clavicle on to the chest. At no portion should the parallel lines be separated by less than two inches. This strap of skin and subcutaneous tissue is raised and sewn with its skin edges together on its posterior surface, making a tube pedicle flap, according to the method I have described in other situations. By suitable undermining the neck skin can be approximated beneath the pedicle flap, which is left attached above and below. Drainage should be provided in the neck.

(Interval of 1 to 2 months, preferably the latter, should be allowed.)

Second Stage.—(*a*) Division of pedicle from chest. Opening of seam of pedicle enough to cover two-thirds of lower lip. (*b*) Dense scar tissue excised from lower lip and pedicle sutured into raw area provided on both skin and mucous membrane aspects.

(Interval of 1 month or longer.)

Third Stage.—Division of neck end of pedicle; opening up of the seam; excision of the remaining scar tissue, and pedicle "draped" round new oral aperture.

The excision of scar tissue must be complete.

INCOME TAX.

Partnership: Decease of Partner.

"PUZZLED" writes: A, B, and C were in partnership and made up their accounts to December 31st; in January, 1925, A died and B and C took over the practice, and paid both instalments of the tax payable in 1925—that is, as for the year ended April 5th, 1925. A's executors refunded his share for the first instalment, but demur to refunding more than half of the second instalment, although by far the greater part of the money received up to April 5th was for work done before A's death, for which, of course, A's executors received his share.

*** In our opinion the executors are right. "Puzzled" should bear in mind the fact that the tax in question is for the profits of the year 1924–25, not for the cash received in that year. Since A's death all the profits belong to B and C, and they are liable to account for tax accordingly. It is true that in computing the assessment the cash receipts have been taken as the gross income, but this is merely as a matter of convenience and because in the long run the amount of cash received over a period of years should be equal to the *value* of the professional bookings. Having arrived at an assessment by that means, the question of cash, as distinct from bookings, should be put on one side, and the matter looked at as if the assessment represented the profits or earnings of the practice for the financial year, whether received in cash or still on the books.

Bad and Doubtful Debts.

"G. H. G.'s" firm base their income tax returns on bookings rather than on cash receipts; are they justified in deducting a percentage of the bookings as representing the probable amount of bad debts, and if so, what percentage?

*** This is one of the most difficult questions arising on medical practitioners' returns. The legal position is that the practitioner is entitled to a deduction for bad and doubtful debts, but the onus of establishing what is a fair amount rests on him. The final decision lies with the District Commissioners of Taxes, and we understand that in some cases they require evidence in the form of a schedule of outstanding debts setting out the nominal amount and probable value of each debt. However reasonable such a requirement may be in the case of a trader claiming an allowance in respect of a comparatively small number of doubtful debts, it is, we feel, unfair in the case of a medical practitioner whose fees are notoriously not only difficult to collect, but also subject to deductions on grounds which would not carry much weight as regards debts between, say, a manufacturer and his customers. In the circumstances we regard a percentage deduction as a legitimate form of computation. As regards the percentage that should be selected, it is impossible for us to suggest a figure. Bearing in mind that the practitioner can be called upon to defend his claim, and also that it must depend largely on the circumstances of the particular practice, the best suggestion we can offer is that the books for previous years should be examined to ascertain what has, in fact, been the average loss by bad debts, and the percentage so calculated applied to the amount of the book debts outstanding at the close of the period forming the basis of the average.

LETTERS, NOTES, ETC.

ESTIMATION OF SUGAR.

DR. J. BARKER SMITH (London, S.E.) writes: In the JOURNAL of November 28th, 1925 (p. 1040), I mentioned a crucible lid for easily ascertaining a glycosuric urine, even when it contains only small quantities of sugar, such as 2 per 1,000, from a droplet of urine. Permit me to say that the Thermal Syndicate, Ltd., make a small silica disc (No. T/A9/121) for the purposes of my char test, etc. I have always used a silica crucible lid, and the small silica disc should be still more advantageous; its great smoothness, however, has no great advantage. When we realize that so small a quantity as a fiftieth part of a milligram of sugar will be evidenced by the residue char left after washing and rubbing the carbonized droplet of urine, it seems to me the char test should be of universal use by medical practitioners, even for quantitative, as well as qualitative, estimation of sugar, both in blood and in urine. The stickiness of the extract, the odour of caramel when discolorization begins, and the adherent residue char, are all characteristic of quantity, and one droplet of urine the size of a large pin's head is sufficient.

RHEUMATOID ARTHRITIS: ITS SEPTIC ORIGIN.

DR. GAVIN A. E. ARGO (Digboi, Upper Assam) writes: In his note on "Rheumatoid arthritis: its septic origin" (October 24th, 1925, p. 773) Major-General Sir Patrick Hehir states that all classes of Indians wash their mouths after every meal, and infers that by so doing pyorrhoea alveolaris is prevented. In the past few months I have examined the mouths of between 1,200 and 1,300 adult Indians, and approximately 94 per cent. of them have pyorrhoea alveolaris. I have not noted what percentage of these wash their mouths after meals, but am informed it is a more or less general custom. Washing their mouths with water after meals may get rid of a certain amount of food debris, but it is not clear how this custom gets rid of the tartar and pockets, which all these Indians show, and without getting rid of which it is difficult to see how the pyorrhoea is very much benefited.

ECHINOCOCCAL CYSTS IN CAMELS.

IN reply to Dr. J. C. Milne (Hurghada, Egypt), who asked a question about the occurrence of echinococcal cysts in camels (BRITISH MEDICAL JOURNAL, December 19th, 1925, p. 1206), Dr. G. W. Sudlow (Stoke-on-Trent) writes: Whilst serving as a temporary officer in the R.A.M.C. I was stationed, in the summer of 1918, in the Kharga Oasis, Libyan Desert. One unit under my charge was a company of Bikanir Camel Corps. Their camels were Indian, not Egyptian. After several unaccountable deaths of camels in their lines the Special Service officer attached to them asked me one day to see a sick camel. It was a fine beast, as were they all, apparently in their prime, and much larger and finer than the Egyptian camel. The history was that it had been off its feed for a few days, and was obviously ill and in pain. It died that night, and next day I conducted a *post-mortem* examination—no mean task. I found practically every abdominal organ riddled with cysts, large and small. I sent specimens of liver and kidneys for bacteriological report, which in due course confirmed my diagnosis (*post mortem*) of hydatid disease. In all I made five or six *post-mortem* examinations on similar cases occurring in their camel lines within a few weeks. In my series of cases I saw both pleural and peritoneal cavities involved by the disease, also lungs, liver, spleen, and kidneys. The Indian officers of the camel corps kept dogs, which had the run of the camp, and the surrounding desert abounded in jackals, so that the source of infection was not far to seek. The camels' fodder was tibbin; this was stacked in the open in the camel lines, and evidently was being urinated upon by the infected dogs and jackals.

THE FIRST LONDONERS.

DR. FERDINAND REES (Southend-on-Sea) writes: If your annotation (December 12th, 1925, p. 1138) correctly represents what Professor Parsons said, he must have made some slips. The Mediterranean race, usually called Iberian, the Long Barrow people, were the first race. What proof has he that another race, the round Barrow or Beaker people, intervened between the Iberians and the Celts? I am not disinclined to believe it, but it certainly has not been stressed up to now. Taylor, in *The Origin of the Aryans*, says: "but as there can be little doubt that the people of the round barrows introduced into Britain what is usually called 'Celtic' speech, it will be convenient, though perhaps incorrect, to designate the people of the round barrows as the Celtic race." The question is, were they what we have been accustomed to call Goidels, or did the Goidelic wave of Celts come after them? Professor Rhys does not seem to know anything about these Beaker folk: he only talks of two Celtic waves, the Goidelic and the Brittonic. Professor Parsons is made to say that the Goidels or Gaels were believed to have passed rapidly to Ireland, Scotland, and the Isle of Man, and that the Brittones, reaching this country about 600 B.C., probably called themselves Cymry. But Professor Rhys makes it quite clear that the name Cymry, or Comrades, was only adopted by the Brythons after Cunedda came down from the Northern Wall with his Brythons, who conquered the Goidels who were then in power in the north-west and in a great portion of the south of what is now known as the Principality of Wales. The Princes of Wales always from this time claimed descent from Cunedda Gwledig, or Ruler.

VACANCIES.

NOTIFICATIONS of offices vacant in universities, medical colleges, and of vacant resident and other appointments at hospitals, will be found at pages 32, 33, 36, and 37 of our advertisement columns, and advertisements as to partnerships, assistantships, and locumtenencies at pages 34 and 35.

A short summary of vacant posts notified in the advertisement columns appears in the *Supplement* at pages *19* and *20*.