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Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

THE TECHNIQUE OF INJECTIONS FOR VARICOSE VEINS.

INJECTIONS for varicose veins should not be undertaken in a haphazard manner nor by one who is unfamiliar with other intravenous injections; he should, preferably, have watched the procedure in the hands of others before attempting it himself. Should that not be possible the following description of the essentials may be of help to him.

After a complete examination of the patient, including the heart, lungs, urine, and internal organs—especially the pelvic in women—the legs should be observed first in the upright and then in the recumbent position. Ask the patient to take a deep breath and look for the effects of respiration in the enlarged veins of the thigh—if they are present—and note its effect either by sight or touch with the finger applied over the vein.

Select the lowest dilated vein or swelling in it; this corresponds to the site of incompetent valves. With a pledget of cotton-wool dipped in tinct. iodi paint the skin over the proposed site for injection and well beyond it. Remove the iodine with spirit. Disinfect the hands with soap and water, and rinse with spirit.

Use an all-glass 5 c.cm. syringe with a nickel needle 0.45 mm. in diameter and having a very sharp, short, bevelled point. It must be boiled before use.

To insert the needle exactly into the lumen of the vein is of primary importance. Two methods can be used—namely, the patient either stands or is lying down. The former position will be useful for small veins, which are often associated with ulcers or eczema; they cause greater pain and give rise to more symptoms than do the larger ones, which are easily punctured with the patient lying down. If the patient is standing, the needle is alone inserted; as soon as blood begins to drip from it he lies down. Connect the already filled syringe to it and inject the fluid while the patient is taking a deep breath (*British Medical Journal*, April 7th, p. 594). If the vein is large insert the needle, already attached to the syringe, and watch for blood to flow into the barrel, then—and then only—inject. In very large veins I sometimes put the patient in the Trendelenburg position after inserting the needle and then inject. The injections are always given towards the trunk; often, however, it will be seen that the vein has been blocked below the site of puncture, and not, as one might expect, above it. Three or more injections can, if desired, be given at the same sitting, but it is well to test the reaction obtained at the first one by giving only one injection of from 2 to 5 c.cm. of the solution.

As the injection proceeds ask the patient repeatedly if he feels any stinging or burning; if he does stop the injection at once, for either the needle has become displaced or the fluid has ruptured a dilated vas vasorum, causing leakage into the surrounding perivascular tissue. Should a swelling appear over the vein during the injection, with or without pain, stop the injection at once. This pain, however, must not be mistaken for cramp, which is felt in many cases and is of good omen as regards end-results; it only lasts a few minutes and passes off—"the wasp sting," on the contrary, increases. As soon as the injection has been given wait for a full minute, then remove the needle quickly, and apply at once firm pressure over the site of puncture with a piece of cotton-wool to prevent any of the blood charged with the solution from escaping into the tissues. This detail is of great importance; it is one way of preventing pain and a possible slough.

After the injection the patient should lie quiet for ten to fifteen minutes while the site is dressed. The puncture is closed with a drop of newskin or collodium. Five or six inches of a 3 or 4 inch bandage is soaked in a solution of zinc oxide, glycerin, and mucilage of acacia āā 2 oz., and applied, folded three or four times, to the part injected; this is kept in place by a few turns of the bandage and a safety pin, and is not removed till the next visit, the object being to lessen any inflammatory reaction.

The number of injections required varies considerably: in some cases one or two, in others ten to twenty are necessary. The length of the vein occluded is also variable; I have seen one injection of 5 c.cm., given below the knee, obliterate the whole of the great saphenous vein as far as the femoral ring. In other cases the same amount only blocked 3 or 4 cm. of the vein; on an average 5 to 8 cm. are dealt with by each injection.

The injection itself is painless except for the prick of the needle. Cramp is fairly frequent on the whole, but gives no indication from its severity as to the amount of vein acted upon; it, however, proves that the injection has been effectual. Stinging or burning should never occur; if it does, withdraw the needle at once and inject 5 or more c.cm. of sterile water into the surrounding tissues in the hopes of diluting the caustic solution and preventing a blister, the forerunner of a slough which, if formed, takes some weeks to heal. Sloughing is the only serious complication likely to happen; most often it is due to some fault in technique, but at times it seems to be unavoidable even while taking the greatest care. Periphlebitis (aseptic), also endophlebitis may occur; although these are painful they are sure signs that the vein has been obliterated. The same condition can result without pain. If the reaction is acute prescribe rest for a day or so; the application of heat to the part gives relief, and the redness and swelling quickly disappear, especially if liberal applications of the zinc lotion are made several times daily. Some patients are liable to feel faint at the first injection, though not subsequently as a rule; this does not prevent the injections being given.

I have used this technique with most gratifying results for more than three years in a considerable number of cases, employing at first a solution of pure NaCl of from 15 to 20 per cent., but latterly of 15 per cent. My reason for using this substance to the exclusion of all others is that: (1) it is very effectual; (2) it can easily be prepared; (3) it can hardly be called a drug, and precludes any possible idiosyncrasy on the part of the patient; (4) if required, from 5 to 15 c.cm. can be given at one sitting without fear; and (5) the solution is self-sterilized. Small or large veins can be injected and cured by its use. I can see no advantage gained by using other substances, which can and have caused untoward symptoms of a more or less serious nature.

T. H. TREVES BARBER, M.D., B.Sc.

"HERNIA" INTO THE BROAD LIGAMENT.

ALTHOUGH there are many possibilities of strangulation of the bowel through intra-abdominal peritoneal sacs, the following record of a case to which I have found no parallel in the literature may be of general interest.

A multipara had been operated upon nine years previously for a strangulated left femoral hernia. The bowel then implicated was found to have two perforations which were infolded. A complete recovery was made and the patient regained good health. Recently she was admitted to the hospital again with abdominal pain, distension, absolute constipation, faecal vomiting, and other signs of acute obstruction, but no cause for the condition could be deduced. Owing to the rather prolonged period of onset (the symptoms had been coming on for four days) it was thought that adhesions might be responsible.

An exploratory abdominal section was performed through a left paramedian incision. The major part of the small intestine was found to be greatly distended. The obstruction proved to be situated in a lower loop of the ileum, a portion of which, approximating to a Richter's hernia, was found to be strangulated at the neck of a peritoneal invagination into the posterior aspect of the left broad ligament. The neck of the "sac" was incised, thus releasing the bowel which could not be withdrawn otherwise, and was then sewn up. An uneventful recovery was made by the patient.

I am indebted to Mr. Reid for permission to record this case.

W. EDMONDSON DORNAN, M.R.C.S., L.R.C.P.,
House-Surgeon, The Royal Victoria and West Hants Hospital, Boscombe.

THE DURATION OF STAPHYLOCOCCUS AUREUS SEPTICAEMIA.

THE reference in the *British Medical Journal* of August 25th (p. 348) to the Bundaberg disaster is such as to make the duration of *Staphylococcus aureus* septicaemia a matter of considerable clinical interest. The Commission appointed to investigate the disaster expressed the view that forty-eight hours was the usual minimum duration of fatal staphylococcal septicaemia, whereas certain of the children at Bundaberg who were inoculated with what was to all intents and purposes a strong culture of *Staphylococcus aureus* died in twenty-four hours. Children, of course, would tend to succumb more quickly than adults, as the dose per kilogram of body weight would, *ipso facto*, be relatively greater. But that *Staphylococcus aureus* can kill quickly even an adult the following instance will show.

G. D., a female patient of the East Sussex County Mental Hospital, suffering from recurrent mania, was noticed by one of us (W. D.) to have a boil on her neck on the evening of August 21st. On August 22nd, at 2.30 a.m., she complained of pain, was excited and noisy, and was given a draught of paraldehyde at 3.40 a.m. She slept until 6 a.m., and then again complained of pains all over. She was found to have a temperature of 100° F. There was some coughing, and the pain persisted; the latter was especially referred to as coming from under the left breast, and she expectorated a little from then onwards. She was removed to the infirmary at 8 o'clock that morning. Her temperature never rose higher than 102.4°. She became seriously ill and very livid in colour, and the medical officer on duty was called to her at 6 a.m. on August 23rd, when her temperature fell to 99°. She died two and a half hours later, the duration of illness being thirty hours.

Necropsy: Features of Note.

Lividity of face, lips, and ears; a recent crop of medium-sized boils on the back of the neck, one of which was sloughing.

Head.—Sero-sanguinous exudate below the scalp, having a circular but larger area with a centre corresponding to the sloughy boil. Intense pink vascular congestion of the meninges. Wasting of the cerebral convolutions. No abscesses.

Thorax.—The right pleura was adherent at the apex. Sparse, scattered petechiae were present over the visceral pleura. The left pleura showed similar petechiae. One superficial area of necrosis was seen, a quarter of an inch in diameter. The lungs were of a deep red colour and showed here and there darker coloured patches suggesting early infarction. The pericardium showed petechiae on the visceral aspect. The heart was of the "renal" type, the muscle being hypertrophied and fibrotic, and the aorta showed early atheroma.

The blood was fluid.

Abdomen.—The peritoneum showed intense pink engorgement. The liver was soft and fatty, and the spleen diffluent and slightly enlarged. The kidneys showed changes usually associated with chronic interstitial nephritis, the capsule stripping with difficulty, reduction of the cortex, and an enlarged pelvis, full of fat. Signs of fatty cortical degeneration were also noted.

Cultures taken, with due cauterizing precautions, from the spleen and lung showed a pure heavy growth of *Staphylococcus aureus*.

Comments.

The mental patient has notoriously poor resistance and often succumbs early to infection. The general metabolism is usually upset, and most patients suffer from mild chronic acidosis.[1] At the same time it is unusual for a staphylococcal septicaemia to be so quickly fatal, thirty hours being a remarkably brief illness for an adult. In the light of the Bundaberg fatalities the case has, however, a topical interest.

We are indebted to Dr. F. R. P. Taylor, medical superintendent of the East Sussex Mental Hospital, for permission to publish the case.

W. A. DUNCAN, M.B., Ch.B.Ed.,
Assistant Medical Officer.

GEOFFREY SHERA, M.D.Cantab.,
Pathologist, East Sussex County Mental Hospital.

TROPICAL LIVER ABSCESS ACQUIRED IN ENGLAND.

THE occurrence of a case of tropical liver abscess in a man who had not travelled outside Great Britain appears to be of sufficient interest to merit recording.

The patient, a man aged 49, was caretaker at the Burnley public abattoir. He became ill ten or eleven months before admission to hospital. The first signs of infection were diarrhoea (four to six motions a day) and the passage of much mucus. About two months later he noticed a quantity of blood and slime in his stools and complained of pain and tenesmus; the straining did not relieve the pain, but tended to make it worse. Restriction to milk diet for six weeks relieved the diarrhoea for a period of eight weeks, during which time he felt quite well. Then followed another attack of diarrhoea (five to six motions a day), but this time there was no pain, tenesmus, or blood in the stools, only a little mucus at the end of the motion. He had no pain, but there was slight tenderness over the liver, and probably slight enlargement of this organ, since a diagnosis of gall-stones was made. Later he was suddenly seized with severe pain over the liver, "as if someone had stuck a knife in him"; he also began to complain of pain in the right shoulder and upper arm. The pain over the liver came and went for about six weeks after its appearance, and frequently woke the patient at night; the diarrhoea also came on in attacks. Hypnotics were given to subdue the pain, and finally the patient was admitted to the Victoria Hospital, Burnley. During his illness he had lost weight.

On admission he was thin and emaciated; the skin was muddy, and he looked very like a man with advanced carcinoma. The skin had lost its elasticity. The abdomen was very thin, but a bulging was seen in the right hypochondrium extending into the epigastrium. There was no pain over the liver, but there was slight tenderness. The liver was greatly enlarged, and its edge extended half an inch below the level of the umbilicus. The enlargement was uniform and the edge was smooth on palpation. Nothing else of note was found in the abdomen. A rectal examination disclosed no tenderness, and no growth was felt. The examining finger returned covered with mucus.

He subsequently complained of such intense pain over the liver and in the epigastrium that he could not sleep without morphine. The diarrhoea persisted, and a large, red, oedematous, tender swelling developed over the right costal margin. On *x*-ray examination a large shadow was seen in the right hypochondrium extending over nearly all the liver area, which was mapped out by palpation. Screening showed that the diaphragm on the right side was pushed up and did not move with respiration. Numerous *Entamoebae histolyticae* were found in the stools. At an operation a large liver abscess was opened, and about two pints of chocolate-coloured pus was drained off. No amoebae or cysts were found in the pus, which was examined three times during the next six days. After the operation he was given saline solutions, farinaceous diet, pulv. ipecac. co., and emetine bismuth iodide grain 1 t.i.d. The diarrhoea grew worse, and injections of emetine hydrochloride were tried. Two days after the operation hiccup developed, which was temporarily relieved by oil of cloves, but in spite of all treatment the patient went rapidly downhill and died seventeen days after the operation.

This case was especially interesting in that the patient had never been abroad and did not know anyone who had suffered from or been in contact with amoebic dysentery. The source of infection was not traced. Another point was the difficulty of diagnosis, and this was only finally accomplished after a microscopic examination of the stools had been made. At different stages of the illness the condition appeared to be gall-stones, carcinoma, and subphrenic abscess in turn. It would seem well to make a routine examination of the stools in all cases of obstinate diarrhoea, which persists without obvious cause in spite of the usual treatment.

I am indebted to Mr. Callam, honorary surgeon to the Victoria Hospital, and also to Dr. Haworth, honorary physician, for their permission to publish this case.

Bradford. J. CAMPBELL GILROY, M.B.Ed.

LARGE OSSICLES IN BOTH KNEE-JOINTS.

THE following case of ossicles in apparently healthy knee-joints seems to be worthy of record.

A soldier, while performing his duties in his company kitchen, was suddenly seized with acute pain in the right knee-joint. He was a dalesman from Westmorland, and, though accustomed to travel over rugged hillsides and moorland, had never had any previous trouble with either knee-joint.

On examination, some hours after the attack of pain, a slight effusion was present in the right knee-joint, and a large bony body was felt in the outer and anterior portion of the suprapatellar pouch. This body could be moved across the synovial pouch from side to side. Examination of the left knee revealed a similar body in the same position.

As soon as the slight synovitis of the right knee had subsided the ossicle was removed by an incision on the outer side of the patella; the joint was then closed in layers in the usual manner. For convenience of nursing, the left ossicle was removed a few weeks later.

Both ossicles were lying quite free in the joints and had no connexions or adhesions whatsoever. They were oval, somewhat the shape of a Brazil nut in section, a little more than one and a half inches in their longest diameter, and eburnated on their posterior faces where they came into contact with the femora. The synovial membrane in contact with them was vascularized and velvety in appearance.

Convalescence was rapid and the patient walked perfectly as soon as allowed to do so.

The interest of this case lies in the size of the ossicles and the fact that the condition was bilateral. No current theory of the genesis of intra-articular bodies seems adequate to explain such a condition arising in a healthy man with perfectly healthy joints.

W. BLIGH, O.B.E., M.D., B.S.,
Temporary Major R.A.M.C.
Wool Military Hospital.

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Dr. EDWARD JOHN PARRY, who died on September 3rd in his seventy-eighth year, was one of the senior members of the medical profession in South Wales. He received his medical education in Edinburgh, obtaining the diplomas L.R.C.P. and L.R.C.S.Edin. in 1879, and graduating M.D.R.U.I. two years later. His professional life was spent almost entirely in Glamorganshire, and he became, soon after commencing practice, principal medical officer to the Garw Valley collieries, an appointment which he held until 1916. During the war Dr. Parry, who was a member of the British Medical Association, served as chairman of the county medical recruiting board. He took an active part in public affairs and was a member of the first county council elected in Glamorgan, serving also on several other public bodies and being one of the senior magistrates for the county. A keen supporter of the Liberal party in politics, he was for many years president of the Mid-Glamorgan Liberal Association; efforts to induce him to become a candidate for Parliament were, however, unavailing. Dr. Parry gave himself freely to the service of the miners among whom his work lay, and was a generous friend to any movement designed to advance their welfare, notably in the promotion of efforts to secure the advantages of higher education for the miners' children.

The following well-known foreign medical men have recently died: Dr. VINCENZO DE GIAZA, formerly professor of hygiene at Pisa University; Dr. F. ALOY, professor of medical chemistry at the Toulouse Faculty of Medicine, and corresponding member of the Académie de Médecine; Dr. LAGRANGE, honorary professor of clinical ophthalmology at the Bordeaux Faculty of Medicine, corresponding member of the Institut de France and Académie de Médecine, and Commander of the Legion of Honour; Dr. MARC LANDOLT, president of the French Society of Ophthalmology; Dr. CABANÈS, the prolific and entertaining writer on the curiosities of medical history, and editor of *La Chronique Médicale*, aged 60; Dr. GIOVANNI DI CRISTINA, professor of clinical pediatrics at Palermo, and author of numerous articles on splenic anaemia, chloroma, leishmaniasis, and the etiology of scarlet fever and measles, aged 52; Professor FERNANDEZ FIGUEIRA, an eminent pediatrist of Rio de Janeiro; and Professor STARKOW, a Riga anatomist, aged 54.

Universities and Colleges.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

DEMONSTRATIONS.

THE autumn course of demonstrations of specimens in the Museum, to be given in the theatre of the College, Lincoln's Inn Fields, W.C., will commence on Friday, October 19th, when Sir Arthur Keith will deal with the problems of human anatomy which arise out of the identification of a skull attributed to Lord Darnley (see *British Medical Journal*, September 8th, p. 456, and September 15th, p. 505). On October 26th and November 2nd he will discuss the development of the human foot and its bearings on club-foot and other orthopaedic disorders. Demonstrations of surgical specimens will be given by Mr. T. W. P. Lawrence on October 22nd and 29th and November 5th. The demonstrations, which are open to advanced students and medical practitioners, commence at 5 p.m.

Medical News.

THE inaugural address at the Westminster Hospital Medical School will be given by Mr. A. C. Powell, M.A. (headmaster of Epsom College), in the board room of the hospital on Monday, October 1st, at 3 p.m. The chair will be taken by Sir William Goschen, K.B.E. The annual dinner of past and present students of Westminster Hospital will be held in the Royal Adelaide Galleries, Gatti's Restaurant, on the evening of the same day, at 7.30 o'clock, with Sir James Purves-Stewart in the chair.

THE annual dinner of the Chelsea Clinical Society will be held at the Hotel Rembrandt, Thurloe Place, on Tuesday, October 23rd, at 7.30 p.m. Members are asked to inform Mr. L. A. Harwood (90, Sloane Street, S.W.1) as early as possible of their intention to be present and the number of their guests.

THE winter session, 1928–29, at University College Hospital Medical School opens on Monday, October 1st, when an introductory address will be delivered in the Library by Sir Thomas Barlow, Bt., M.D., F.R.S., at 4.30 p.m.

THE annual general meeting of the Medical Sickness, Annuity, and Life Assurance Society will be held at the First Avenue Hotel, High Holborn, W.C.1, on Monday, October 8th, at 4 p.m.

THE Fellowship of Medicine and Post-Graduate Medical Association announces that a series of four lecture-demonstrations in electrotherapy will be given by Dr. C. B. Heald at the Royal Free Hospital at 5.15 p.m. on Wednesdays, beginning on September 26th. There will be an all-day course in diseases of the throat, nose, and ear at the Central London Throat, Nose and Ear Hospital from October 8th to 26th; the clinical course, operative class, or pathology class may be taken separately. Courses will be given at the Chelsea Hospital for Women in gynaecology, from October 8th to 20th; at the London School of Hygiene and Tropical Medicine in tropical medicine, on Tuesday and Thursday afternoons from October 9th to November 1st; at the Hospital for Sick Children, Great Ormond Street, from October 15th to 27th. At the Royal Free Hospital Professor Louise McIlroy will give four lecture-demonstrations in ante-natal treatment on Fridays at 5 p.m., from October 26th to November 16th. There will also be weekly clinical demonstrations at various hospitals in medicine, in surgery, and in ophthalmology, and a weekly demonstration at the Wellcome Museum of Medical Science. Syllabuses are obtainable from the Fellowship of Medicine, 1, Wimpole Street, London, W.1.

THIS year's Galton Lecture, which was given by Mr. C. J. Bond, and was entitled "Some Causes of Racial Decay," has been printed as one of the People's League of Health pamphlets, with the permission of the Eugenics Society. It can be obtained from the Secretary of the People's League of Health, 12, Stratford Place, W.1; price 6d. We gave some account of this Galton Lecture in our issue of February 25th (p. 315).

THE number of convictions for drunkenness in England and Wales in 1927, as shown in the recently issued Home Office *Licensing Statistics* for that year, was 65,166—a decrease on the previous year of 1,960, or 2.9 per cent.—this being the lowest since 1919. A decrease was also recorded in the number of on-licences for the sale of intoxicating liquors, and it is shown that there has been a sustained fall in the number of on-licences in proportion to population over a prolonged period. At the beginning of 1908 there were 27.24 licences per 10,000 of the population and at the beginning of 1927 there were no more than 20.19 licences per 10,000 of the population. It is stated in the report that to some extent a better distribution of licences is to be preferred to a mere reduction in the number. Convictions for drunkenness due to the consumption of methylated spirits have increased by 10 per cent.—from 389 in 1906 to 428 last year. Under Section 40 of the Criminal Justice Act, 1925, which came into operation at midsummer, 1926, 1,438 persons were in 1927 convicted of drunkenness while in charge of mechanically propelled vehicles, and were disqualified for twelve months from holding a motor driver's licence. The number in the second half of 1926 was 804.

MESSRS. EDWARD ARNOLD AND CO. announce for early publication *Modern Problems in Neurology*, by S. A. Kinnier Wilson, M.D., and a *Text-Book of Surgical Diagnosis*, in two volumes, edited by A. J. Walton, F.R.C.S.

THE total diphtheria death rate in 1927 in the large cities of the United States was higher than in either of the two preceding years. From 1923 to 1926 inclusive the total diphtheria death rate in these cities had fallen regularly every year. In all European countries also the incidence of diphtheria was unusually high in the winter of 1927–28, and in Italy and Poland it was higher than at any time during the past five years.

THE thirteenth French Congress of Legal Medicine will be held at the Paris Faculty of Medicine, under the presidency of Dr. Georges Brouardel, from October 9th to 11th, when the following subjects among others will be discussed: expert evidence in social questions, introduced by Professor Balthazar; industrial accidents, comparative results of external methods and osteosynthesis in the treatment of fractures of the leg, introduced by MM. Charbonnel and Massé of Bordeaux; professional intoxication by hydrocarbides, introduced by M. Duvoir of Paris; anti-social reactions in epidemic encephalitis, introduced by M. Fribourg-Blanc of Paris. The subscription is 60 francs. Further information can be obtained from Dr. Piéchelièvre, 24, Rue Gay-Lussac, Paris.

IN 1927 only four cases of small-pox occurred in Germany. These had all been introduced from foreign countries. In the same year no fewer than 14,800 cases were notified in England and Wales.

DR. ALBERT R. COOK, senior physician to the Mengo Hospital of the Church Missionary Society and consulting physician to the Government European Hospital, Kampala, has been awarded the silver medal of the African Society in recognition of his work in Africa. Dr. Cook has in thirty-two years built up a highly efficient and extensive medical mission among the people of Uganda.

THE Department of Scientific and Industrial Research has published the thirteenth report on the investigation of atmospheric pollution (obtainable from H.M. Stationery Office, London, or through any bookseller), dealing with observations in the year ended March 31st, 1927; this is in continuation of the series of reports of the Advisory Committee on Atmospheric Pollution, hitherto issued by the Meteorological Office, the change following upon the transfer to the Department of Scientific and Industrial Research of responsibility for the Government's share in the work. The Advisory Committee will become a standing conference of co-operating bodies. In the report the deposit of impurity at 80 different stations in the United Kingdom is considered; a classification is made according to standards of increasing quantity of deposit, this being denoted by the letters A to D in order of quantity of pollution. It is satisfactory to note that there has been a substantial improvement in atmospheric purity in the areas covered; in 1914–15 the number of stations ranking as A and B was 54 per cent. of the total; in the year under review the number was 87 per cent. of the total. A steady decrease in the quantity of sulphates deposited in London and Glasgow has been observed, and it is stated that this is, at least in part, due to the increasing use of coal gas, this having presumably replaced raw coal. The tables included in the report give details month by month of the deposits collected at the various stations, showing wide variations in their composition. A section dealing with suspended smoky matter in the air illustrates the effect of the coal stoppage of 1926, while the obstruction of ultra-violet radiation by smoke is brought out by a curve which indicates that nearly the whole of the ultra-violet rays is cut off by a comparatively small amount of smoke in the air. Much of the matter contained in this slim volume—it contains less than sixty pages—is of considerable scientific interest, and should be of some practical value to those engaged in public health work, but its publication at the net price of 6s. 6d. will not encourage a wide circulation.

THE Commonwealth Department of Health (Central Office) will be transferred from Melbourne to Canberra, the federal capital of Australia (Federal Capital Territory), as from October 1st, 1928.

THE twenty-fifth anniversary of the foundation of the German Institute for Investigation of Cancer, which is attached to the Charité Hospital in Berlin, was recently celebrated by a special meeting under the presidency of Professor Friedrich Kraus.

SIX series of post-graduate courses in English will be held in Paris under the supervision of the University medical school; in most cases these are associated with practical work. Ten lectures on diseases of the bronchi, with pathological and radiological demonstrations, will be given by Professor Sergent, at the Charité Hospital, from October 29th to November 3rd. A course of nine lectures on diseases of the heart and vessels will be given by Dr. Clerc, at the Laribosière Hospital, from October 20th to 30th. Dr. Armand-Delille and Dr. Weill-Halle will hold a course in diseases of children from October 8th to 20th at the Charité Hospital, and Professor Gosset will give a five-day course on surgery of the digestive tract and liver, with operative demonstrations and operations on the dog, at the Salpêtrière Hospital, commencing on October 15th. Drs. Morax and Lemaître will conduct courses in ophthalmology and oto-rhino-laryngology covering the period from October 2nd to 26th. Further information and detailed programmes may be obtained from the secretary of the Association pour le Développement des Relations Médicales, Salle Béchard, Faculté de Médecine, 12, Rue de l'Ecole de Médecine, Paris VI^e.

THE following appointments have recently been made in foreign faculties of medicine: Professor G. Katsch of Frankfurt, professor of internal medicine at Greifswald, in succession to Professor Straub; Dr. L. Kumer of Vienna, professor of dermatology and venereal diseases at Innsbruck; Dr. Alfred Linck of Königsberg, professor of oto-rhino-laryngology at Greifswald; and Dr. Luiz Barbosa, professor of clinical pediatrics and infantile hygiene at Rio de Janeiro, in succession to the late Professor Nascimento.

THE proceedings of the thirteenth Congress of Medicine of Northern Countries, held at Copenhagen under the presidency of Professor V. Bie, have recently been published as a special supplement to *Acta Medica Scandinavica*, under the editorship of Dr. A. Norgaard, the general secretary, the communications appearing in English, French, and German.

Letters, Notes, and Answers.

All communications in regard to editorial business should be addressed to ***The EDITOR, British Medical Journal, British Medical Association House, Tavistock Square, W.C.1.***

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The ***TELEPHONE NUMBERS*** of the British Medical Association and the BRITISH MEDICAL JOURNAL are *MUSEUM 9861, 9862, 9863,* and *9864* (internal exchange, four lines).

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QUERIES AND ANSWERS.

DIET IN "GALLSTONE DYSPEPSIA."

"LOCUM" writes: I shall be grateful if one of your readers will prescribe a suitable dietary for a patient suffering from "gallstone dyspepsia." He has been operated on several times, and his symptoms are now supposed to be due to adhesions in the neighbourhood of the duodenum.

CORNS.

"W. J. B. S." writes: In further reply to "H. A. A." (July 14th, p. 85), I use the salicylic cannabis indica corn plaster, covered again by a larger piece of adhesive plaster. This sets up a poultice action. The application should be renewed each day, removing the epidermis that has been softened. In the case of an ordinary corn the core usually comes out after the first day.

TREATMENT OF COLI BACILLURIA.

DR. GEORGE WILLETT (Keynsham, Bristol) writes: In reply to the inquiry by "I. M. S." (September 15th, p. 513), I suggest the trial of mercurochrome bladder washes, and, failing that, one of silver nitrate. As the urine is constantly acid, perhaps it might help matters if, for the time, it was rendered alkaline, as *B. coli* flourish in both an acid and an alkaline medium. Possibly the presence in the urine of crystals of calcium oxalate may explain part at least of the general condition and the headache.

"P. T. J." writes: I have recently had a very stubborn case of *B. coli* infection of kidney and bladder, and have obtained two consecutive negative cultures at two months' interval from the use of acriflavine. Messrs. Boots (Nottingham) have made a tablet of this drug, otherwise so inconvenient to administer, which my patient has been able to take regularly.

DR. A. A. BISSET (Harrogate) writes: If treatment by intestinal douches has not been already tried, they might diminish the bacilluria. Many cases of coli bacilluria show mucous colitis and swelling of the right kidney. Intestinal douches, properly administered over a period of three to four weeks, in most cases effect a cure. A diet containing a large amount of vitamin B is also a valuable adjunct to treatment.

"F. H. E." writes: I suggest that "I. M. S." employ mercurochrome. One ounce of a 1 per cent. solution is used. The patient is put to bed. The bladder is emptied by a No. 10 catheter, to which a tube and funnel are attached. The funnel is then raised and the warmed mercurochrome solution allowed to trickle in. No pain is caused. The solution is retained for half an hour. A second application is rarely necessary—perhaps in one case out of five.

VAGINISMUS.

"G. L." writes in reply to "C. A." (September 8th, p. 473): My answer is: (1) Consult a gynaecologist; (2) do not resort to psychotherapy. "C. A." states that the vagina has been twice stretched without result, but he has not carried out the essential after-treatment, which consists in passing a vaginal dilator and showing the patient how to pass it on herself.

"G. P." writes: I had a similar case some time ago. The vaginismus readily responded to vaseline and cocaine, smeared on to the vulva by the patient herself.