Hallux Valgus and Rigidus

Sir,—Mr. W. J. Eastwood (October 17th, p. 784) is mistaken. I do appreciate hemiphalangectomy. I was introduced to it by Sir Robert Jones and Mr. McMurray at cockcrow one morning in Liverpool. Receiving it from the best possible authority I used it with confidence and a careful choice of case for ten or more years. It gave good results—indeed, the best results that I had hitherto been able to obtain ; but where metatarsalgia had previously been present it offered no relief, and in some cases, previously free, metatarsalgia subsequently developed. For these reasons I tried to devise an operation which would set the joint free in a similar way, but with the virtue of helping rather than the vice of diminishing the intermetatarsal control. I worked out the new operation in December, 1934, and we for convenience termed it the " 1935 model," but I am perfectly ready to sponsor it.

I am sorry I gave Mr. Eastwood the impression that I " stretched " the adductor structures. I put them into tension exactly as a transplanted tendon is sutured under tension. The after-treatment gives them protection until they are capable of carrying on.

I hope Mr. Eastwood will await a full description of the operation (to appear shortly in the *Journal of Bone and Joint Surgery*), and not condemn it without giving it a fair hearing, or, better, a fair trial.—I am, etc.,

Oxford, Oct. 23rd. G. R. Girdlestone.

Plastic Operations for Hydronephrosis

Sir,—Sir John Thomson-Walker reproves me for basing my article upon foreign literature instead of British textbooks. Nearly everything that has been written upon the reduction of hydronephrotic sacs in British textbooks comes from Sir John's own accomplished pen. The theme of my article was that at the present time major plastic procedures are very rarely employed in Britain, and when I did the work upon this subject the 1913 edition of Sir John's well-known *Genito-Urinary Surgery* alone was available. It was this fact, and other careful inquiries, that compelled me to refer to the work of those foreign surgeons who were perfecting the technique of these conservative measures.

A striking testimony to the truth of my theme was that at a well-attended meeting of the Urological Section of the Royal Society of Medicine last year, where I showed some cases, the only other surgeon present who had embarked on these operations was the president, Mr. Ogier Ward.—I am, etc.,

London, W.1, Oct. 25th. Hamilton Bailey.

Treatment of Spondylolisthesis

Sir,—A paper on " Spondylolisthesis: With a Description of a New Method of Operative Treatment and Notes of Ten Cases," by Mr. Walter Mercer, has appeared in a recent number of the *Edinburgh Medical Journal* (1936, xliii, 545). In this letter I am concerned only with the new operation that he has described.

In brief, it consists in placing blocks of bone (taken from the ilium) into a broad slot cut in the L5 – S1 disk and the adjoining vertebral surfaces—a most attractive operation. It is, however, a little disappointing to find that of the cases operated on only two were dealt with by this method. The illustrations depict the operation as performed at the usual level—that is, L5 – S1. Mr. Mercer tells us that he has never actually done this: in his two cases the luxation was between L4 and L5. (In the case notes it is stated that in these two cases, 9 and 10, the *x*-ray film showed displacement of the fourth lumbar body on the sacrum—a serious misprint.) The author *assumes* that his operation could be performed with equal ease at the usual level, though surely it would be almost impossible if the forward luxation of L5 were at all marked.

Mr. Mercer advises the use of two blocks of bone from the ilium, which are to be " screwed into place to ensure their retention. If they are not screwed in it has been found that when the patient is lifted off the table the lumbo-sacral angle may be opened up and the wedges of bone spring out." How does Mr. Mercer know this, seeing that he has not yet operated at the lumbo-sacral joint? If a comparable accident happened in one of his L4 – L5 cases, why is there no mention of it in the notes? If it happened in a case operated on by a colleague, this should have been mentioned.

Here is a new, and perhaps valuable, operation ; but no dates are given in the case notes and no pre-operative or post-operative *x*-ray films shown. It is a pity, too, that one patient died, " and for this the trauma of the operation must be blamed "—a high mortality rate in an operation for such a benign condition.

If this operation had been described only in a medical journal these criticisms would not have been made public. But it appears in the new second edition of Mr. Mercer's textbook, with no indication of the insecurity of the foundations of the operation—not even a reference to the full paper to be published subsequently. This is a serious lapse in a textbook that is now well known and should stand above all else for sound teaching. Surely one is entitled to expect a little less of the fond parent in the author of such a work.—I am, etc.,

Stanmore, Middlesex, Oct. 21st. H. J. Seddon.

Care of the Sea-sick

Sir,—One admits that any active bits of machinery are doing something in the machine, but on reading Dr. John Hill's paper on sea-sickness, in the *Journal* of October 24th, one is struck by the unimportance singly of all but visceral sensations. Optical illusions of rise and fall can be corrected by the horizon ; *mal de mer* is not a vertigo severe enough to cause vomiting ; novel muscle sense experience but alters our stride along the deck. The essential sensations that distress are the feelings of undue abdominal lift and of vanishing abdominal support.

The nerve energies aroused, which culminate in sea-sickness, can be augmented to that point mainly by emotion or mainly by direct sense impressions, or equally by both combined. In an established case of *mal de mer* we can also conceive of equally raised vagus and sympathetic activity, or of unequal activity of these on a partnership basis of the more of one the less of the other.

Examining what the patient does, one finds that the most obvious and most neglected prodromal symptom is a natural holding-in of the abdominal wall and diaphragm against the lurch of the ship. The most important preventive step for the traveller to take is to learn to cease this emotional and irrational self-guarding. His abdominal contents won't fall out. Within fairly wide limits of weather this trick is sufficient alone to prevent sea-sickness. The dog conditioned to salivate at the sound of the bell soon ceases to do so if food never arrives, and the " sea-dog " will tend to cease to " bring up " his food, in part because the apparent risk to his anatomy continues never to materialize. Relaxation might not prevent simple regurgitation, say, while leaning over a wash-basin during a lurch of the ship, but nausea and malaise are absent.

A single lesson in relaxation before sailing will produce the desired result. Augmentation of undesirable neurone energy is cut down in two ways: the relaxation of abdominal roof and wall minimizes sense impressions from, and circulatory disturbance in, the abdomen, and anxiety is diminished by the increased intellectual discrimination and by the sense of power to use a credible and provable means of diminishing discomfort. The same prescription applies to the discomfort of foetal kicks in late pregnancy, to vomiting in the first stage of labour, and to car-sickness. —I am, etc.,

Ilford, Oct. 25th. W. Thomson Brown, M.B., Ch.B.

Avitaminosis

Sir,—We note that Dr. E. J. Wright, in an article in the *Journal* of October 10th (p. 707), states that " no note of a vitamin A concentrate being used " was made in the paper by us to which he refers. That is so, but in point of fact we treated seven cases in the stage of subacute combined degeneration of the cord, three of which also showed the epithelial lesions of the early stages of the disease, with 2 oz. of cod-liver oil daily for seventeen days followed by injections of 2 c.cm. of radiostoleum daily for a further week. There was no appreciable improvement in any of the signs or symptoms, epithelial or other. Radiostoleum was the vitamin A concentrate recommended by Dr. Wright in a previous paper.

Dr. Wright also states that we made no allowance in a certain experiment for storage of vitamin A in the body. If he will refer again to our paper he will see we found that a sample sixty of the cases of the epithelial disease became quite well on the addition of marmite and of no special source of vitamin A to the diet, so we saw no reason for theorizing about the storage of vitamin A in the body.

We have little doubt, however, that Dr. Wright is often dealing in Sierra Leone with a " polyavitaminosis " ; nor have we disputed this.—We are, etc.,

J. V. Landor.
R. A. Pallister.

London, S.W., Oct. 19th.

Blood Groups and Paternity

Sir,—As the one who carried out the blood-grouping tests in the case of disputed paternity referred to by Dr. John C. Thomas in the *Journal* of October 24th (p. 844), I am glad to have the opportunity of publicly expressing my disappointment at the fact that the requisite sera for testing for M and N types are not readily obtainable in London. When I found that both mother and child in the case in question belonged to group A, while the putative father belonged to group O, I decided to test for the M and N factors. I discovered that the only laboratory in London that had fresh sera for these tests was the Galton Laboratory at University College, but they refused to part with them for medico-legal purposes. I was referred by that laboratory to the pathological laboratory of St. Mary's Hospital, but I was informed by the latter that they had no fresh sera in stock, and that it would take some days to get such sera. As the appeal at the Hertfordshire Quarter Session was about to be heard before such sera would be ready the test had perforce to be abandoned.

Perhaps this letter would stimulate some of the more important laboratories to keep these sera in stock.—I am, etc.,

London, W.1, Oct. 26th. W. M. Feldman.

Typhoid Fever Carriers

Sir,—Dr. W. G. Aitchison-Robertson (*British Medical Journal*, October 10th, p. 739) mentions the disgust of " some of our Eastern friends " at the " filthy habits of our people " who do not wash hands or anus after a visit to stool. In a paper in a health journal ten years ago I wrote:

" One lesson we might learn from the Indians: they are surprised at the lack of cleanliness among Europeans, who use nothing but dry paper to cleanse themselves after a visit to stool. Many years ago (in 1900) an Indian doctor told me this, and since that time I have always provided myself with a piece of well-wetted paper for use on these occasions. I strongly recommend this simple reform."

A few days after the appearance of this article a visitor called to show me a rough paper-wetter he had devised for use in w.c.'s. Together we worked out the details, and we evolved a simple and practical device to be fixed to the wall and to take the standard toilet roll. The paper is drawn over a roller that wets it (except the edges). If a dry piece is desired the paper is raised so that it escapes contact with the roller.

The inventor interviewed a number of firms that should have been interested—stores, makers of toilet rolls, etc.—but he was unable to induce any firm to take it up. Since that time (1927) I have had this paper-wetter in use ; I should be sorry to be without it, but I am bound to admit that it has aroused practically no interest ; persons using the w.c.'s in which it is installed seem to avoid using it as a paper-wetter ; they prefer dry paper! The most hopeful way of introducing cleanly habits would be to teach young children, but any special apparatus would probably prove unsuitable for schools because the children would be sure to " play monkey tricks " with it. I am, however, strongly in favour of an educational drive, and I suggest it might be introduced as a part of the newly announced movement for physical training. —I am, etc.,

London, W.1, Oct. 20th. A. C. Jordan.

Sanatorium Treatment in England

Sir,—Dr. Gurney Champion's letter (October 10th, p. 740) was doubtless intended to correct a mistake, and to call attention to the services of Dr. Jane Walker, without any intention of belittling the good work of Dr. Bardswell, who already had a distinguished sanatorium record when appointed at Midhurst.

Although originally a British notion, first advocated (1747) in Scotland (Bulstrode, Report of the Medical Officer to the Local Government Board, 1908, p. 119), and first carried out by Bodington near Birmingham soon after 1840, the modern inspiration for sanatorium treatment came from Dr. Otto Walther of Nordrach Colonie, and from the rival school of Brehmer and Dettweiler. Dr. Jane Walker and Dr. F. W. Burton-Fanning deserve credit for their experimental sanatoria at Downham Market in 1892 and at Cromer in 1895 respectively, of which the former has resulted in the East Anglian Sanatorium with its satellites, the latter in the Mundesley and Kelling sanatoria.

Most of the sanatoria for the middle classes were more or less founded after Walther's ideas. He had far less to do with the " working class " sanatoria, as he did not believe in cure from a few months' sanatorium treatment. Several of the early British sanatoria for the middle classes were founded by his patients or assistants, including Nordrach upon Mendip (Dr. Thurnam, 1899), Linford (Drs. Mander Smyth and Felkin, 1899, *not* 1897), Pendyffryn Hall (Dr. Morton Wilson, 1900), the Vale of Clwyd Sanatorium (Drs. Crace-Calvert and Fish, 1901),