of my sons had it when nearing his fourth birthday. With reference to the arthritis that occurs after tonsillitis and its differentiation from acute rheumatism, we are dealing with a difficult problem. The distinction between the two may not be cut-and-dried. After all, acute rheumatism is most certainly a streptococcic infection. This much we can say: the effect of tonsillitis on patients with valvular disease of the heart the result of rheumatism is often very profound. I have seen many cases of simple endocarditis become malignant as the result of a superadded throat infection.

Dr. Camps does not mention the cinema as being a factor in the spread of these infections. Since the advent of the "talkies" these places of amusement are tremendously popular. The atmosphere in most of them is terrible, and I am sure that if Dr. Camps and his co-workers exposed a few plates in some of them they would obtain luxuriant growths.

—I am, etc.,

Aberdare, May 27th. AMBROSE W. OWEN.

Omental Plug in Stomach Perforation

SIR,—Anent the controversy between Captain A. T. Andreason and C. L. Isaac concerning the use of an omental plug in gastric perforation. I have used omental plugs in perforated gastric ulcers for the past fifteen years in all cases in which the size and thickness of the callus surrounding the perforation made it impossible to overlap the edges thereof by means of interrupted sutures. The plug I use is a free section of great omentum fashioned into an hour-glass shape, one half of which is poked through the perforation. The plug is reinforced by an omental flap sutured around the ulcer area at a distance of from one to two inches from the margin of the induration. My only failure so far was encountered quite recently in that rare anomaly of simultaneous gastric haemorrhage and perforation. In this particular case a secondary haemorrhage occurred on the fifth post-operative day, with exitus of my patient.

Trusting this transatlantic opinion may be of some interest to my British colleagues,—I am, etc.,

GEORGE DE TARNOWSKY,
Professor of Surgery, University of Illinois School of Medicine.
Chicago, Illinois, May 14th.

Gastrectomy

SIR,—May I refer briefly to a few points in the controversy which my paper has unwittingly raised. Criticism has been directed against its manner and its matter. For any offence that may have been caused by my references to gastro-jejunostomy among those surgeons who made the roads upon which we have travelled hitherto, I should like to apologize unreservedly. In mitigation I may say that my paper was condensed from the notes of a series of post-graduate lectures, and that I was forced to abbreviate the first of these, which had already been published, into a few sentences. A conclusion robbed of its premisses is unavoidably dogmatic.

The views of many of these writers differ, I believe, from mine less in fundamentals than in the extent to which they would be prepared to carry out the principles I have suggested. Some have since been to see me, and, if not convinced, have at any rate modified their opposition in consequence. Mr. Irwin's letter is an admirable expression of the standpoint of those who wish to defer judgement till more evidence is available. Mr. Marshall's questions are answered in my address in the *Lancet*, of which I have sent him a copy; his line from Shakespeare, apt though it is, is not quite so pertinent to the present situation as to the two which precede it.

Mr. Paterson speaks from an experience greater than mine, and I cannot find fault with his temperate disapproval. I hope, however, that every surgeon will settle the point he raises about the neutralizing effect of gastro-jejunostomy for himself. An average reduction in acid level of 30 per cent. suggests that Mr. Paterson's observations were made in the post-operative stage. Any severe abdominal operation, not necessarily gastric, will depress the functions of the stomach for some weeks, but that the rapid emptying which is the real cause of a high acid curve in the ulcer patient should be remedied by a fresh opening at its most dependent part is hard to understand. My own experience has been that the acidity is not found to be reduced when the case is examined after a year, and Hurst, Ryle, and Conybeare have found the same.

Lord Moynihan maintains that by careful selection, technical artistry, and prolonged after-care, gastro-jejunostomy can be kept in the pre-eminent position which it occupies in this country if in no other. My difficulty in accepting such a view is that the failures which have forced me reluctant from the fold have mostly been the patients of men whose judgement is beyond reproach and whose technical ability is above criticism.

The problem in its simplest form is not that of gastro-jejunostomy *versus* gastrectomy, but of gastro-jejunostomy for active duodenal ulcer without stenosis *versus* physiological gastrectomy for the same condition, should it ever require surgery. Gastro-jejunostomy is a short-circuiting operation, and for a mechanical obstruction it provides a mechanical and eminently satisfactory remedy. For ulcers without stenosis it can only be supported by the statement that it is successful. The acid-reducing gastrectomy with prepyloric section and a valvular stoma, a totally different operation from gastrectomy for cancer, is planned to combat the causes of ulceration and to avoid the immediate dangers and late failures of the textbook resection. It has been called mutilating and dangerous: it is reasonable and safe. That it is as safe as gastro-jejunostomy I have been able to convince those surgeons who have visited me; its mortality cannot be estimated till it happens. That it is reasonable should be apparent to those who regard it in terms of function and form, and not of form alone, and who are familiar with the experimental work of Mann, Florey, and Meulengracht.

If this correspondence has done nothing else it has revealed a very wide acceptance of the standpoint that gastro-jejunostomy is not the simple and safe remedy for ulcer that we believed it to be ten years ago, and that it must only be applied after most searching consideration of the circumstances of the individual case. The number that will be found suitable after such a scrutiny will vary with the individual surgeon; as the failures come to light, and as the results of efficient medical treatment, and of gastrectomy as a physiological measure where medicine has failed, become appreciated, I believe they will be few.
—I am, etc.,

London, W.1, May 26th. W. H. OGILVIE.

Septicaemia due to Brucella abortus following Operation

SIR,—I have read with great interest the report by Drs. Potter and Harburn, in your issue of May 25th, of a case of septicaemia due to *Brucella abortus* following operation.

This is an extremely interesting case, and raises more points than can be dealt with in a letter, but I should like first of all to agree with the authors that this confirms my supposition, which they quote, that the onset of undulant fever may be due to the lowering of the patient's

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