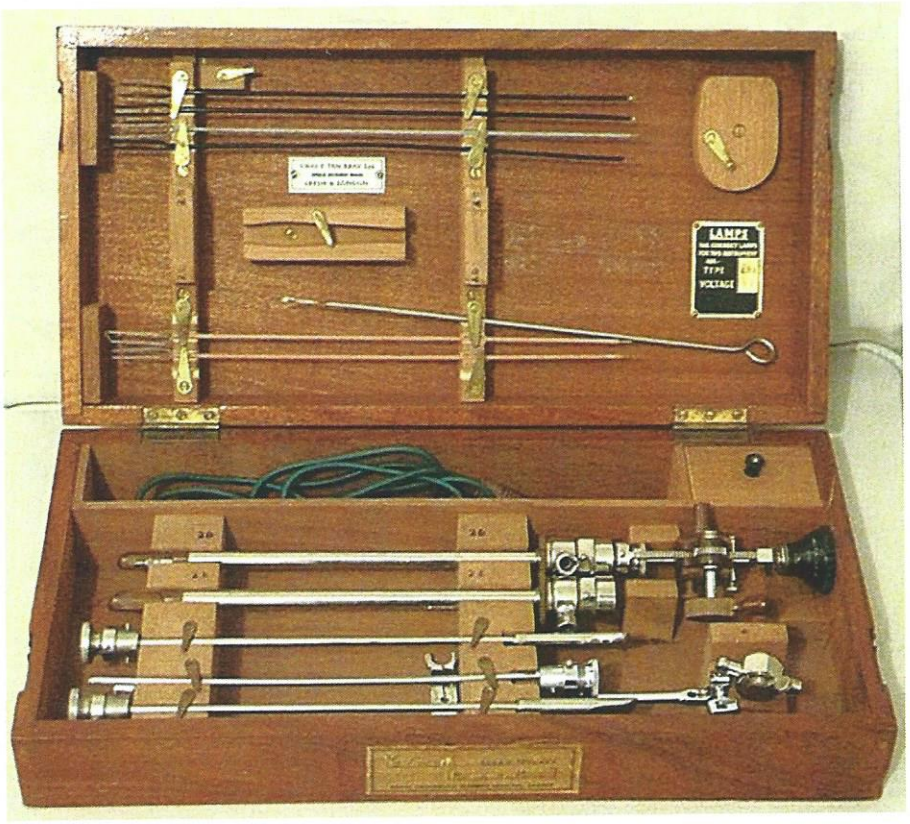



*Fig. 1 Cased Millin's resectoscope by Thackray Ltd (Image; Museum of Urology)*

pasted onto the wooden case, described it as a 'McCarthy Resectoscope' used by Mr R.A. Mogg in the Royal Hamadryad Hospital in Cardiff (fig.2).

A 'resectoscope' is an endoscopic urological instrument for the removal of obstructing tissue from the prostate and bladder neck. The word

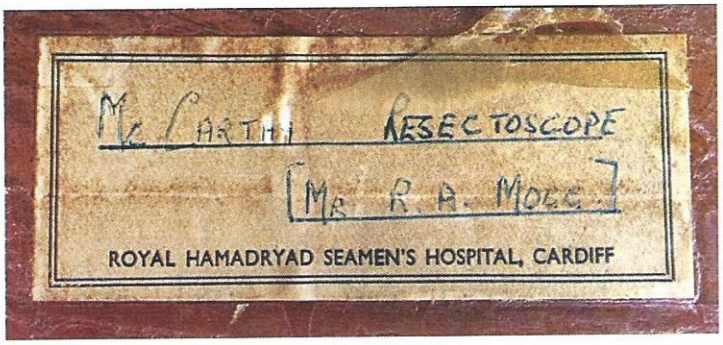



*Fig. 2 Label on the case (Image; Museum of Urology)*

was first used by Maximilian Stern (1843–1946) of New York in 1926. His resectoscope allowed him to remove 'spaghetti like' slivers of prostate, however the undamped electrical cutting current didn't coagulate well so bleeding was a problem. In 1931, Theodore Davis (1889–1973), a South Carolina urologist with a background in electrical engineering, invented his own resectoscope with both cutting and coagulation current diathermy controlled by a foot switch. In the same year, Joseph McCarthy (1874–1965) combined Stern's resectoscope, Davis's dual current and his own excellent panendoscope to produce a practical and usable instrument. The Stern-McCarthy resectoscope soon became the choice of urologists worldwide. On subsequent examination however, it became apparent that Mr Mogg's instrument was *not* a McCarthy resectoscope.

Another label on the wooden case showed it was manufactured by the Thackray company in Leeds. Chas.F.Thackray Ltd. was established in 1902. Charles Frederick Thackray was a pharmacist, but by 1908 was also selling instruments and at the suggestion of Lord Moynihan (1865-1936), the famous Leeds surgeon, Thackray soon began manufacturing his own. At some point in the 1950's the company took over the London based British Cystoscope Co. Examination of a Thackray catalogue from around this time revealed the instrument to be a 'Millin resectoscope'. Terrence Millin (1903–1980) was born and trained in Ireland. He is well known in urol-

ogy for his 1945 Open Retropubic Prostatectomy procedure. However, earlier in his career he worked with Edwin Canny Ryall (1865–1934) at All Saints Urology Hospital in London. Canny Ryall was a pioneer of endoscopic urology in Great Britain and trained Millin.


*Fig. 4 The Royal Hamadryad Hospital Ship (Image; Public Domain)*

The surgeon named on the old label was Richard Arthur Mogg (1911-1980) who was born in Cardiff (fig.3) and trained at the Welsh National School of Medicine, qualifying in 1935. In 1946, he became a Consultant Urologist in the United Cardiff Hospitals founding the Urology Department at the Cardiff Royal Infirmary.

*Fig. 3 Mr R.A. Mogg (Image; BAUS)*

The Royal Hamadryad Hospital in Cardiff took its unusual name from a ship: HMS Hamadryad was a 46-gun frigate from 1823. By 1866 her time as a warship was over and she was taken to Cardiff and beached on the attractively named 'Rat Island' [fig. 4]. The town's medical officer, Dr Henry Paine (1817-94) was worried about the potential disease that sailors were bringing into Cardiff and so the town paid £2791 to have the old ship fitted out as a hospital. By 1905 a new hospital was built on land and took on the old ship's name. It remained a seaman's hospital until 1948 and continued as a hospital under the NHS. It later became a psychiatric hospital finally closing in 2002.

This old resectoscope in its wooden case, thrown out of the theatre, left in an attic and then sold on eBay for a few pounds is now a valuable piece of urological history. In itself it is just an old medical instrument but as part of the Museum of Urology it has become a way of telling the stories of the Trans-urethral Resection of the Prostate; two famous urologists, both past presidents of the British Association of Urological Surgeons (BAUS); a hospital in Wales that cared for thousands of sailors then the local people of Cardiff, and an instrument company that supported surgeons and urologists for many years.

Jonathan Charles Goddard
Curator of the Museum of Urology, hosted by BAUS
Consultant Urological Surgeon, Leicester General Hospital

# LORD ROBERT PLATT AND THE 'WITCH-DOCTOR'S BONES'

PETER & JULIE MOHR

One of the more unusual items in the Manchester Medical School Museum (MMH) is a set of four carved wooden tablets catalogued as 'witch-doctor's bones' (fig.1). They were commonly used by tribal healers ('*nganga*') as a ritual object to contact the ancestral spirits to divine the reason for an illness or other problems. The tablets or 'divining dice' are called '*hakata*' and originally came from the Shona people in colonial Rhodesia. They are a rare object, although there are other examples in the British Museum - how they ended their journey in the Manchester Medical School is a complicated story.

*Figure 1. The set of wooden hakata tablets (10x2cms)*

They were donated to the MMH collection in 1973 by Douglas Black FRCP (1913-2002) when he retired as Professor of Medicine. He had been appointed in 1946 as Research Lecturer in Medicine to the new Professor of Medicine, Robert Platt FRCP (1900-78). In 1952 Black gained his FRCP and it was at the RCP Fellowship award ceremony that he met Michael Gelfand FRCP (1912-85) from Rhodesia who was also receiving his Fellowship. He was a specialist in tropical diseases and became Professor of African Medicine, he was also an expert on the culture of the Shona people, especially the work of tribal healers and their use of magic and herbal remedies (fig.2). The following year Prof. Platt visited South Africa and Gelfand gave him the set of *hakata* to pass-on to Douglas Black, who kept them in his office for 20 years.

**The *Nganga* and his *Hakata***

Professor Gelfand described the complex culture of the Shona people, which was centred around a belief in ancestral spirits who controlled life events for better or

*Figure 2. Prof. Gelfand with a Nganga from Mrewa near Salisbury (1964)*

worse. If an ancestor was offended then that could cause bad luck or illness. Prior to the twentieth century the main job of the 'witch-


*Figure 3. The cartoon with Prof. Platt's article*

doctor' was to identify the 'witches' who were conjuring 'evil spirits' to cause misfortune. White colonials stigmatised the phrase 'witch-doctor' and regarded the *nganga* as a powerful nuisance and introduced a 'Witch Craft Suppression Ordinance' in 1899, which threatened both the witch and the witch-doctor with two-years hard labour.

By the 1940s-50s the *nganga* was dealing mainly with family illness, healing and herbalism. He uses the *hakata* as divination tablets to connect with the spirit world and divine the reason for the illness. The tablets are carved with symbols on one side and are plain on the back. A family member would consult the Nganga and perhaps ask, 'my brother is very ill, will he recover?' The *nganga* would quickly cast the *hakata* on the ground and interpret the 'throw' – there are sixteen possible combinations; nine of them indicate a poor prognosis, four are ambiguous and only three predict a good outcome. A series of further questions are answered by further casts; the Nganga may use different sets of *hakata* for different questions. He would also advise on herbal treatment or sometimes scarification or cupping. Some *nganga* specialised in infertility, epilepsy or herbalism. Others provided magic talismans to prevent bad luck or deal with non-medical problems such as farming or marriage. Gelfand befriended many *nganga* and they sometimes referred Shona patients directly to him at the African Hospital. His detailed anthropological research revealed a very complicated system of Shona healers with a wide regional variation in the use of rituals, *hakata* and herbal recipes. About a third of *nganga* are women, but they don't use the *hakata*.

**Professor Platt's visit to South Africa**

In 1953 Robert Platt was invited to spend two months as visiting professor at the University of Witwatersrand, Johannesburg. He recorded his visit in the *Manchester Medical School Gazette* accompanied by a rather bold cartoon done by 'JWW' (fig.3). Platt flew on the Comet accom-

*Figure 4. Portrait of Lord Platt in the RCP*

panied by his cello so he could play with the University orchestra. He had a busy schedule of medical lectures and tours of hospitals interspaced with social visits to other towns and professors' homes. It was a relief for him to be 'free from administration, clinical responsibility and research, and all the interruptions of a professor's life'. He described the political tension and the problems caused by Apartheid and was appalled by the native Townships: '80,000 people living in squalor...bathing in a river infested with bilharzia'. He visited the Kruger Park and Victoria Falls. He concluded: 'back to Manchester to hard work...South Africa is a great county containing many fine and friendly people. But I would rather be in England'.

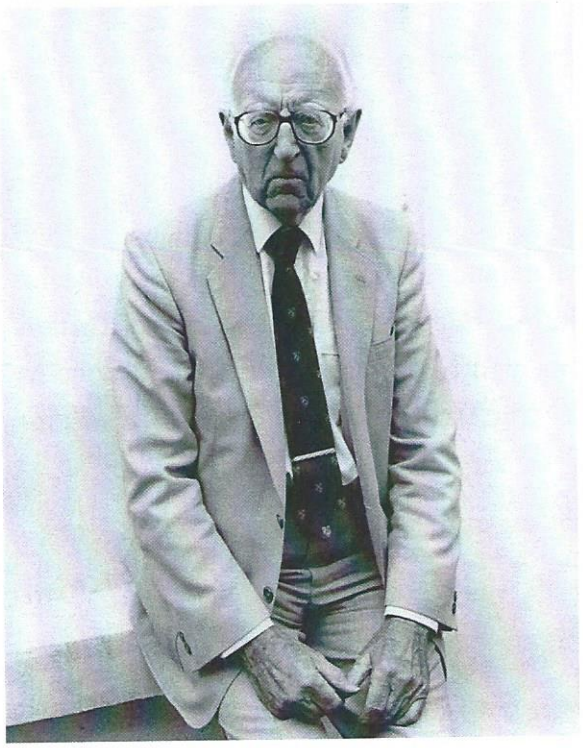


*Figure 5. Portrait of Sir Douglas Black in the RCP*

The startling cartoon shows Platt as the witch-doctor casting the 'bones' and a 'native' holding club over him - this figure is in fact Douglas Black - a juvenile pun on his name! The rats and kidneys signify Platt's research done by Black in the laboratory; perhaps he's waiting for promotion? Is Platt divining his own future or Black's or both? He was discontented and perhaps he had been offered a job in South Africa. In any event, he stayed at Manchester and became President of the RCP in 1957 (fig.4). Black became Professor in 1959 and President of RCP in 1977 (fig.5). However, the cartoonist, a medical student, Joseph Winton Williams, was more prophetic than he knew: he shows Platt holding a femur - perhaps an omen of Platt's accident in 1978 when he slipped on some steps in the RCP and fractured his neck of femur! He was admitted to UCH and died a few weeks later in hospital.

**References**

[1] M. Gelfand, *Witch Doctor* (1964); *The African Witch* (1967); *Medicine & Magic of the Mashona* (1956)

[2] R. Platt, 'Impressions of South Africa', *Manchester University Medical School Gazette*, June 1953, p.10-14.

[3] R. Platt, *Private & Controversial* (1972)

# THE HOFFBRAND COLLECTION OF DELFTWARE APOTHECARY JARS AT THE ROYAL COLLEGE OF PHYSICIANS

At the HMES meeting in April Alan Humphries presented a paper about the collection of apothecary Delftware jars at the Royal College of Physicians, and this will hopefully be published in a future issue of the *Bulletin.* The summary below is taken from the RCP website: https://www.rcplondon.ac.uk/news/hoffbrand-collection

The collection comprises 183 Delftware jars (1640s - 1745), collected by Professor Victor Hoffbrand, FRCP, and is the largest privately-owned collection of English delftware apothecary jars in the country. They were used to store medicines and herbal ingredients and are decorative with blue & white designs and Latin names of their contents. English Delftware is a type of tin-glazed earthenware, fired and then dipped in a tin oxide glaze to make them white and opaque. The blue designs were painted onto the surface and then re-fired.

Dutch Delftware was brought to England c.1567 by Antwerp potters fleeing religious persecution and who set up potteries in Southwark and Lambeth. There are four main types: 'wet jars' for liquids with a spout & handle; round cylinder 'dry jars'; small 'dry jars' for pills and large 'dry jars' for shop display. The contents of the jars covered a wide range of herbal and botanical ingredients. The collection is displayed and can be visited at the RCP. A detailed illustrated account can be found in *English Delftware Apothecary Jars and their Contents* (2017), by A Humphries, H Oakeley & V Hoffbrand (reviewed in this issue).

Peter Mohr

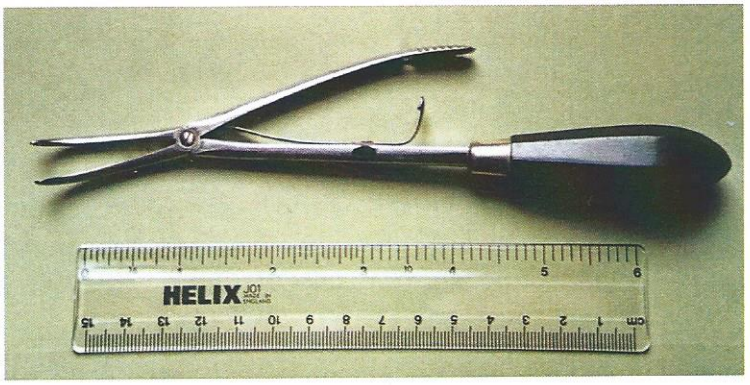
# BOOK REVIEWS

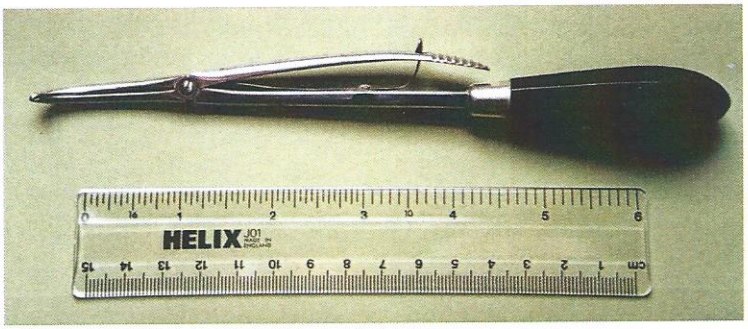
**English Delftware Apothecary Jars & their Contents. The Victor Hoffbrand Collection**
By Alan Humphries, Henry Oakeley & Victor Hoffbrand
www.oakeleybooks.com (2017), Leeds & London
A well-produced book, full detailed account of the 202 jars. Their contents, use, decoration, manufacture, nomenclature, all fully described and accompanied by excellent photographs.
Hard cover £20 Soft cover £12

**De Historia Urologiae Europaeae (volume 24)**
Edited by P van Kerrebroeck & D Schulthesis
European Association of Urology (2017)
This book is the product of 6th Congress on the History of Urology (2016). It includes a wealth of well-written articles which provide a truly international perspective of development of urology, including China and Russia. The book is well illustrated and referenced. Jonathan Goddard, a HMES member, has co-authored two of the papers including an account of the contribution to urology of Spencer Wells (1818-96) .
Paper back (no price)

**Urology under the Swastika**
Edited by D Schulthesis & FH Moll (EAU)
Davidfonds, info@davidsfonds.be (2017)
This impressive book is the work of over 40 authors who have traced the effects of National Socialism on Jewish doctors specializing in urology, not just those under the Nazis, but also other Fascist regimes across Europe and Russia. The biographies of hundreds of Jewish surgeons and specialists have been compiled country by country, documenting their careers and systematic suppression. This book is a *tour de force,* hundreds of references and illustrations — a salutatory record and lesson for future historians.
Hard cover (£75)

**WHAT IS IT? (August 2016)**

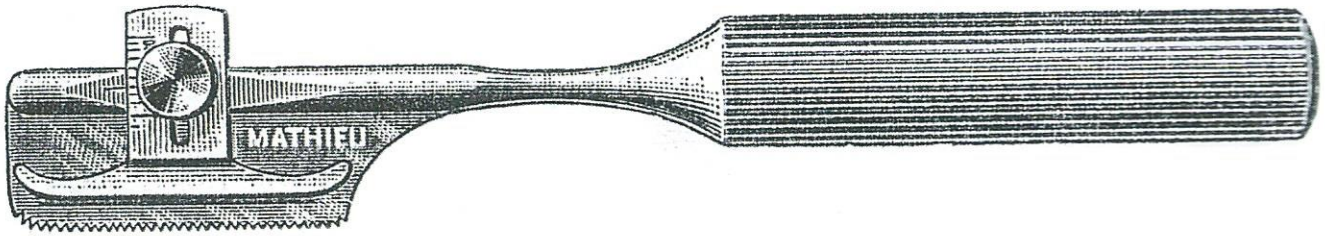



***Answer***

This is J.F. Dieffenbach's needle-holder of the 1830's and represents an instrument well ahead of its time with jaws controlled by a 'catch' operated unimanually. However it may have been utilised only in Germany for I found no comments on its availability in Britain. Dieffenbach was an important surgeon and wrote 'Operative Surgery' in two volumes.

**WHAT IS IT? (September 2017)** What is this (French) instrument?


***The 'What is it?' series in the Bulletin are all compiled by John Kirkup. Any correspondence please to john.kirkup@doctors.org.uk***