SIR,—Sir James Barr, in his article on "The Soldier's Heart," emphasizes the need for more calcium in the food of soldiers.

About five years ago I pointed out in the *Hospital* of February 4th, 1911, that there was this great deficiency, and I laid the matter before the Director-General, A.M.S., who replied "that a board was about to sit on the question of food supply, and that my suggestions would be put before them."

Evidently the board did not agree either with the opinions of Sir James Barr or yours truly,

Swansea, April 19th. G. ARBOUR STEPHENS.

THE INGUINAL INCISION FOR INTRASCROTAL AFFECTIONS.

SIR,—The article by Mr. Maylard in your issue of April 22nd (p. 589) is of great interest as a reasoned explanation of the choice of site for the incision in intrascrotal affections. That the choice of the inguinal region in most such cases may not be novel he is careful to point out, and would be the first, as is well known to surgeons here, to welcome information tending to place points of surgical treatment in historical sequence. I therefore take the liberty of giving one or two references on the question.

In an article entitled "Six cases of hydrocele in infants treated by operation," published in the BRITISH MEDICAL JOURNAL of February 22nd, 1913, Mr. James H. Nicoll, surgeon to the Western Infirmary, Glasgow, dealt with the incision discussed by Mr. Maylard. The article was illustrated by a plate with two figures showing the hydrocele sac being pushed up into the inguinal incision. The object of Mr. Nicoll's article was not so much to draw attention to the situation of the incision (since that was made according to his practice of many years) as to give specific instances of the wide scope of operations which might advantageously be performed at an out-patient department. Mr. Nicoll has used the inguinal incision for intrascrotal affections (where the scrotal skin is sound) for about twenty years. I myself have witnessed his use of it in hundreds of cases during the past seven years.

In their *Manual of Surgery* (vol. iii, Operative Surgery, 1913, p. 578), Thomson and Miles quote Winkelmann as recommending the inguinal incision for hydrocele. These authors also recommend it for castration if the skin of the scrotum is not involved in the disease (p. 572).

Beesly and Johnston, in their new *Manual of Surgical Anatomy* (Hodder and Stoughton, 1916, pp. 262, 268) describe the inguinal incision for radical cure of hydrocele, and on p. 266 give it as an alternative to the scrotal incision for excision of the testis.—I am, etc.,

Glasgow, April 25th. CHARLES BENNETT, M.B.

THE FEES OF GENERAL PRACTITIONERS.

SIR,—I think every one will admit that the medical profession has come forward very freely in many directions during the present crisis, but I also think that we should be justified in looking after our own interests a little, both for our own sakes and the sakes of those who are serving, and the present gives an opportunity which will never arise again to do two things—(1) to raise our fees; (2) to teach the public to allow medical men more freedom.

Expenses all around are increasing, while the fees of general practitioners in England remain grossly inadequate, and it is our own fault that they are so. My own fees are as high as the custom of the district will allow, but the other day a small local tradesman came into my surgery, remained fifteen minutes, obtained important advice as regards his health, and a bottle of medicine which cost me at least 1s., and paid me 3s. 6d., which I am sure he thought was quite enough. The next day the same man visited the dentist, remained ten minutes, had two teeth extracted, and willingly paid 7s. 6d. Could I quote a better example to support my plea that general practitioners should raise their fees, so that we might have some prospect of earning enough to retire, instead of dying in harness, as most of us do at present?—I am, etc.,

May 1st. GENERAL PRACTITIONER.

JEJUNOSTOMY AND JEJUNO-COLOSTOMY.

SIR,—Mr. Handley thinks that the procedure I advocate for post-operative faecal or intestinal vomiting—namely, jejunostomy with subsequent restoration of the jejunum—is a more severe one than his proposal of jejuno-colostomy *plus* caecostomy, and quotes a paragraph from my paper in support of his opinion. Quotations divorced from their context are fallacious; he should have added at least the following further quotation:

> It is true that after jejunostomy a second operation to close the opening has to be faced, but this is not such a serious undertaking as might at first sight be thought.

That a risk is incurred is of course obvious; but on the other hand, Mr. Handley's proposal involves a risk in my opinion still greater—the performance of an intestinal anastomosis during a period of acute obstruction.

Mr. Handley says that caecostomy openings often close spontaneously; they do, but not by any means always. But what of the opening between the jejunum and transverse colon? Does that close spontaneously? And if it does not, to what extent is it injurious to the patient? These are questions which cannot be answered on one recently operated on case.

Mr. Handley claims that his proceeding improvises a physiologically complete intestinal canal. An intestinal canal consisting of the oesophagus, stomach, and a few inches of jejunum and colon is not physiological; neither is a communication between the jejunum and colon. He misuses the term.

He assumes that the successful result he achieved in the case published in his recent paper was due to the possession by the patient of this "physiologically complete intestinal canal." I hold that it was due to the fact that in the making of it he drained the jejunum, and that there is really no difference therefore in the *rationale* of the two procedures.

Our difference of opinion seems to me to be chiefly due to a different conception of the primary agencies underlying the symptoms of acute intestinal obstruction. As I understand him, he believes them to be situate outside the bowel (peritonitis), whereas I believe that it is to changes occurring inside the bowel that the symptomatology must be primarily ascribed, and that peritonitis is merely a common accompaniment. Thus all the symptoms may be present without any peritonitis, and, conversely, the most profound peritonitis is often seen without any of the symptoms of intestinal obstruction.—I am, etc.,

London, W., May 2nd. VICTOR BONNEY.

WOUNDS OF JAW AND FACE.

SIR,—The papers and discussions at the annual general meeting of the British Dental Association on June 15th, 16th, and 17th (to be held at the house of the Royal Society of Medicine) will be entirely devoted to the important subject of war injuries and gunshot fractures of the jaws and the best methods of treatment. There will also be an exhibition of appliances and splints, improved and adapted for the most efficient use under the new war conditions.

May I, by your courtesy, appeal to those of your readers who have been treating cases of jaw injuries to contribute models, appliances, splints, skiagrams, etc., to the exhibition? It is particularly requested that in sending exhibits the following points should be observed:

1. The case containing the exhibit should include a note of the exhibitor's name and address, and a list of all the exhibits contained in the case.
2. That each part of the exhibit should have the exhibitor's initials attached to it by means of a small piece of gummed paper.
3. That all exhibits should reach the house of the Royal Society of Medicine, 1, Wimpole Street, W., not later than Friday, June 9th.

—I am, etc.,

F. N. DOUBLEDAY,
Honorary Secretary, Museum Committee.

19, Hanover Square, W., May 1st.

THE New York Academy of Sciences will celebrate the centenary of its foundation in May, 1917.