

syringe with a size 20 needle. Before the surgeon is permitted to start, even if the patient has not received the whole of the contents of the syringe, another syringe is taken, this time a 20-c.cm. for preference with a thicker needle. A Luer-Lok two-inch needle, size 18, is suitable. The needle can be inserted into the same vein as that already used, and the syringe is then secured to the forearm by a piece of "elastoplast" and the patient's wrist is bandaged to the table in case he lightens and tries to bend up his elbow. It is a great advantage to use, if at all possible, a vein an inch or two distal to the bend of the elbow, as the needle is then less easily dislodged and the syringe can be more readily strapped to the forearm in the correct position. When the syringe is empty it can be removed from the needle without dislodging the latter, especially if a long needle is used. If the arm is very slightly tilted upwards so that the antecubital fossa is a little above the level of the heart the tendency for blood to flow back into the syringe will be obviated, and the needle will normally remain full of pentothal and so be less likely to become blocked.

The method I have described can be combined with inhalation anaesthesia very easily if desired, and most of the time the anaesthetist can be sitting in his usual position at the head of the table. It takes only a moment to change the syringes. The patient is spared unnecessary discomfort if a small needle is used at first, but the use of a really large needle afterwards prevents blocking of the needle and spares the anaesthetist the necessity for using elaborate apparatus to prevent it from blocking.

Surely it is time that anaesthetists diverted their energy into more original and profitable channels and carried out the simple process of giving continuous pentothal in the simple manner that is so readily available to all who are prepared to put a needle into a vein and then inject pentothal down it, as and when necessary, with nothing more ingenious than one (or two) syringes.—I am, etc.,

J. D. LAYCOCK,
Major, R.A.M.C.; Anaesthetic Specialist.

Blind Intubation

SIR,—I have just seen Mr. Hamilton Bailey's plea (Sept. 29, p. 440) for block anaesthesia in dealing with cases of Ludwig's angina. I think it worth while to mention the method of blind intubation in the conscious patient, the tube being passed after the nose has been sprayed with cocaine, further cocaineization of the pharynx and larynx being achieved via the tube itself. Once the tube is in place, the operation can be performed under gas-and-oxygen anaesthesia, and the tube left *in situ* until the patient is again fully conscious. With this method there is no anxiety about the airway, and it can be performed by anyone with a knowledge of the technique of blind intubation.—I am, etc.,

JOHN L. INSLEY.

Anaesthesia in Threatened Obstruction of Air Passage

SIR,—I have read with interest Mr. Hamilton Bailey's letter (Sept. 29, p. 440) on the question of the administration of gas-oxygen anaesthesia in cases of acute inflammation threatening obstruction to the air passage. Although I have had very little experience of cases of Ludwig's angina I have treated, on numerous occasions, acute inflammatory swellings round the pharynx, deep pharynx, and larynx, which have required surgical intervention. There is a certain amount of risk of obstruction arising even if only local anaesthesia or regional block anaesthesia is employed. If before administering gas-oxygen anaesthesia an airway is passed between the teeth, or a small wedge of rubber such as dentists use placed between the molar teeth, it will always be possible to direct a laryngeal inspection tube. It is not usually possible to insert a mouth airway owing to trismus or faucial inflammation, but it is always possible to put something in to keep the teeth from getting into contact. This form of treatment is, of course, conditional on the fact that the anaesthetist is fully acquainted with laryngeal and tracheal intubation.

The chief reason for my bringing up this question again is to draw attention to the fact that in my opinion all specialist anaesthetists should be thoroughly trained in direct laryngoscopy and bronchoscopy during operation within and around

the air passage. I always feel much happier if I know that in an emergency I can call for an endoscopy set to be brought to me in a few seconds (suction should, of course, always be available). I cannot help thinking that many anaesthetic fatalities could have been avoided in the past, even where the operation for which the anaesthetic was given had no direct relation to respiration. The technique of laryngoscopy and bronchoscopy, especially the former, is not very difficult to learn.—I am, etc.,

London, W.1.

D. F. A. NEILSON.

Diiodo-hydroxyquinoline in Lamblia

SIR,—The detailed report of Air Cmdre. T. C. St. C. Morton (June 16, p. 831) points to the successful use of diodoquin in cases of amoebic dysentery, particularly recommending this principle in view of its many advantages. The author points out that diodoquin has no effect on lamblia, and I should like in this connexion to refer to two cases which were treated successfully, and which are worth while mentioning as they did not tolerate atabrin—i.e., the lamblia resisted atabrin.

Case 1.—A geologist, 38 years old, suffered from diarrhoea. On examination it was found that it was caused by lamblia; he was treated with the usual method of 3×0.1 g. atabrin for five days. The attacks of diarrhoea became numerically less, but did not cease completely, and examination of the stool 10 days after completion of the atabrin cure again showed free lamblia and lamblia cysts in an abundant quantity. Diiodo-hydroxyquinoline was therefore prescribed in a dosage of 5 tablets a day for 10 days. The remarkable result was that the diarrhoea stopped within two days, and a stool examination immediately upon completion of the treatment yielded negative results. The patient has been free of complaints for more than a year now, and a recent examination of the stool did not show any lamblia.

Case 2.—A woman teacher, aged 25, who frequently suffered from spastic attacks in the right upper quadrant of the abdomen, was operated on, as x-ray examination showed the presence of gall-stones. The attacks were thus eliminated, but periodical diarrhoea set in, which did not react to the usual therapy. An examination of the duodenal juice showed free lamblia. A test with the usual atabrin cure could not be made, as atabrin was not on the market at that time. Diiodo-hydroxyquinoline, as in Case 1, 5 tablets a day for 10 days, was therefore prescribed, with striking results, for the subjective complaints as well as the lamblia ceased to exist.

I suggest that the success of the lamblia treatment may depend on the quantity of diiodo-hydroxyquinoline administered. It has, in any case, been astonishing how promptly the desired effect set in in the two cases mentioned above.—I am, etc.,

Jerusalem.

L. SCHINDEL.

Perspex in Orthopaedics

SIR,—The article on perspex in orthopaedics (Sept. 29, p. 423) is interesting, but I should like to suggest that the authors have taken great pains to produce a plastic shell which is not as satisfactory as the plaster-of-Paris shell they use as a model. The authors list many advantages of perspex but fail to utilize them, the most important presumably being the waterproof nature of perspex, a property which can be given to plaster by means of varnish or a local waterproof shield. The other advantages are not utilized. Nobody can say the method of blowing the shell is quick or easy; the permeability to light is destroyed by the fact that condensation makes an absorbent lining essential to prevent the skin becoming sodden; and a non-ambulatory patient will not worry about the saving in weight.

I draw attention to this matter as I hope the use of perspex and allied plastic material will not be discredited by its employment in unsuitable cases. We must use the advantages to the full and avoid using this new material just because it is new and intriguing. Perspex scores on the following important points: (1) Lightness; (2) permeability to x rays; (3) local alterations by moulding are allowed throughout the course of treatment. In spite of what Scales and Herschell say, moulding is not easy and is a waste of time and material for short-term cases. To conclude, perspex is at present a useful expedient in many cases while a suitable "spread-on" type of plastic is being developed. It is not a universal replacement for plaster-of-Paris and should be employed only where its advantages are

utilized, such as in the splinting of peripheral nerve palsy and the fractured burnt extremity.

Regarding the processing of perspex, I gave a few hints in the *Lancet* of June 26, 1943 (p. 803), and *Journal* of Feb. 12, 1944 (p. 236).—I am, etc..

A. MACGOWAN.

Experiences of a Medical Prisoner of War

SIR,—As I was one of the British M.O.s at Torun for 3½ years, may I be permitted to offer a postscript to Dr. B. Markowski's interesting article (Sept. 15, p. 361).

When British doctors were allowed to go to Stalag XXA in 1940, all the sick who had been treated by the Polish M.O.s until then were unanimous in praise of the devotion and skill with which they had been helped. Everything possible was done for the sick, despite desperate lack of drugs, instruments, and sick accommodation. After those grim early days conditions improved very much. Fort XIV remained a hospital, but most of the patients were moved into huts at ground level, and continuous pressure on the German authorities produced other improvements.

With regard to the treatment of Russians, Dr. Markowski's article hardly does justice to the atrocious conditions under which they died. His estimate of an 80% mortality is probably true. I know that in the one month of November, 1941, out of one fort of 1,200 Russians, 270 died. The fort had been overcrowded a few months before, with only 300 British prisoners! When I arrived at Torun the diphtheria epidemic had run its course and two wards full of paralyses were left. All these showed eventual complete recovery.

Apart from very early days, starvation was not seen among British P.O.W.s in this area, except those who had been confined in the notorious military prison at Graudenz. An interesting point about the latter was that men who had been there for three months were in a much worse condition than those who had served sentences of several years. The long-term prisoners appeared to become adjusted to the insufficient ration. Unfortunately complete notes on about 100 of these cases were removed during a search and not returned; evidence of this character was never popular in Germany. Differential treatment of P.O.W.s was marked. The treatment of "Badoglio Italians" in 1943 was almost as bad as that meted out to the Red Army in 1941.

Among common diseases in a minor way various septic skin conditions took a high place. This we thought to be due to dietary deficiency. In view of the fact that a very similar high proportion of "I.A.T." is found in German P.O.W.s in this country, however, on a vastly different and well-balanced diet, one is led to think that a lack of immunity to local micro-organisms may be a more potent factor in the aetiology.—I am, etc.,

Aveley, Essex.

JOHN KENNEDY.

Medical Views of Nurses' Training

SIR,—The Liverpool Hospitals Staffs Association consists of the honorary medical staffs of the nine Liverpool teaching hospitals. The following resolution was passed at a general meeting this week, and it is hoped that you will have space to publish it:

"This Association express their deep concern with the increasing trend towards demanding of nurses too detailed a theoretical and scientific knowledge, to the discouragement of practical craftsmanship. The members of this Association believe that the qualifying standard for registration should be based very largely on practical experience and vocational training. For all higher and specialized forms of nursing, a further and more scientific type of training should be demanded."

—I am, etc.,

Liverpool.

A. KIRK WILSON.

Women in Labour

SIR,—Reading Dr. Kathleen Vaughan's letter (Sept. 29, p. 443) recalled to my mind, first, that some years ago the same observations on the maternal squatting position were reported in one of the medical journals, but whether by Dr. Vaughan or not I cannot now remember. Secondly, six years ago I was urgently summoned to a confinement case—a young married

woman who lived alone with her crippled mother. When I entered the bedroom I was surprised to find the bed empty, but on the far side I discerned the patient naively squatting on the chamber-pot in which she had given birth to a premature baby which weighed 3 lb. and is a healthy girl to-day. The only point about all this is that if it proves anything it is that this rather simple girl, ignorant of the usual procedure and left entirely to her own instincts and resources, had adopted what is most probably the natural position for labour.

Finally my contribution, as a general practitioner of 25 years' standing (though not all spent in general practice), to those correspondents on domiciliary midwifery is, let me attend all my cases in hospital, whether they be normal or abnormal, rich or poor.—I am, etc.,

Keighley.

WRIGHT LAMBERT.

SIR,—In the *Journal* of June 30 (p. 925) there appears a letter from a Mr. Eric Coldrey which interested me greatly. For many years I have practised the induction of labour for the purpose of limiting the size of the child to the easy capacity of the mother. I have delivered several post-Caesarean cases without any difficulty, and a considerable number of cases with very small pelves where I had to induce at 5½ to 6 lb.

I have preached this "small baby" idea at every opportunity but have made few converts because, like Mr. Coldrey, all are afraid of using rupture of the membranes as part of the induction (and the most essential part). Rupture of the membranes is a certain and safe method of induction providing it is not done blindly. It should be done at the level of the internal os with the tip of the index finger in contact with the end of the instrument used, whether a curved long artery forceps or one of the specially made puncturing catheters. I have used this method of induction in many hundreds of cases and am convinced of its absolute safety. I use it in conjunction with the medicinal treatment mentioned by Mr. Coldrey.—I am, etc.,

M. SCHWARTZ.

B.W.I.

Chief Medical Officer, Trinidad Leaseholds Ltd.

Telling the Patient

SIR,—During a recent short visit to England I have had forcibly brought to my notice a matter which has often troubled me in the past because of its fundamental importance in the treatment of ill people. In my capacity as medical specialist I have been attached to a military hospital with a large outpatient department for a period of six weeks while awaiting my ship. What impressed me most while I worked in the outpatient department was not the obviously careful and detailed examinations and investigations lavished upon the patients by their unit doctor and by specialists (for most of the men had seen several specialists), but the fact that in only a small proportion did the patients possess accurate information regarding their particular illnesses. Most of them were quite uninformed about diagnosis, prognosis, and treatment, and when questioned would quickly show that they had their own ideas—quite inaccurate—based upon a few words picked up from their doctor or orderly.

As an example of this I can remember a man of 20 who had weakness and wasting of muscles of one leg due to anterior poliomyelitis contracted at the age of 12 years. He had an unsuitable job in the Army involving excessive use of the leg, and, in consequence, he had some discomfort. He was first seen by a medical specialist, who correctly made the diagnosis of "old poliomyelitis" and referred him to an orthopaedic surgeon. He later decided that no orthopaedic treatment was necessary. The patient, misinterpreting what he had overheard, decided that his condition had gone beyond the stage when treatment was worth while and, naturally enough, became extremely worried, both as regards his future in the Army and his future as a wage-earner. A five-minute interview in which the exact state of affairs was explained to him in simple language completely relieved his anxiety.

I encountered exactly the same difficulty in an E.M.S. hospital during the first three years of the war. The young medical men working there were keen to reach an accurate diagnosis and to apply the correct treatment as soon as possible. Many of them, however, failed to appreciate the importance of the few moments necessary to explain to the patient the points about