effect of the glycol. Posterior intercostal nerve blocks should not be made within 3 in. (7.5 cm.) of the midline, so as to avoid any possibility of tracking along the nerves towards the cord.

Like Mr. Oldham, I have encountered uncomfortable neurological sequelae following axillary intercostal nerve blocks for upper abdominal operations, but in only five of the 46 patients followed up; three complained of anaesthesia persisting for more than eight weeks (one for four months), one of localized paraesthesia for about eight weeks, and one of intense hyperaesthesia from the thirteenth to the fifteenth day as the analgesia wore off. At the same time, this particular series demonstrated that bilateral intercostal nerve block could ensure a virtually painless wound in 83% of patients, so that fewer narcotic injections were required and early movement and expectoration both made easier for the patient. The dosage did not exceed 2 ml. per nerve, and 1.5 ml. was found to be adequate. It is to be hoped that improvements in the analgesic agents will enable the method to be developed with even fewer side-effects, but in the meantime the deposition of strongly hypertonic preparations near the spinal cord should be avoided.—I am, etc.,

London, N.2. HENRI ROUALLE.

Treatment of Plummer-Vinson Dysphagia

SIR,—The opinion of Drs. J. A. W. Bingham and J. S. Logan (*Journal*, September 19, p. 650) that no quantity of iron will ever correct the dysphagia of the Plummer–Vinson syndrome is not in agreement with my own small experience.

The reason for the changes in the tongue, mouth, pharynx, and oesophagus is that the epithelium of the upper alimentary tract is sensitive to iron deficiency, which impairs the constant replacement of cells which is normally taking place. Therefore, unless these atrophic changes in the pharynx and oesophagus have developed too far, they should, like the changes in the tongue, be corrected by the administration of iron.

I have recently followed up the progress of six patients who had attended hospital with hypochromic anaemia and dysphagia during the last five years. One patient had died from carcinoma of the pharynx, and one patient still had both anaemia and dysphagia; but the dysphagia had been relieved in two out of the four patients in whom the anaemia had been corrected.—I am, etc.,

Liverpool, 5. JOHN W. B. FORSHAW.

SIR,—In the *Journal* of September 19 (p. 650) one read with interest the article on the nature and treatment of Plummer–Vinson dysphagia, by Mr. J. A. W. Bingham and Dr. J. S. Logan. I hope they will forgive me for drawing their attention to the fact that it is incorrect to call this syndrome by the name of "Plummer–Vinson."

I would refer them to a letter written by the late Sir Arthur Hurst.[1] He mentioned that it was he himself who coined the heading of "Plummer–Vinson syndrome" in 1925, and he acknowledged his mistake. He admitted that he had neglected to refer to what had been written by Drs. D. R. Paterson and Brown Kelly in 1919. They described the syndrome as a clinical type of dysphagia associated with mucosal changes and anaemia. It was Paterson, too, who was the first to mention that post-cricoid carcinoma was far too frequent a complication to be a mere coincidence. It is worth remembering also that Vinson first described the dysphagia as hysterical.

Do not let us neglect the contributions of those who have practised the art of medicine in this old country of ours. Paterson, not long before he died, wished the syndrome to be called that of "upper dysphagia," but I prefer to hear of it as the "Paterson–Brown Kelly syndrome."—I am, etc.,

Cardiff. R. D. OWEN.

REFERENCE

1 *British Medical Journal*, 1939, 1, 1201.

Penicillin Cover for Dental Extractions

SIR,—I was interested to read the letter by Dr. F. R. Coffin (*Journal*, September 5, p. 571) regarding penicillin cover for dental extractions.

Though positive bacterial cultures may be obtained from the blood of apparently healthy persons there is an increase of positive cultures (to 34%) after multiple tooth extractions in patients with no obvious gum disease, and to 75% from patients with severe gum infection.[1 2] These organisms almost certainly come from the gingival sulcus around the teeth and are driven into the blood stream by the movements of the tooth during extraction.

The number of organisms in the gingival sulcus may be unaffected by systemic penicillin, and is only effectively reduced by cauterizing the sulcus immediately before the extraction of the teeth.[3] It would seem, therefore, that enough penicillin should be given pre-operatively only in order to produce a bacteriostatic concentration in the blood and that this concentration should be maintained during the time of operation and for 24 hours post-operatively, by which time all bacterial blood cultures are negative.

A further "booster" dose of soluble penicillin may be given one hour pre-operatively. The penicillin cover does not have to be extended over a long period of time provided that the dosage is adequate and regular.—I am, etc.,

London, N.W.1. J. MCL. SINGLETON.

REFERENCES

1 Okell, C. C., and Elliott, S. D. (1935). *Lancet*, **2**, 869.
2 Elliott, S. D. (1939). *Proc. roy. Soc. Med.*, **32**, 747.
3 Fish, E. W., and Maclean, I. (1936). *Brit. dent. J.*, **61**, 336.

Paraplegia in Paget's Disease of Bone

SIR,—In this unit we have had an example of paraplegia complicating Paget's disease of bone, and a brief reference to it may help to complete the picture of this complication so well painted by Mr. R. G. Robinson (*Journal*, September 5, p. 542) and add another case to the 44 published ones to which he refers.

In November, 1939, an engineer, aged 61, with osteitis deformans of the skull, spine, and most of the skeleton, complained of stiffness and weakness of his legs. From time to time, when he was in bed, involuntary withdrawal movements of the legs occurred. He had a prominent dorsal kyphosis, spastic paraplegia in extension with patellar and ankle clonus, extensor plantar reflexes, and loss of appreciation of light touch over the lower abdomen and legs. Cisternal myelography showed spinal block at the level of the seventh thoracic vertebral body, and on December 5, 1939, laminectomy was performed. The bone was particularly vascular and compressed the dural tube, which was decompressed but not opened. He recovered from his paraplegia, returned to work, at which, because of the war, he continued for $3\frac{1}{2}$ years beyond the normal retiring age, and for 11 years following his operation remained well and was able to get about. Three years ago there was a recurrence of paraparesis and partial spinal block was demonstrated. With rest in bed the condition improved, but mental deterioration occurred, and he died with senile dementia in April of this year, aged 75.—I am, etc.,

Cardiff. LAMBERT ROGERS.

Primary Ovarian Pregnancy

SIR,—In the *Journal* of September 19 (p. 677) there is an interesting appreciation of the late Dr. G. P. Anning in which the writer mentions that in 1900 Anning reported a case of primary ovarian pregnancy published in the *Transactions of the Obstetrical Society of London* which "is believed to be the first reference to this unusual condition to be published."

I well remember this incident of long ago. The case was published under the names of Anning and Littlewood—Anning being the general practitioner in the case and Little-