Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

A CASE OF CONGENITAL TRANSPOSITION OF THE HEART.

ROBERT Y., aged 17, was admitted to this ship suffering from phthisis. I found that there was no cardiac impulse at all on the left side, but the apex beat was felt in the fifth interspace under the right nipple; the impulse was of a diffuse nature; the sounds were very indistinctly heard to the left of the sternum. At the base the sounds were faint, whilst at the apex they were well heard; no murmur was detected in any area. Percussion showed the area of cardiac dullness to extend from the fifth right interspace to the sternum, but no dullness was made out to the left of the sternum. The upper limit of the heart was difficult to define on account of the pulmonary dullness in that region. The liver and spleen were in their normal positions.

From the above it seemed that the heart was the only organ transposed, and this was confirmed by *x*-ray examination. The plate was clear on the left side of the chest, but on the right side there was a shadow which merged with the liver shadow below, and which had a curve to the left resembling that thrown by the normal right side of the heart. The patient did not seem to have any inconvenience apart from some breathlessness on exertion, but this might partly be due to his lung condition.

It was thought at first that the heart had been drawn over to the right side by contraction of the lung due to the phthisis present, but further examination was against this. The chest wall was hardly retracted at all, while with such a complete drawing over of the heart one would have expected much less lung tissue to be present than was made out from the physical signs. One would also have anticipated the presence of some murmur due to twisting of the vessels, but no such murmur was detected.

The condition seemed to be congenital, and this opinion was strengthened by the patient's statement that a doctor had remarked about four or five years previously that his heart was in an unusual position. I think the case is worth recording in view of the rarity of transposition of the heart alone without any of the other viscera.

ROBERT AITKEN, M.D.,
H.M. Hospital Ship *Plassy*. Temporary Surgeon R N.

STERILIZATION AND PREPARATION OF CATGUT.

I CAN confidently recommend the following method as one producing a clean ligature or suture material, and an ideal result, as far as tensility and necessary durability are concerned, not to mention the comparative diminution of chemical impregnation, which has been a frequent and fertile source of irritation in the depth of aseptic wounds:

1. Raw catgut, free from fat, as supplied by surgical purveyors, is wound up in loose rolls and placed in a Mayo Robson's or Jellett's bomb, which is almost filled with a mixture of equal parts of rectified spirit and ether. The bomb is then placed in a kettle of hot water and boiled for half an hour for fine catgut, and for one hour for the larger sizes.
2. The catgut is then removed from the bomb by a sterilized forceps and placed in a glass bottle containing a solution of 90 per cent. absolute alcohol and 10 per cent. formalin (40 per cent. solution). The catgut is kept in this mixture for forty-eight hours.
3. It is next similarly taken out of the alcohol-formol mixture and immersed and washed for half an hour in a basin of pure ether.
4. Finally, it is placed in a bottle filled with equal parts of ether and alcohol, in which it is retained until required for use.

JOHN O'CONOR, M.A., M.D., T.C.D.,
Senior Medical Officer, British Hospital, Buenos Aires.

TREATMENT OF SCABIES.

THE following is the method of treating scabies I have carried out for a good many years. It is quick, simple, cheap, and only one working day is lost.

The morning the patient is seen he is rubbed all over with sulphur ointment; ʒ jss is plenty, made with vaseline ʒ x, sulphur ʒ ij. No bath before is necessary. He then puts on the same infected clothes, not to soil clean ones, wears the underclothing for twenty-four hours, and then has a hot bath with plenty of ordinary soap; when dry, he puts on all clean clothes and returns to his ordinary duties. Before getting into the bath he collects all his dirty clothes and things he has been using the last few days, including bedding, for disinfection. If no disinfector is available they are put into an izal solution for twenty-four hours; he then washes and dries them.

Under this treatment I had not to send a patient to a hospital, never saw a case of sulphur dermatitis, nor the disease spread to messmates.

G. H. FOOTT, M.D.,
Southampton. Fleet Surgeon (retired).

TONSILLECTOMY.

IN an article in the BRITISH MEDICAL JOURNAL, August 11th, p. 184, the view is submitted as hardly assailable that surgeons who claim to be able to completely enucleate every tonsil with the guillotine are in error, and go to an unjustifiable extreme. The evidence in favour of this view is that other surgeons combine partial dissection with the use of a guillotine. I submit that the evidence in no way warrants the conclusion.

Without entering upon the question of the superiority of one method over another in results, it will be admitted that in hospital out-patient practice the saving of time, the choice of anaesthetic, and the safety of the patient in returning straight home, must lead to the use of the guillotine method. I contend that some surgeons find that after the experience of some thousands of cases they are able, with the guillotine, to deal with every case with which they are confronted, both in child and adult, and require to use no other method.

In my opinion enucleation of the tonsil by the guillotine, in the more difficult cases, requires more practice, and what might be called "knack," than perhaps any other surgical operation. I admit that the length of practice necessary for this complete proficiency with the guillotine would not be worth undertaking for its own sake while there is the method of dissection to fall back upon. But the hospital tonsil day comes round and round, and when this degree of proficiency has been arrived at all other methods appear superfluous—longer, and less safe.

I would suggest that, with few exceptions, the two camps of guillotine or dissection advocates correspond with those continually engaged in hospital out-patient tonsillectomies, and those freed of this duty.

Bristol. H. BODKIN.

AN UNUSUAL CASE OF STRANGULATED HERNIA.

A MAN, aged 45, was admitted to Kingston Victoria Hospital on August 13th. He had noticed a small lump in his right groin for several months. Suddenly, under effort at lifting, it became large and hard, making him vomit and groan with pain. I found a tumour above Poupart's ligament extending up and out to the anterior superior spine, taut as a drum, and immobile. There was a dimple over the external ring where the intercolumnar fibres constricted it. No attempt at taxis was made. The gut at operation was found coal-black but shining, and was returned.

The hernia was congenital, with a lateral sac between the two obliques, interstitial, intraparietal. The gut in the side sac was twisted as well as strangulated. The loop in the scrotum was much less tense and cyanosed; the neck of the sac was very narrow, and creaked like cartilage when snicked. More than a couple of feet of gut were involved. The case was puzzling at first. The man has made a good recovery.

Kingston-on-Thames. J. E. S. BARNETT, F.R.C.S.

CONGENITAL ABSENCE OF ANTERIOR ABDOMINAL WALL.

THE following case may be of some interest to the readers of the JOURNAL.

On August 13th I was called to a confinement—Mrs. H., 10-para—being informed by the messenger that "there was something coming which was not the baby." On my

arrival I discovered fetal intestine presenting at the vulva. Abdominal palpation showed the child lying transversely with its head in the left iliac fossa. With the kind assistance of Dr. K. I. Shalaby, who administered the anaesthetic, internal version was performed and the child delivered. It proved to be a teratosomian, with complete absence of the anterior abdominal wall. The placenta was directly attached to the abdominal viscera.

This condition appears to be sufficiently rare to merit publication.

Lemington-on-Tyne. H. C. COXON, M.D.

Reviews.

WOUNDS OF THE LUNG IN WAR.

EARLY in the war it became clear from Sir John Rose Bradford and Dr. T. R. Elliott's observations that the lessons of the South African war enunciated by Sir G. Makins as to the prognosis and treatment of haemothorax might require considerable revision. The chest wounds in the Boer war were mainly due to bullet wounds and infection rarely followed unless the chest was tapped or opened, and therefore, generally speaking, the policy of non-intervention held the field. It still is true that closed bullet wounds of the chest seldom become infected, but in the present war large and open shell wounds of the chest play such an important part that wounds of the lung formerly regarded as benign now show a high mortality. Thus, in a recent monograph based on the experience of the French Medical Service, PIERRE DUVAL[1] points out that the total mortality of 3,453 cases of wounds of the lung has been 688, or 20 per cent.; the mortality diminishes as the distance from the fighting line increases, being estimated at 25 to 30 per cent. in the casualty clearing stations, at 18 to 20 per cent. in the motor ambulances, and at 10 to 12 per cent. in the base hospitals round Étaples. No less than 60 per cent. of the deaths occur within the first two days, and these are almost entirely due to haemorrhage and mechanical interference with respiration. The frequency of early death from haemorrhage has urgently raised the question of surgical interference, and while there seems to have been general agreement at the discussion at the Société de Chirurgie (1916–17) that such a course was logically correct, the authorities fell into two camps as to the desirability of its practical application: Hartmann led the supporters of the conservative standpoint, while Duval urges, in favour of opening the chest in order to stop the bleeding, a table of 34 cases of thoracotomy (17 from his own practice), with 67.7 per cent. of recoveries. The surgical technique is obviously an essential factor in deciding the question of operative treatment in wounds of the chest; in pre-war times the fear of pneumothorax dominated the position, and led to the employment of elaborate apparatus of German origin designed to maintain a low atmospheric pressure around the operation field, and to raise the intrapulmonary pressure. The object of these measures—namely, absence of pulmonary collapse—when attained, has the grave disadvantage that it interferes most materially with necessary examination, manipulation and treatment of the lung. Duval's experience has changed this point of view, and would revolutionize the treatment of lung wounds; the production of a slow and progressive pneumothorax is not specially dangerous, allows a complete examination of the lung, which can be brought out of the operation wound, and, unlike laparotomy, does not cause shock or a fall of arterial blood pressure. Further statistics of the results of the early treatment of haemorrhage due to wounds of the lungs by thoracotomy as advocated by Duval will therefore be awaited with great interest.

The sequels of wounds of the lungs, though a familiar subject, has been attractively dealt with by EMILE MALESPINE,[2] who analyses 294 cases seen at a base hospital three months after the original injury, an interval which ensures that the results are uniformly remote. Empyema was, of course, the commonest and most important sequel, others being varying degrees of pleuritic adhesions, pulmonary fibrosis and emphysema. Secondary haemoptysis occurred spontaneously in cases with an intrapulmonary projectile, as a result of its extraction, and at the onset of an interlobar pleurisy. Although the clinical manifestations may suggest the presence of traumatic tuberculosis the available evidence is against this conclusion. Functional disturbances—pain, dyspnoea, and cough, in the order of their frequency—are common, most persistent after the closure of the wound, and extremely difficult to cure.

[1] *Les plaies de guerre du poumon.* Notes sur leur traitement chirurgicale dans la zone des armées. By Pierre Duval, Médecin-chef de l'Ambulance Chirurgicale automobile No. 21. Paris: Masson et Cie. 1917. (Med. 8vo, pp. vi + 139; 14 figures, 5 plates. Fr. 8.)

[2] *Les séquelles des plaies de guerre du poumon.* By E. Malespine. Thèse Lyon, 1917, p. 59.

SYPHILIS AND THE ARMY.

WE have already had occasion to notice a good many of the books issued in the French *Collection Horizon*, and in nearly all cases have been able to speak of them in high terms of praise. They are small books, and may be studied with special advantage by members of the Army Medical Service. The volume we are now noticing, on syphilis in the army,[3] by Dr. THIBIERGE, is not inferior to any of its predecessors. With Matthew Arnold, we cannot but concede to our allies with admiration the gift of "sweetness and light" in what they write, even if, as in the present case, it be but a volume on war medicine. Dr. Thibierge writes with a simple clarity and a reasonableness that carry conviction.

If in form the French army practice with regard to the treatment and the regulations regarding syphilis differs from ours, on analysis it is seen that the methods of the two armies are to all intents and purposes the same. We in England would perhaps lay more stress than does Dr. Thibierge upon the value of the Wassermann test, yet while in discussing the frequency of syphilis in the general population before the war an English writer would almost certainly have called attention to the data afforded by the Wassermann test as to the frequency of the disease in the great cities of the empire, it has to be admitted that we cannot produce adequate figures to demonstrate that since the war the incidence of the disease has increased. With Dr. Thibierge we have to be content to state our belief that this is probably the case, basing that belief on the experience of the individual practitioner.

The author deals with his subject under the following heads: Frequency of syphilis in the army; origin of syphilitic contagion in the army; the national danger of syphilis; social consequences of the disease; symptoms and diagnosis (50 pp.); treatment, special conditions governing treatment in the army; mercurial treatment, arsenical treatment, combined arsenical and mercurial treatment, plan of treatment at different periods of this disease; technique of intravenous injection (in all 70 pp.); hygiene; prophylaxis, including instruction, supervision of cases after treatment; instruction of troops regarding venereal disease, personal precautions, establishment of local centres for the treatment of venereal disease affecting the civil population, and supervision of prostitutes.

NOTES ON BOOKS.

THE sixteenth edition of *Minor Surgery and Bandaging*,[4] originally written fifty-six years ago by Christopher Heath, and afterwards kept up to date by Mr. Bilton Pollard, has now been prepared by Mr. MORRISTON DAVIES, whose name was associated with the last edition. The whole work has been revised, but, except for the final chapter on gunshot wounds, the general plan is unchanged. Without materially altering the scope and character of such a compendium it would not be feasible to deal in any general way with the great mass of knowledge which has been acquired since the war on the subject of military surgery. The chapter on wounds and their infections may, however, prove useful as a slight introduction to the subject for beginners. The character of the work as a whole is too well known to need description here. House-surgeons, dressers, and junior

[3] *Le Syphilis et l'Armée.* Par G. Thibierge, Médecin de l'Hôpital St. Louis. Collection Horizon. Précis de Médecine et de Chirurgie de Guerre. Paris: Masson et Cie. 1917. (8vo, pp. 196. Fr. 4.)

[4] *Minor Surgery and Bandaging (Heath, Pollard) for the Use of House-Surgeons, Dressers, and Junior Practitioners.* By H. Morriston Davies, M.D., M.C.Cantab., F.R.C.S. Sixteenth edition. London: J. and A. Churchill. 1917. (Cr. 8vo, pp. 485; 252 figures. 8s. 6d. net.)

unfair restriction on the legitimate freedom of action of medical practitioners so placed, and I cannot think that such can be the intention of the authorities.—I am, etc.,

Newcastle-upon-Tyne, Sept. 24th. WILLIAM MARTIN.

Obituary.

THE death of Lieut.-Colonel FREDERICK ROBERT SWAINE, I.M.S., of Ranchi, removes, perhaps, the oldest European official resident in the Province of Bihar and Orissa. Colonel Swaine came to Ranchi in the Seventies, and, after spending the greater part of his service in that station, settled there when he retired twelve years ago. He had a wonderful knowledge of the town and its inhabitants, and had done valuable service as a municipal commissioner for a great many years.

WE regret to record the death of Dr. ARTHUR BADCOCK, who died suddenly on September 16th, after an illness of some months' duration. Dr. Badcock was the son of the late Rev. J. Badcock, D.C.L., Vicar of Stroud, Gloucestershire. After completing his studies at the Leeds School of Medicine he qualified in 1886, was appointed resident medical officer to the York Dispensary, and subsequently settled down in practice in succession to Dr. Hall at Clarence House. In 1902 he succeeded his partner, Dr. Weekes, as honorary medical officer to the York Dispensary, of which for some years he was senior honorary officer. He took a keen interest in the management of the York Dispensary and in all professional matters in York. From July, 1914–1917, he was president of the York Medical Society. He was held in high esteem by his medical colleagues and by a wide circle of friends and patients. He leaves a widow, the daughter of the Rev. J. L. Challis, late Rector of Hartwell-with-Stone.

The Services.

EXCHANGE.

CAPTAIN R.A.M.C., in F.A. three years in France, would like to exchange with M.O. in England.—Address, No. 3300, BRITISH MEDICAL JOURNAL Office, 429, Strand, W.C.2.

Medical News.

THE American Red Cross has appropriated £20,000 for medical research work in France.

THE opening meeting of the thirty-sixth session of the West London Medico-Chirurgical Society will be held at the West London Hospital on Friday, October 5th, at 8.30 p.m.

THE seventh Norman Kerr Lecture will be delivered before the Society for the Study of Inebriety by Major W. McAdam Eccles, R.A.M.C.(T.F.), on Tuesday, October 9th, at 5.30 p.m., in the Robert Barnes Hall, 1, Wimpole Street, Cavendish Square, London, W.1. The subject of the lecture will be War and Alcohol.

LIEUT.-COLONEL SIR ALFRED PEARCE GOULD will deliver the first Hunterian Lecture before the Hunterian Society on Wednesday, October 3rd, at 9 p.m., at the House of the Royal Society of Medicine, 1, Wimpole Street, W. The subject of the lecture will be Modern Antiseptics.

MESSRS. LONGMANS announce for early publication a volume by Mr. Henry Carter, member of the Liquor Control Board, entitled, *The Control of the Drink Trade: A Contribution to National Efficiency, 1915–1917*, giving a full account of the work of the Board in restricting the sale of drink, and providing industrial canteens, and also of the State purchase of enterprises at Gretna, Carlisle, and elsewhere.

THE Special Health Committee of the Calcutta Corporation recently considered whether the present campaign against rats and the system of payment of a reward of half an anna for each live rat should be continued. The campaign was started several years ago by the Plague Department, and has been continued with indifferent results. During the last year 138,386 rats were killed and 40,213 dead rats were found in the streets. The total cost of the campaign works out to Rs. 3,374 per annum. In Bombay during last year the total expenditure was Rs. 35,590, and the number of rats collected was 943,346. In Madras the total expenditure during the last year was Rs. 6,709, and the total number of rats killed was 138,611.

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.*

QUERIES.

J. D. asks for information or references in medical literature relating to the symptoms, and more particularly the *post-mortem* appearances, in any known cases of poisoning by "bitumastic"—an anticorrosive fluid and paint applied to the water tanks of ships, etc.

LETTERS, NOTES, ETC.

TREATMENT OF WHOOPING-COUGH.

DR. T. DUNCAN NEWBIGGING (Abington, Lanarkshire) writes that he has had satisfactory results during a recent epidemic of whooping-cough by the following treatment. A small wet brush is dipped into crystals of zinc sulphate so that they adhere; the brush is applied to the fauces, chiefly to the uvula, the patient being instructed to keep the powder in place as long as possible. In some instances one application has effected a cure, even in fully established cases; in others two were necessary.

ACTION OF ADRENALIN.

DR. I. HARRIS (Liverpool) writes: In an interesting paper on trench nephritis Lieut.-Colonel Michell Clarke, M.D., F.R.C.P., in the JOURNAL of August 25th, recommends adrenalin in the treatment of those cases "attended with low blood pressure." May I point out that adrenalin does not exercise any permanent influence on the blood pressure? Adrenalin administered intravenously raises the pressure for a few seconds only; adrenalin given by the mouth has a more lasting effect on pressure, but only because the process of absorption of this substance into the circulation is extended. Adrenalin is not only indicated in low blood pressure, but is equally valuable in cases of nephritis attended with high blood pressure. Adrenalin acts as a diuretic and diminishes albuminuria in cases of nephritis irrespective of blood pressure. A case with a high blood pressure, published in the last issue of the *Liverpool Medical Journal*, has done extremely well under adrenalin.

INFECTIVE JAUNDICE—A CORRECTION.

LIEUT.-COLONEL W. E. HUME asks that the following corrections may be made in the paper on infective jaundice by Dawson, Hume, and Bedson, published in the JOURNAL of September 15th, 1917: (1) Page 345, second column, line 36, for "April and May, 1917," read "April and May, 1916." (2) As the paper only treats of one type of infective jaundice, the title would be better described "Infective Jaundice (Spirochaetosis Icterohaemorrhagica)."