Ludwig's Angina

SIR,—I have had a considerable experience of Ludwig's angina and have studied the literature and case reports for many years.

Oedema of the epiglottis is frequent, but I have not seen laryngeal obstruction. Tracheotomy instruments have always been ready when operating on these cases, but I have never had to use them. I believe that the reported fatalities are due to sudden heart failure. These patients are exhausted, ill, and suffer from severe toxaemia. Danish surgeons say the injection of novocain into the masseter and internal pterygoid muscles abolishes trismus.

If the U.S.A. Davis gag is used intubation is facilitated and the anaesthetic is continued during intubation. Moreover, the direct laryngoscope can be used with the Davis gag in position. Most surgeons agree that the abscess is found in the submaxillary gland fossa deep to the gland and superficial and deep to the mylohyoid muscle. In one case sepsis around an impacted wisdom tooth produced a lateral retropharyngeal abscess. A good exposure and access to the abscess was obtained by the Davis gag. All acute retropharyngeal abscesses should be opened with the use of this gag. Ludwig's angina can be drained by a large bow incision; the wound is opened widely by retractors and the abscess is found by dissection. When the abscess is found a finger is introduced to break down loculi and a small vertical incision is made to the lowest point of the abscess. A drainage tube is inserted for 48 hours only.

All these cases and deep abscesses in the neck so treated have made an uneventful and rapid recovery. I do not consider that the removal of the submaxillary gland or incision from the mouth into the neck is desirable or necessary. Also a drainage tube passed from the mouth into the neck wound causes discomfort, impedes feeding, and is unnecessary.—I am, etc.,

London, W.1. E. D. D. DAVIS.

Enteritis in Scotland

SIR,—A current outbreak of enteritis in Scotland is rousing public interest and causing comment in the Press and elsewhere. The ailment has been loosely described as "dysentery," but neither the pathogenic germs of this nor of other enteritic diseases have been isolated. The illness is mild, causing personal inconvenience and waste of industrial time rather than serious physical disability. In the absence of positive bacteriological evidence, may I put forward a theory based on personal experience?

Our wartime diet includes a much greater amount than formerly of tinned and other preserved foods, containing chemical substances, usually sodium nitrate, sodium nitrite, boric acid, and sulphur compounds. There must be few of us who do not ingest a certain amount of these chemicals weekly. It seems reasonable to suppose that a chance arrangement and superimposing of some of these common foods may give just that amount of cumulative irritation to set up an enteritis. In addition to tinned foods, one must not forget that preservatives are present in sausages and in "mince"—i.e., the uncooked minced beef sold by butchers—both very popular items of diet in Scotland, particularly in industrial areas. On at least six occasions during the past year a sudden enteritis, affecting my own household and others, was preceded by a meal of sausages which were fresh, palatable, and highly reputable.

It is a striking testimony to the purity of our food and water supplies that in the sixth year of war we are still without an epidemic of enteric infection. I would suggest that the amount of preservatives, in our home-produced food at least, might now be safely lowered for our national convenience.—I am, etc.,

Dyce, Aberdeenshire. MARGARET S. M. MCGREGOR, M.D.

Conservative Treatment of Duodenal Ulcer

SIR,—A recent statement by a speaker at the Royal Society of Medicine that perforated duodenal ulcers rarely recover without surgery prompts me to write concerning a conservative treatment of this condition.

I noticed when operating on perforated duodenal ulcers that often one had to remove an omental plug before suturing the perforation, and that often when assisting at a subtotal gastrectomy the patient had previously had a duodenal "leak" which had healed. After making these observations I decided to attempt a conservative treatment of perforated duodenal ulcer.

My small series of patients were six men—three between the ages of 20 and 30 and three between the ages of 60 and 65. On admission the clinical diagnosis of perforated peptic ulcer was in each case confirmed by a colleague. Immediately the diagnosis was confirmed morphine 1/4 gr. was given intravenously and an intravenous drip of 5% glucose in saline begun. Next the stomach was emptied by a wide-bored stomach tube, which was then removed, and a Ryle's tube passed nasally into the stomach and left *in situ*. The stomach was aspirated every half hour for the first 24 hours, every hour for the next 24 hours, and every 3 hours for the subsequent 24 hours. During the whole time the Ryle's tube was in use frequent mouth washes were given. For the first 24 hours morphine 1/4 gr. was given every 4 hours if abdominal pain returned, but I did not find it necessary to give it after that time. The intravenous glucose-saline was continued for the whole of the first 3 days, after which the patients were put on a Sippy diet, and in no case were there any ill effects and each patient made an uninterrupted recovery.

After a month each patient was examined radiologically and in each case the presence of a duodenal ulcer was confirmed. I am very grateful to Mr. G. W. Beresford, F.R.C.S., for his permission to carry out this method of treatment.—I am, etc.,

Southlands Hospital, Shorcham. E. W. BEDFORD-TURNER.

Incidence of Peptic Ulcer

SIR,—Sir Henry Tidy's interesting article on the incidence of peptic ulcer (March 10, p. 319) has social implications. The only factor I can think of which could affect the incidence of gastric ulcer in women about 1913 is that the period in question coincided with the cessation of tight lacing.

The increase in the incidence of duodenal ulcer perforations in men at the time of the worst London "blitz" may be accounted for by the greater exhaustion on the part of men than of women. Nearly all men in London at that time were doing frequent night duty in addition to daily work. Women constantly lost sleep too, but those with children at least rested when the children rested. And men smoked more—especially at night.—I am, etc.,

Leeds. R. A. MURRAY SCOTT.

Immunization against Tetanus

SIR,—There must have occurred to many practitioners in rural areas the desirability of inoculating substantial sections of the civil population with antitetanus toxoid. I refer particularly to workers on farms and small-holdings and those connected with horses, etc. How often do patients present themselves with injuries received in the course of their occupations, sometimes contaminated with dirt to a greater or lesser degree, and the problem always has to be considered whether or not to give antitetanic serum prophylactically. It is impracticable to do so in every case, and, as recent correspondence in the *Journal* has shown, tetanus not infrequently results from insignificant injuries.

Experience during this war has demonstrated the great value of inoculation of soldiers with antitetanus toxoid, and I write to suggest that the organization which must have been set up for the production of the toxoid in sufficient quantities should be used after the war (earlier, if possible) for the benefit of susceptible sections of the civil population.

There is the interesting question whether or not inoculation should be a general practice, comparable to that adopted and urged for children in the case of diphtheria. I should be interested to learn the views of your readers on this point.—I am, etc.,

Sturry. L. J. GREEN.

Identification of Gas Cylinders

SIR,—We have read with interest the note on the "Identification of Gas Cylinders" (March 17, p. 381), and particularly the concluding sentence that accidents due to misidentification of gas cylinders are not, unfortunately, rare, and that if the anaesthetists would agree upon standard markings doubtless manufacturers would at once meet their wishes.

Unfortunately the matter is not so simple as your contributor apparently believes, since the solution of the problem involves negotiation and agreement between several interested parties in this country and over-seas; it is not dependent on the anaesthetists alone.

Steps to deal with the situation that exists have been taken already by the Council of the Medical Defence Union and the Association of Anaesthetists acting in conjunction with national manufacturers of gaseous anaesthetics and anaesthetic apparatus. At a conference of these parties it proved practicable to secure the adoption of and the assurance of the immediate application of a "short-term policy" whereby the manufacturers undertook to carry out the following improvements related to the identification of gas cylinders:

1. The effective colouring of cylinders containing gaseous anaesthetics to enable the cylinders and their contained gases to be identified unmistakably by the colour employed.
2. The labelling or stencilling of the cylinders with the appropriate name of the contents or the chemical formula.

A "long-term policy" dealing with the undermentioned aspects of the problem was prepared and submitted to a special committee established under the aegis of the British Standards Institution. This committee consists of representatives of the professional, technical, and commercial interests involved and it has a reference calling for an examination and report upon suitable measures that may be adopted for the avoidance of accidents arising from errors of identification of gas cylinders and on other cognate matters relating to the use of coloured tubing, adapters, outlets, safety valves, etc. It is eventually hoped that a common measure of agreement will be secured with regard to standard specifications on these several items of equipment that are commonly employed by anaesthetists in their work.

The "long-term policy" envisages:

1. The incorporation of safety valves in cylinders containing gaseous anaesthetics.
2. The use in hospital and private practice of non-interchangeable couplings.
3. The use in hospital and private practice of an approved colour scheme for anaesthetic tubing.
4. The regular periodic servicing and inspection of anaesthetic apparatus in hospitals by approved manufacturers.
5. The use of fixed metal tubing in place of rubber tubing on integral machines.

Manufacturers are anxious to assist in every direction possible, but emphasize the impracticability of introducing extensive and costly changes in the midst of a war when labour problems are acute and material is in short supply. International standards and specifications will also call for consideration by the committee, and it is sincerely hoped that progress will be made to obviate the confusion arising from the interchanging and use of gas cylinders of foreign origin.—We are, etc.,

JAMES FENTON,
President, Medical Defence Union.
ARCHIBALD D. MARSTON,
President, Association of Anaesthetists.

SIR,—Every practising anaesthetist will applaud your medico-legal note (March 17, p. 381), since each of us is looking forward to the time when all cylinders are distinguished not only by colour but also by size of nozzle. I believe that the Association of Anaesthetists is at this moment actively engaged in obtaining this, and their efforts are receiving the sympathetic attention of manufacturers. Accidents are not heard of because most of them terminate favourably, but if Prof. Macintosh's suggestion were adopted that all anaesthetic deaths should be reported we should learn a lot about connecting up cylinders wrongly.—I am, etc.,

London, W.1. R. ERSKINE-GRAY.

SIR,—It is to be hoped that anaesthetists and hospital authorities will give careful attention to the medico-legal problem involved under the heading "Identification of Gas Cylinders" (March 17, p. 381).

With this problem in view the anaesthetic apparatus in the new operating theatre at the South Middlesex Emergency and Fever Hospital was specially designed. Here we do not rely on any colour system (as your contemporary recommended), but employ such devices as non-interchangeable yokes and couplings, so that a tragedy such as you describe is rendered impossible. By means of an automatic alarm system employing apparatus of a type used for many years in industry, and not "Heath Robinson" devices, another prevalent cause of anaesthetic deaths—namely, unobserved failure of oxygen supply—is eliminated.

All safety devices cost money, but where human lives are at stake this is of secondary importance. Pious recommendations are of no avail, but these deaths *could* be prevented by a suitable Act of Parliament compelling manufacturers and hospital authorities to adopt certain standards of safety in design, testing, and installation.—I am, etc.,

Twickenham. NORMAN R. JAMES.

Barotrauma

SIR,—Dr. A. B. Alexander (Feb. 24, p. 276) has suggested that the aural lesion produced in certain circumstances by changes of atmospheric pressure should be described as a "tubo-tympanic pressure syndrome" on the grounds of greater accuracy. With diffidence the following reply is submitted to his criticism of "otitic barotrauma," the term used by the Royal Air Force for the last three years. The former term is more general and therefore less accurate; it could be stretched to cover the case of the aviator who has "got away with" flying with a cold and has managed to maintain sufficient ventilation through his Eustachian tubes during descent to avoid damage to his drums, although experiencing symptoms. Such a patient would not be considered to be suffering from "otitic barotrauma," but would still be classifiable under the all-embracing "tubo-tympanic pressure syndrome."

Your correspondent objects to "otitis." If we accept the definition of inflammation as the response of injured but living tissue to the initiating trauma, then there can be no objection on terminological grounds. Clinically as well the classical features of inflammation are present—viz., *dolor, tumor, rubor, atque functio laesa.* Admittedly the *calor* component is more difficult of proof, but hyperaemia is an early sign and so *calor localis* would be there for any diligent seeker.

There can be little quibbling about "barotrauma," which is a gem of a word in both derivation and description. "Barotraumatic otitis" is therefore just as accurate a term as "traumatic synovitis" and better perhaps than "industrial dermatitis." Custom has led to the use of pure Latin for describing diseases of the ear, and so by analogy the condition should be "otitis barotraumatica." Some indulgence is here requested for the well-known word-coining propensities of the members of the R.A.F., who with their American friends are intolerant of redundancy, and so the anglicized "otitic barotrauma" has been produced with the doubtful disadvantage of interchange of noun and adjective but with an economy in a couple of syllables. Terminological purists can best settle with their consciences by using the abbreviation "O.B.," which, like "C.S.O.M.," has the great merit of brevity so woefully lacking in "tubo-tympanic pressure syndrome."

In conclusion I would like to thank Wing Cmdr. J. E. G. McGibbon for drawing attention to the benefits derived from auto-inflation with the head tilted slightly backwards (*B.M.J.*, Feb. 10) in correction of my statement in an article of earlier date.—I am, etc.,

R. M. S. MATTHEWS.

Another View on the Bassini Operation

SIR,—Like Elihu, the son of Barachel the Buzite, of the kindred of Ram, my wrath has been kindled and I am constrained to speak. For years it has been the fashion to malign the Bassini type of operation for inguinal hernia. I speak from memory, but so far as I recollect, during a discussion on inguinal hernia some years ago, Prof. Grey Turner was the only one who had a kind word to say in favour of this operation. As far back as 1927, when the Association of Surgeons met in Glasgow under the presidency of the late Prof. Archibald Young, I gave figures concerning 80 cases of inguinal hernia treated in Prof. Young's wards. Most of these had undergone an operation of the Bassini type. Prof. Young