

of the best forehand drives ever known—those of Johnston and Harada—he will find that in them the forearm is locked in full supination, as well as the wrist in full extension, against the impact of the ball. In the backhand shot, however, the thrust is against the thumb, and tends to flex the wrist, so producing at each impact a jerk on the extensors which alone resist it.

As to the part played by bad shots, it does not require any very recondite calculations of ballistic centres to ascertain that it is the mishit ball that jars the wrist; and quite possibly an imperfect contraction of the muscles renders them more liable to injury of this or any other kind.

As I am only too well aware of the breach of sporting etiquette which it is to mention mechanics or anatomy in discussing a game, I feel I must apologize for the converse sin of touching on the technique of a game in a medical journal.—I am, etc.,

London, W.I, Jan. 6th.

DENIS BROWNE.

SIR,—The correspondence on this subject has been so comprehensive that one is tempted to “leave it at that,” were it not that a treatment of sovereign utility has not been mentioned in your columns. I refer to the oldest form of electricity used in medicine, yet one, in this country at any rate, much neglected—static electricity. The form of it which is of great use in “tennis elbow” (or “tennis arm,” Dr. A. A. Warden terms it, and this coincides with my own experience) is the static wave current. The effects of this current are chiefly or entirely mechanical; the current causes tissue contractions—the coarser ones which can be seen, and finer contractions within the tissues—perhaps 120 contractions to the minute. It is not difficult to understand why the application of this current to the elbow should improve the condition and remove the congestion and exudation, which are the invariable concomitants of all forms of tennis elbow.

While agreeing with Mr. Paul Bernard Roth that “tennis elbow is due to several pathological conditions,” I am of opinion that there is in all, or most of these conditions, one common factor—namely, a serous effusion, possibly, an inflammatory congestion of the synovial membrane, and an inflammatory exudation, the “coagulable lymph” of John Hunter. Erichsen pointed out the theory of treatment many years ago. “If,” said he, “the disease progress favourably, these products are completely absorbed.” In the static wave current we have an agent which will, by its mechanical action, disperse that congestion and so improve the circulation that these products are readily absorbed; and by hastening the absorption of morbid products it compels the disease “to progress favourably.”

Turrell of Oxford, in speaking of this form of electricity, used by him for a sprained ankle, in which the pathological conditions are not altogether dissimilar, said, “I am not exaggerating when I state that during the football season I daily see examples of the immediate and lasting benefits of the static wave current in this class of case.”—I am, etc.,

London, W.I, Jan. 6th.

F. HOWARD HUMPHRIS, M.D.

SIR.—May I offer a suggestion as to the treatment of “tennis elbow” in those cases which are in the primary stage? The patient declines to stop his game; he is not quite bad enough. Yet every jerk given the elbow increases the mischief. Why not, then, induce him to wear an angular metal splint, braced by the usual armlets, with buckles above and below the joint, the whole fixed at a wide but varying angle, adjusted by a screw? Such a splint may at first feel cramping and cumbersome, but the player will probably soon accommodate his action to the fixation, as so many men have done in other injuries. If such a splint was well made and comfortably adjusted, it ought, theoretically, to take the jerk, and to prevent the drag and strain on the joint, which is the principal factor in producing tennis elbow. At any rate, such a splint is worth trying, when the only alternative is complete cessation from play.—I am, etc.,

T. M. CORKER, Major-General.

Junior United Services Club,
Jan. 6th.

HEALING OF THE TONSIL FOSSA AFTER TONSILLECTOMY.

SIR,—A contributor to your issue of December 28th, 1929 (p. 1156), assumes as a criterion of tonsil infectivity, among other things, “the presence of any tissue in the tonsil beds after tonsillectomy.” He is perpetuating a common fallacy, that besets many physicians, that any residuum remaining in the tonsil fossa after complete enucleation is tonsillar tissue. In so doing he disregards the manner in which the healing occurs in the raw area left after removal of the tonsil. This heals up in a manner similar to any other uncovered wound—namely, by the formation of granulation tissue, which then becomes epithelized over, a process that is complete from the fourteenth to the twenty-first day. The formation of this granulation tissue interests the physician from two aspects.

1. One of the characteristics of this granulation tissue is its ability to bleed easily on the mildest of trauma, and it is this that gives rise to the majority of cases of secondary haemorrhage after tonsillectomy. A cough, bolting of solid food, or any such trauma is liable to dislodge a portion of the fragile granulation tissue, and produce a haemorrhage that is sudden in onset, spontaneous in cessation, and severe in amount. The surprising thing is that secondary haemorrhage is as rare as it is. Silver nitrate stick applied locally will always control this bleeding.

2. But this tissue formation has another significance. On occasion it is apt to be exuberant in bulk, and present as a fleshy mass in the tonsillar fossa. It is then by the uninitiated mistaken for a piece of tonsil left behind at operation, and its removal by further operation is advised. This excrescence should be removed, as exuberant granulations elsewhere, by the caustic stick, and not the scalpel. As I have had occasion to state elsewhere (*Clinical Journal*), there are physicians who are always of the opinion that unless tonsillectomy is performed by their own surgeon, the tonsil has never been satisfactorily extirpated. When they observe this mass of residual granulation tissue they invariably inform the patient, or the latter's parents, that the operation has been imperfectly performed, and has to be done again. They dwell with unwonted enthusiasm on the evils that will result from the retention of these pernicious “tonsil” remains. It is a matter calling for the display of much tact to disabuse the mind of such a patient and to reassure him that no further operation is called for. And all this is a result of ignorance of the normal pathology of the healing of the tonsil bed after tonsillectomy.—I am, etc.,

London, W.I, Dec. 28th, 1929.

N. ASHERSON.

SECURITY OF TENURE IN PUBLIC POSTS.

SIR,—Readers of the correspondence on security of tenure in public posts will be interested to note your extract (December 28th, 1929, p. 1215) giving the considered opinion of the Royal Commission on the subject. The Commission's recommendation is satisfactory so far as it goes, but it does not directly protect the officer's pension, and therefore does not meet the view expressed in your leading article of March 9th, 1929 (p. 461), in which you stated:

“And certainly it will be necessary to secure changes in the Local Government and other Officers Superannuation Act so that an officer who has completed a certain number of years of service and is dismissed from his appointment shall be entitled, in the absence of evidence of misconduct, to a pension in accordance with his years of service. . . .”

Most of the Local Government Superannuation Acts protect the officer's right to a pension if he becomes incapacitated by sickness before he has served the statutory number of years. For example, the Asylum Officers Superannuation Act (1909) provides:

“Any established officer . . . who is permanently incapacitated for asylum duties after ten years' service by injury or illness, mental or bodily, medically certified and not attributable to his own misconduct, shall be entitled, on resigning or otherwise ceasing to hold office or employment, to receive during life or incapacity a superannuation allowance. . . .”