perforating gastric ulcer, 2 died of complicating chest conditions (these four cases should not have been attempted), 4 cases died of pyaemia—the result of hesitation and delay in doing the first part of the operation.

Most of these cases were undertaken during the great rush when all the staff were working under great pressure, and the results must be judged accordingly.

Viewing the matter in the light of the experience gained and the conclusions drawn in this paper, I do not see why the mortality after this operation in selected cases should surpass that of amputation as a routine treatment, and some of the results obtained seemed so excellent that the procedure deserves further trial.

The average duration in hospital before complete drainage was ten days. The average period before excision was sixty days. Six weeks after that most of the cases were ready to go to England. The average stay in hospital was thus about four months.

I desire to express my thanks to Lieut.-Colonel E. C. Hayes, R.A.M.C., for permission to publish these notes, and for his encouragement; to Captain Lazarus-Barlow, R.A.M.C., for his valued co-operation in the examination of the fluids taken from the joints; and above all to the nursing staff, the theatre sisters, and the colleagues associated with me in the treatment and care of these cases.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

THE DETECTION OF DEAFNESS.

IN the JOURNAL of August 25th, p. 252, I see a suggestion by Dr. Eyre as to the detection of deafness, which I must frankly say I do not understand. Is it intended to convey that because a man hears words whispered six or eight inches from his better ear that he is therefore not "hard of hearing"? If this be not implied, what is the point of the memorandum?

The question as to the detection of deafness is by no means simple, even for the expert. Roughly, the class of cases in which malingering may be suspected falls under three categories:

1. Simulation of one-sided deafness.
2. Exaggeration of deafness which is actually present.
3. Simulation of complete deafness.

As the various methods employed for the detection of simulation are discussed in textbooks, I shall merely refer to those which seem to me most useful. Where the patient states that one ear is quite deaf, this may be verified or the reverse by connecting his ears with the mouths of two observers by means of speaking tubes. Each whispers words into his mouthpiece, and the malingerer will probably soon give himself away by repeating those spoken into the deaf ear. The same result may be attained by the employment of a binaural stethoscope with one limb occluded.

Exaggeration of deafness which is actually present is much more difficult to discover, and even the expert will find such cases difficult. Repeated tests, used at intervals, together with weighing the objective appearances and data derived from the history and comparing them with previous experience, afford the best prospect of success.

These, however, will not assist us very much where complete bilateral deafness is simulated. It has been suggested to try the effect of a loud voice to waken the patient from sleep, while it has also been proposed to employ anaesthetics, but the latter requires the assent of the patient. In such instances I see no method available excepting that of espionage, and if possible inquiry directed to those who have known the patient.

It is, of course, very important that injustice should be excluded, and for this reason it is desirable to impress upon those who examine that the tests employed should not be liable to fallacy.

In examining soldiers it will often be found that an inaccurate statement is made from carelessness, but without any intention to deceive. Thus, if the tuning-fork be applied to the middle line of the head, we shall often be told that the fork is perceived only in the better hearing ear, even if the deafness be not due to involvement of the nerve apparatus. Again, we shall be told that if the good ear be closed the fork is no longer heard. I have seen this so frequently among men who obviously had no desire to impose upon me that I have ceased to attach any value to the phenomenon.

P. MCBRIDE, M.D.,
Consulting Surgeon, Ear and Throat Department, Royal Infirmary, Edinburgh.

RUPTURE OF UTERUS: RECOVERY.

ALTHOUGH annular rupture of the uterus in the neighbourhood of the cervico-vaginal attachment is sufficiently common to be described in the larger textbooks, the following case presents unusual features which make it worth placing on record:

I was called to the patient late in the evening of April 3rd by a midwife on account of prolonged labour. The os was fully dilated, the membranes unruptured, and the head and umbilical cord presenting.

On rupturing the membranes the cord immediately prolapsed outside the vulva; no pulsation was to be felt. The head was above the brim of the pelvis, which was flattened in its antero-posterior diameter. I performed internal version without difficulty, but was unable to extract the after-coming head; in endeavouring to extract, I caused a fracture of the cervical vertebrae and pulled away the body of the child, leaving the head behind and tearing through the cord in the process. The head being well pressed down by the midwife, I then perforated and extracted with difficulty with a cranioclast.

On examining again after delivery of the head I found an annular rupture of the uterus extending completely round the cervico-vaginal attachment except for a thin pedicle by which the uterus was still attached posteriorly; the placenta had escaped into the abdominal cavity. I seized the uterus with a pair of craniotomy forceps, placing one blade in the cavity and the other outside, and dragged it down through the vagina; the remaining attachment I ligatured as high up as possible, and so completed the separation of the uterus.

The pulse by this time was very bad, but there were no signs of haemorrhage, and, the nearest hospital being fourteen miles away, I decided to adopt an expectant attitude, and in the meanwhile applied restoratives.

On the following day the pulse was stronger, rate 132, and I considered her fit to stand laparotomy. Mr. Washbourn, of Gloucester, saw her with me in the afternoon, and opened the abdomen in the middle line below the umbilicus. A moderate amount of blood clot was removed from the pelvis, but there was no recent haemorrhage; the placenta was found in the neighbourhood of the splenic flexure; the abdomen was quickly closed with the exception of a gauze drain into the pelvis.

A week later, the discharge through the wound having become purulent, I sent her into Gloucester Infirmary, where she was treated by douches, etc., and discharged five weeks later with the wound closed.

The patient had been married four years, and had had two previous pregnancies; the first terminated in the expulsion of a stillborn fetus (described by the midwife as "macerated") at the eighth month; the second in a miscarriage at the seventh week. The uterus was normal to the naked eye, and it was impossible to determine where the rupture had commenced.

I am indebted to the courtesy of Mr. Washbourn in publishing the later part of this case.

Cinderford. GEORGE F. RIGDEN, M.B., B.S.Lond.

A HUGE MESENTERIC CYST IN A YOUNG MARRIED WOMAN.

MESENTERIC cysts are extremely rare things. The subject of the instance here reported is a young married woman, aged 25. She had never been pregnant, and menstruation had been recurring regularly, although during the last eighteen months the periodic loss had been increased somewhat. She had never experienced pain in connexion with menstruation. Five weeks before coming under my care she began to experience some difficulty in fastening her corsets, and this increased so rapidly that during the last three weeks she had to dispense with them altogether; this increase in size was her sole trouble. On cross-questioning, she stated that her "stomach" had always, as long as she could remember, been rather big.

I found the abdomen very prominent; it was occupied by a swelling which extended from the pelvis to 5 in. above the umbilicus. The percussion note over the tumour was everywhere dull. The right flank was resonant; the left was dull; fluctuation was readily elicited. By vaginal examination I found the cervix located anteriorly towards the right side. I could not differentiate

the body of the uterus. In the left pelvis was felt a portion of the abdominal swelling. The base of the swelling in the pelvis was traversed by a peculiar network of fine fibrous bands, and this physical sign made me think the tumour might be in the substance of the broad ligament.

Operation.—I experienced the greatest difficulty in gaining an entrance into the peritoneal cavity, as the tumour was in the lower third of the abdomen incorporated with the anterior abdominal wall. On attempting to find the peritoneal cavity the tumour, unfortunately, ruptured, and from it flowed about a gallon and a half of haemo-biliary-looking fluid. When I eventually reached the greatly curtailed peritoneal sac I found the small intestine everywhere incorporated with the sac of the original tumour. The sac was stitched to the abdominal wall and drained. None of the pelvic organs could be felt, a fact which made me think the swelling must have started in the lowermost part of the mesentery and have developed extensively both up into the abdomen and down into the pelvis.

London, W. JAMES OLIVER, M.D., F.R.S.Edin.

RESUSCITATION OF THE NEW-BORN INFANT BY HEART MASSAGE AND OXYGEN.

ON several occasions I have found it possible to resuscitate a baby by heart massage in the manner suggested by Dr. Fisher in the BRITISH MEDICAL JOURNAL of August 18th, p. 215.

Recently, after a prolonged labour due to disproportion between the head and the pelvis in a primipara, aged 39, the child was delivered by forceps at 9 p.m. The cord had been pressed upon high up, and was round the child's neck. The child was white and limp and the heart had ceased to beat. Massage of the heart for some minutes started it beating, and artificial respiration was begun. At 9.30 p.m., though the heart was beating feebly and artificial respiration was continued, the child did not breathe naturally. Oxygen was then given in a very gentle stream whilst continuing respiration artificially for more than an hour, when the child began to breathe feebly by itself; he was still cold. Wrapped up in wool and warmed blankets, surrounded by hot-water bottles, he was placed near a fire, and oxygen slowly and continuously administered. By 4 a.m. the child became warm, and at 9.30 a.m., twelve hours after birth, oxygen was discontinued, and he was bathed and dressed. On visiting him later in the day I found him very yellow and his lips much swollen. He is now doing well.

Stevenage, Herts. ARTHUR DE VINE.

A CASE OF PNEUMOCOCCAL PERITONITIS WITH ACUTE GASTRIC DILATATION.

THE rarity of the condition may make it worth while to record the following case:

Pte. W., aged 20, Middlesex Regiment, was admitted on February 12th with a temperature of 104° F., under Dr. Syrett. Pneumonia was diagnosed, first on the left and later on the right side also. The attack was severe, the temperature reaching 104° on February 13th, 15th, and 20th; then the temperature fell gradually to 99° on February 22nd. The pulse also fell from 132 to 98. Hope was raised that the patient was recovering, but vomiting of dark bilious fluid began, and at 6.30 p.m. the same day, in consultation, we found peritonitis and tympanites reaching up to the fifth rib. Obstruction was diagnosed. It was considered that the patient was too weak for operation. The vomiting became more copious and urgent. At 11.45 a.m. on February 23rd the patient died.

A *post-mortem* examination was made four hours later, and so much did the stomach fill the abdomen that at first no other organ could be seen save the liver. The fundus was pushed up to the fifth rib, and the greater curvature reached to within an inch of the pubis. The transverse colon was in the true pelvis, where the ileum lay quite empty and collapsed. The colon was contracted also. The duodenum was stretched to a diameter of 2½ to 3 inches. The duodeno-jejunal flexure was normal in size, and must have been pressed on by the mesentery, for gas seemed to be entering merely from manipulation during examination.

There were no adhesions or acute obstructions. There were, however, several flakes of lymph, yellowish-white in colour, thready and toughish, as is characteristic of pneumococcal empyema. These came down on to the smaller curvature and fundus from the diaphragm. It would therefore appear that the stomach was paralysed by toxaemia acting on its nervous plexuses, and that distension occurred, which further caused pressure on the terminal part of the duodenum.

Those practitioners who are robbed, as it were, of their pneumonia cases just as they are on the turn for recovery will naturally feel interested in the question of the frequency of such a condition. Messrs. Rowlands and Turner (*Jacobson's Operations of Surgery*) quote 91 cases of this rare disease, all children under fifteen. In 30 cases the peritonitis was secondary to a lesion elsewhere, especially in the lungs and pleura. Primary infections had occurred in the throat or ear in several cases. Of gastric dilatation of the stomach Osler, in *Principles and Practice of Medicine*, quotes 102 cases. Of these, 42 followed operations with general anaesthesia. The next largest group occurs in the course of severe diseases or during convalescence. It is noteworthy also that we had an outbreak of pneumonia, sore throats, and cerebro-spinal meningitis going on during February, when this case occurred, and our past experience leads us to expect appendicitis with this group in the spring season.

This case is published by permission of Lieut.-Colonel J. Kearney, R.A.M.C., S.M.O. Harwich Garrison.

E. F. SYRETT, M.D.
W. L. CHRISTIE, Captain R.A.M.C., M.D., F.R.C.S.Eng.

GLUE FOR APPLYING EXTENSION IN FRACTURES.

IN a useful note on the application of glue extension (Sinclair's method) in the JOURNAL of July 14th (p. 60) I notice that there is no reference to the use of spirit glue for similar purposes.

In my experience Heusner's glue is as efficient as that described; and, further, it has the advantage for those who do not need to use the application frequently that it is always ready for use as stored; moreover, it is an excellent and cheap substitute for mastisol, and is a much better adhesive than any form of collodion when used for applying gauze to the skin.

I referred to the preparation in an article published in the BRITISH MEDICAL JOURNAL last year ("A simple system of skeleton splinting"), and also in the *British Journal of Surgery* for July (p. 70). The composition I have used is as follows:

Methylated spirit	50 c.cm.
Benzine	25 c.cm.
Resin (commercial)	50 grams.
Venice turpentine	5 grams.

I consider the preparation to be of sufficient value to the practical surgeon to deserve attention.

C. MAX PAGE,
— Field Ambulance, B.E.F. Captain R.A.M.C.(S.R.)

Reviews.

THE THYROID GLAND.

As a record of eminently original investigations extending over fourteen years, and advancing surely step by step to the full understanding and successful treatment of a group of conditions that are as distressful as they are widely spread, Major MCCARRISON'S book upon *The Thyroid Gland in Health and Disease*[1] must rank as the foremost medical publication of the year. It is an outstanding example of that best and most characteristic form of British pathology, the pathology of the active practitioner whose clinical studies and clinical opportunities impel him to investigate, and, with Edward Jenner, to apply the results of his inquiries to the treatment and control of the condition investigated. It promises well for the continued advance of British medicine that in our generation McCarrison does not by any means stand alone, although it may safely be said that there is no one who has pursued his inquiries under greater difficulties or in greater isolation, and therefore with all the greater credit.

The story is fascinating, and as, with characteristic modesty, in the book before us it is implied rather than definitely stated, and then in the appendix rather than in

[1] *The Thyroid Gland in Health and Disease.* By Robert McCarrison, M.D.(R.U.I.), D.Sc.Belf., F.R.C.P.Lond., Lauréat de l'Académie de Médecine, Paris; Major Indian Medical Service. London: Baillière, Tindall, and Cox. 1917. (Crown 8vo, pp. 286, with numerous illustrations. 12s. 6d.)

The Services.

EXCHANGE.

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Universities and Colleges.

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MIDWIFERY.—W. F. Barrett, D. A. Dyer, B. A. M. Henderson, I. Liberman, J. Stephen.

* Section I. † Section II.

The diploma of the society was granted to W. Fletcher Barrett, C. A. W. Chapman, D. C. Clark, E. W. Diggett, A. Selby Green, D. E. Hearn, E. J. G. Sargent, C. Segal, and G. R. Sharp.

Medical News.

AT Hinckley, on August 23rd, Dr. A. W. Jenkins was presented with an address and a pair of bronzes in recognition of his ten years' valuable work as honorary surgeon to the Hinckley and District Cripples' Guild.

COLONEL C. GORDON WATSON, C.M.G., F.R.C.S., A.M.S., assistant surgeon to St. Bartholomew's Hospital, London, and Dr. William E. Audland of Wellingborough, have been appointed Knights of Grace of the Order of St. John of Jerusalem.

THE Rockefeller Institute for Medical Research has, it is stated, undertaken to supply the allied armies with an antitoxin serum believed to be effective against gas gangrene. Cultures of the bacillus were obtained in Europe last year by Dr. Carroll G. Bull and Miss Ida W. Pritchard, and these investigators have experimented on animals with results said to be satisfactory.

MR. E. TEMPLE THURSTON gave in the *Sunday Pictorial* for August 26th some account of the suggestion of the French Government to raise a lasting monument to those who have fallen in the war, by forming a road from the Flemish coast to Alsace, planted on either side with forest trees. The scheme would include the preservation in their present state of the devastated villages and the careful tending of graves.

AN interesting addition has recently been made to the Erskine Hospital for Limbless Men. Lieutenant Napier, the military governor, has presented to the institution Erskine Ferry Inn, an old building beautifully situated on the banks of the Clyde just outside the hospital. Therein are provided convenient refreshment and rest rooms for visitors calling on patients. The opening ceremony was performed by Lady Dunlop, wife of the Lord Provost of Glasgow, and Sir William Macewen, who was in the chair, said that although the hospital was large every part of it was needed, and already about 250 beds had been added to it at the urgent request of the War Office.

AN article in a recent issue of *Le Journal*, Paris, states that the number of permanent nurses employed in the French military hospitals at the outbreak of war was eighty; the number of nurses now temporarily employed is 3,000. In addition there are 62,000 nurses belonging to the various French Red Cross Associations, of whom some 6,000 are in the army zones. The writer of the article makes an eloquent reference to the manner in which the nurses of friendly nationalities, to the number of about 10,000, have come forward to help the French. He refers first of all to the Scottish Women's Hospitals, where a staff of eighty nurses have been maintained for three years, and mentions that Miss Ivens, the *médecin-chef* of the hospital at Royaumont, has recently been decorated with the Legion of Honour. Nurses for other units have been provided by the Russian Red Cross, by a Swiss nursing school at Lausanne, by Italian organizations on the Riviera, and by Spanish organizations at Biarritz.

THE Board of Agriculture has reissued, after revision, a leaflet on jam making in war time. The chief novelty to housekeepers in it is the recommendation to replace one-third of the sugar ordinarily used by glucose (corn syrup or glucose chips, sold retail at 7d. or 8d. per lb.). Directions for making jam with glucose alone are also given. The liquid glucose gives the jam a superior flavour to that prepared with glucose chips, but the objection to both is that they are not so sweet as sugar. It is suggested that this may be remedied by adding a small quantity of saccharine. Copies of the leaflet can be obtained free on application to the Secretary of the Board, 3, St. James's Square, London, S.W.1.

Letters, Notes, and Answers.

CORRESPONDENTS who wish notice to be taken of their communications should authenticate them with their names—of course not necessarily for publication.

AUTHORS desiring reprints of their articles published in the BRITISH MEDICAL JOURNAL are requested to communicate with the Office, 429, Strand, W.C.2, on receipt of proof.

THE telegraphic addresses of the BRITISH MEDICAL ASSOCIATION and JOURNAL are (1) EDITOR of the BRITISH MEDICAL JOURNAL, *Aitiology, Westrand, London;* telephone, 2631, Gerrard. (2) FINANCIAL SECRETARY AND BUSINESS MANAGER (Advertisements, etc.), *Articulate, Westrand, London;* telephone, 2630, Gerrard. (3) MEDICAL SECRETARY, *Medisecra, Westrand, London;* telephone, 2634, Gerrard. The address of the Irish Office of the British Medical Association is 16, South Frederick Street, Dublin.

The address of the Central Medical War Committee for England and Wales is 429, Strand, London, W.C.2; that of the Reference Committee of the Royal Colleges in London is the Examination Hall, 8, Queen Square, Bloomsbury, W.C.1; and that of the Scottish Medical Service Emergency Committee is Royal College of Physicians, Edinburgh.

☞ *Queries, answers, and communications relating to subjects to which special departments of the* BRITISH MEDICAL JOURNAL *are devoted will be found under their respective headings.*

ANSWERS.

DR. FRED. H. HAYNES (Leamington) writes: In answer to "W. M. B." (BRITISH MEDICAL JOURNAL, August 25th, p. 276), I would recommend him to try mercury either by inunction or hydr. creta gr. ½ to gr. j three times a day. It is not generally recognized that epilepsy is usually due to syphilis (inherited), and that mercury in children is almost a certain cure, and often, too, if epilepsy begins at puberty.

LETTERS, NOTES, ETC.

A TOO-PUNGENT MOUTH-WASH.

MR. EDMUND BALDING, L.D.S. (London, S.W.), writes: From clinical observation extending over twenty-five years I can emphatically confirm Mr. J. T. Hall's assertion that highly pungent washes, powders, and pastes are a source of marginal gingivitis. I will even go further, and say that they are a cause of a peculiarly aggravating and distressingly sensitive form of interstitial caries. I make it a rule to question patients suffering from such as to the prophylactic measures employed, and more frequently than not I receive the reply that a carbolic dentifrice is regularly used. Indeed, such a question is often anticipated by patients volunteering the information in an injured tone that they "cannot understand why there should be such an amount of caries when they use carbolic tooth-powder twice a day." Some years ago a chemist showed me a sample of carbolic tooth-powder of his own compounding for which he had a large demand, which he attributed to the large percentage of carbolic acid in it.

KILTS AND DECENCY.

DR. ROBERT CRAIK (Ealing) writes: On boarding a tram at Hammersmith to go out to Fulham last Saturday afternoon it happened that I followed upstairs a soldier of the London Scottish. Looking up as I came to the turn on the stair, I was astonished to have a full view of the soldier's buttocks with the testicles dangling down. Is this considered full dress for the regiment?