Medical Auxiliaries

In a reference to the Cope Committee on Auxiliary Services, Sir Henry Cohen said that there had been some resentment at the phrase "medical auxiliaries," and if it was used to imply a subordinate, an underling, a slave, to whom was assigned the drudgery and menial tasks of medical and surgical practice it was not difficult to understand the hurt. But chiropodists had achieved their professional status by accepting a course of training which gave them special knowledge and skills, and banded themselves together as a corporate body with 4,000 members and 500 students in training. The work of this body had been fully justified by the conclusions of the Cope Committee's report. But he reminded them that a profession had responsibilities as well as privileges. "You must always give of your best; you must not sacrifice yourselves to the worship of Mammon; you must maintain the highest ethical standards of practice; you must remain perpetual students of your subject so that those who entrust themselves to your care may feel confidence in your knowledge, your wisdom, your judgment, and your skill."

Lord AMULREE followed with an address in which he spoke of the medical care of the aged. He stressed the importance of keeping old people so far as possible mobile. The report on this subject by Dr. J. H. Sheldon in Wolverhampton had stated that 40% of the old people visited in the course of the inquiry were found to be suffering from foot trouble; these disorders were specially common among the women. A large number of old people, said Lord Amulree, would obviously benefit from chiropody services, and the absence of such skilled treatment was responsible for immobilizing them to a very great extent. A regular service of chiropody would relieve the hospitals of a considerable burden. He also mentioned the desirability of encouraging shoe manufacturers to issue a much greater variety of shapes and sizes. There would be far less need for chiropody if better-fitting shoes were available.

The programme of the Convention, over which Mr. JOHN H. HANBY presided, included visits to Guy's Hospital Annexe, Orpington, to see operations on orthopaedic cases, and to the Hospital for Sick Children, Great Ormond Street, to see operative and post-operative treatment for children. Mr. T. T. STAMM lectured to the members on the indications for, and the technique of, some orthopaedic operations, and other lectures were given by fellows and members of the society on various chiropodial techniques.

Preparations and Appliances

AN AID TO STARTING AND MAINTAINING DIFFICULT TRANSFUSIONS

Dr. C. A. McC. AITKEN, of Wembley, Middlesex, writes: For difficult transfusions I have found the following modification extremely useful and time-saving and quite as simple as the usual technique.

The needle with adaptor of the transfusion set is put aside and instead a fresh needle is used, attached through a small adaptor and tap to a 5-ml. syringe (preferably with

eccentric nozzle) half-full of normal saline. The needle should be of as wide a bore as possible. The 18 S.W.G. needle 1 to 1½ in. (2.5 to 3.75 cm.) long is of the same bore as the usual transfusion needle (1.25 mm.) and is obtainable from instrument manufacturers. Otherwise the 20 S.W.G. ordinary serum needle (bore 0.9 mm.) of the same length is quite useful, especially if the veins are small, though the tendency for slow running and stopping is greater.

This combination forms an efficient seeker for difficult veins, suction being applied to the syringe till blood flows. A small volume of saline is then forced through the needle to prevent clotting there. With the tap closed the syringe is replaced by the giving end of the transfusion set and the blood allowed to flow.

The syringe is kept in a sterile bowl and is always available for subsequent washing out of the needle, should this become blocked. The combination also greatly facilitates reinsertion of the needle into the vein. The process of restarting a transfusion is thereby greatly simplified and can be completed in a few minutes without any fresh equipment.

Reports of Societies

CONGENITAL PYLORIC STENOSIS

The Section of Paediatrics of the Royal Society of Medicine met on April 27 to discuss the "Treatment of Infantile Hypertrophic Pyloric Stenosis." Although the General Surgeons' and the General Practitioners' Sections had also been invited it was easy to spot the paediatricians. They were, on the whole, kindly-looking men; the younger ones (the Bloomsbury Set in the main) had the worried air of men who think largely in terms of electrolyte balances, and when they were seated one could see that they had not yet acquired the *savoir-faire* of their elder colleagues, who are ready to jump at the first sign of hydrostatic activity on the part of the baby. The meeting was very well attended, in part because it was 10 years since the subject had last been discussed, but also no doubt because the audience looked forward to a renewal of the controversy between physicians and surgeons. This, indeed, followed the expected lines, each side carrying its banner, in its own opinion, to victory, while a few cowardly onlookers preferred to have a foot in each camp.

Dr. KENNETH H. TALLERMAN briefly introduced the matter and then betook himself from the presidential chair to the rostrum as the first opener. He explained that until 1944 he had believed in the surgical treatment of this condition, but had then weaned himself successfully from such an impious belief. While admitting that in the last 15 years or so the surgical mortality had fallen from around 15% to 1 or 2% in expert hands, he was of the opinion that up and down the country it was most probably in the region of 15%. He was sure that medical treatment could do better than this. He accepted that the mortality of surgical treatment depended a great deal on whether the infant was breast-fed or artificially fed. (He quoted Levi's figures of no deaths in 100 breast-fed infants but a mortality of 11% in 46 artificially fed infants.) Since 1945 all his own cases had initially been treated with atropine methonitrate ("eumydrin"). He used a 0.6% alcoholic solution, and he stressed that the dosage must be adequate (15 to 25 drops per day). (This shocked Mr. Denis Browne into referring to babies "tottering on a heavy dose of a dangerous drug.") If after 72 hours vomiting persisted or the child failed to gain weight, he advised surgery. Of his own 67 cases in the last five years, 41 had had purely medical treatment and 26 had required operation. Since it was in any case highly advisable to spend two or three days in the preoperative preparation of a baby, by means of gastric lavage, the modification of its feeding regime and in administering subcutaneous saline, why, he asked, did not the surgeons allow the child the benefits of eumydrin during this period?

The Surgeon's Point of View

Mr. DENIS J. BROWNE accepted the president's challenge to fire a heavy barrage at the physicians. Commenting on Dr. Tallerman's assertion that the surgical mortality was