2. The testes that advocates of hormone treatment describe as being in the inguinal canal before treatment are really in the subcutaneous tissues, between the muscles and the fascia of Scarpa, in a space I have called the "superficial inguinal pouch."[2] I have said for several years that a testis which is in the inguinal canal cannot be felt. This statement has produced many explosions, and a fair number of subsequent agreements; but it has never been refuted on the human body.

To sum up, I submit that the hormone treatment of undescended testis is dangerous, useless, and founded on an anatomical error.—I am, etc.,

London, W.1, March 21. DENIS BROWNE.

Acute Dilatation of the Stomach

SIR,—Although Mr. Hamilton Bailey, in his article in your issue of March 4 (p. 434), states that "acute dilatation of the stomach is encountered after such divergent surgical procedures that nothing profitable is likely to accrue from enumerating them," it is possible that an account of personal cases might prove of interest and stimulate discussion with a view to elucidating its aetiology.

Case 1.—A man aged 35 was operated on for perforation of a peptic ulcer in 1932. Pain recurred nine months later and continued intermittently until 1936, when it became associated with vomiting and loss of weight. A barium meal showed enormous dilatation of the stomach due to pyloric stenosis. Gastric lavage was carried out daily for ten days, and operation was performed on December 16, 1936, under gas, oxygen, and ether. The pylorus was puckered and contracted and the stomach wall hypertrophied. The appendix was removed and a posterior gastro-jejunostomy performed. The following day he was very collapsed and the pulse had risen to 148. He looked extremely ill, but there had been no vomiting. Through a Ryle's tube two pints of frothy peat-like fluid were evacuated and continuous intravenous saline commenced. The stomach was aspirated half-hourly. Improvement was immediate, and by the evening of the fourth day after operation the pulse was normal.

Case 2.—A man aged 55 was admitted to hospital from a train accident. He was very shocked. Temperature 96° F., pulse 120. A radiograph showed fractures of the horizontal and descending rami of the pubes on both sides, also fractures of the ninth, tenth, eleventh, and twelfth left ribs. There was no evidence of injury to the pelvic viscera. A severe lacerated wound was present involving the muscles of the left thigh. This was operated upon the same evening under gas and oxygen. On return to the ward his general condition was fairly good (temperature 100.4° F.; pulse 126). I was asked to see him the following day at 4 p.m. as his general condition had now deteriorated and the pulse was rising steadily. There had been no vomiting. Internal haemorrhage was suspected, but although the abdomen was greatly distended there was no tenderness or free fluid. A catheter specimen of urine showed no blood. A Ryle's tube was passed and a large quantity of the typical fluid evacuated, and aspiration was continued at half-hourly intervals. Continuous intravenous saline was commenced, and coramine injections given at four-hourly intervals. Improvement was rapid. The following day the pulse had dropped to 124 and the patient passed urine in the evening for the first time. On the second day the pulse was 110, and by the fifth day it had fallen to 92. He eventually made a good recovery and was discharged nine weeks after admission.

Mr. Hamilton Bailey rightly stresses the fact that vomiting occurs relatively late. The diagnosis should be made before it occurs. In the absence of haemorrhage a rising pulse rate after injury or operation indicates acute dilatation of the stomach until excluded by gastric aspiration.—I am, etc.,

London, W.1, March 12. CAMERON MACLEOD, F.R.C.S.

[2] Browne, Denis. *British Medical Journal*, 1938, 2, 168.

Direct Inguinal Hernia

SIR,—Mr. W. G. Gill (*Journal*, February 11, p. 263) has drawn our attention to an interesting and rare variety of direct inguinal hernia. I operated upon fifty-five cases of inguinal hernia last year, but I am not aware of having come across one of these until last week.

The patient was a bus conductor aged 46, who had noticed an easily reducible swelling in his right groin for five years. He affirmed that there was no swelling before then, and thought it might have been caused by a strain while helping the driver crank up the bus; clinically it was diagnosed as a direct inguinal hernia. At operation a small sac of peritoneum was found protruding through a very definite round hole in the fascia transversalis of the posterior wall of the inguinal canal, medial to the deep epigastric vessels. The condition was exactly similar to that shown in Mr. Gill's diagram. The diameter of the opening was half an inch, and its edges were tough fibrous tissue of condensed fascia transversalis. I repaired the weakness with fascia lata. A strip was taken from the thigh by means of a fasciotome and split into three lengths. One was used to close the hole in the fascia transversalis; the other two were used to reinforce the inguinal canal by Gallie's method.

It seems to me that this method of repair by using fascial strips gives a sounder reinforcement to the very definite gap than can either catgut or silk. An alternative method would be Mr. Philip Turner's operation in which a flap of fascia lata is turned up beneath the inguinal ligament and used to patch the deficiency in the fascia transversalis.—I am, etc.,

Lewisham Hospital, March 13. G. C. DORLING, F.R.C.S.

Placenta Praevia

SIR,—In the *Journal* of March 18 (p. 586) Dr. Terence Robinson writes: "Dr. Bethel Solomons is reported to have suggested that when Caesarean section was employed the classical operation was the procedure of choice." I did not suggest. I stated definitely that from my experience I had become converted from the lower segment to the classical operation in cases of placenta praevia. The low implantation of the placenta makes the lower segment operation more difficult without achieving better results. There was no mortality from either variety of section for placenta praevia during my Mastership of the Rotunda.—I am, etc.,

Dublin, March 20. BETHEL SOLOMONS.

A Complication of Haemostasis

SIR,—The use of preparations which, following hypodermic injection, check or stop haemorrhage is increasing with their growing effectiveness. I have on several occasions used an injection of stryphnon (Homburg Pharma) with the most satisfactory results. Ten days ago I saw a patient who had in a few hours lost a great deal of blood following an abortion; she was still bleeding and in no condition for operation, and so after packing her vagina and administering an intravenous saline I gave her an injection of stryphnon. The haemorrhage seemed to stop, but the following day I decided to give her a transfusion. I summoned a donor (both were Group O), but on cross-matching found that her serum rapidly agglutinated his corpuscles; it did the same to mine (tested and shown to be Group O three times during the last ten years), to those of a colleague (grouped then and there and found to be Group O), and to those of another colleague (not grouped). So we called off the transfusion. Incidentally, I re-grouped the original donor then and there, and found him still Group O.