

brisk. There was marked and sustained bilateral ankle clonus but no patellar clonus. The abdominal reflexes were present, and the plantar responses were down-going. Co-ordination and sensation were unimpaired. There was no change in the C.V.S. The chest was clear and he was hyperpnoeic. The abdomen was normal, the throat dry but not inflamed, and there was no pyrexia. The serum salicylate level was 33.3 mg./100 ml. Paynocol dosage was cut to 1½ tablets (=15 gr. (1 g.) aspirin) 2-hourly, with some improvement; but next day there appeared to be definite slight increase of tone in both legs, right more than left, and the ankle clonus was definitely sustained on the right side only. Plantar responses were down-going; abdominal and cremasteric reflexes present; arm jerks less brisk than formerly. His back was still stiff and the erectores spinae tender over a wide area. X-rays of lumbar and lower dorsal spine were normal and there was no meningism. Serum salicylates were reported as 44 mg./100 ml. Salicylates were then stopped. Although there was no evidence of haemorrhage and a prothrombin time was not available, it was thought advisable to give vitamin K.

The cause of the apparent early paraplegia was obscure, and in view of the original and persisting lower back symptoms and signs he was transferred to a neurosurgical unit for further investigations, including lumbar puncture, which were all negative. Further medical investigations were: three blood cultures, negative; Hb, W.B.C., M.S.U., X-ray chest and thoracic spine all normal. Gradual improvement continued, and subsequently "disprin" (20 gr. (1.3 g.)) four times a day was reintroduced. E.S.R. on May 18 was 3 mm. in one hour. On May 22 he returned to the original hospital, looking well, and with no abnormal signs in the C.N.S. or locomotor system. The signs in the C.V.S. were unchanged, except that now there was also a rough rumbling diastolic murmur with presystolic accentuation in the mitral area. This murmur could not be heard ten days later, but a faint blowing early diastolic murmur persisted at the left sternal edge, and his pulse was collapsing. He was discharged on June 15, when examination of the C.N.S. revealed no abnormality.

While there is no proof that the neurological state described was due to salicylate intoxication, on the evidence presented (high dosage, high serum salicylate level, reversibility when salicylates withdrawn) this seems the likeliest cause. That idiosyncrasy to salicylates was not responsible is indicated by the tolerance of 80 gr. (5.3 g.) daily when the drug was subsequently reintroduced. At the time a differential diagnosis of disseminated sclerosis was considered, and indeed this cannot be ruled out, but there is less evidence in its favour. A recent inquiry into the patient's health revealed that he has had no further trouble.—I am, etc.,

Weceton, Lancs.

D. E. HYAMS.

#### REFERENCE

- <sup>1</sup> Coburn, A. F., *Bull. Johns Hopk. Hosp.*, 1943, 73, 435.

#### Psychopaths

SIR,—Your correspondent Dr. G. C. F. Roe (*Journal*, November 9, p. 1112) has been misinformed concerning the findings of the Royal Commission. It was not recommended that all grades of amentia should be called psychopaths. It was suggested that idiots, imbeciles, and low-grade feeble-minded patients should be called "severely subnormal," and that patients now known as high-grade feeble-minded should in future be called psychopaths. He states further that the intellectual attainments of idiots and imbeciles are nil, but in fact they extend from 10% to 50% of the average figure of the population. In the case of high-grade aments the intellectual attainment, far from being extremely poor, is in fact only a little below the normal range. I am prepared, however, to concede that not all feeble-minded patients are psychopaths.—I am, etc.,

Driffield, E. Yorks.

J. NEWCOMBE.

#### Femoral Hernia

SIR,—I have used the suprapubic extraperitoneal approach for femoral hernia 81 times, and agree with Mr. Robin Burkitt (*Journal*, November 16, p. 1176) that it is an excellent approach for both uncomplicated and strangulated hernias. Recurrences are extremely rare, and it is unnecessary to do any sort of repair if the peritoneum is well removed. I have had three incisional hernias. These have all occurred in extremely debilitated and chesty patients

with strangulation, but the resulting bulge is almost uncontrollable by any form of apparatus and requires reoperation. This is a serious defect of the operation.

I doubt whether this operation can be attributed to Professor A. K. Henry. Many surgeons had described operations on femoral hernia by the abdominal route, but these were usually transperitoneal. The first description I can trace was by Lawson Tait in 1883.<sup>1</sup> Various surgeons have independently described the extraperitoneal route. The first description was by Sir Lenthal Cheate in 1920.<sup>2</sup> His paper was a model of brevity, consisting of 50 lines and about 460 words. He had used the method for various sorts of hernia, but only mentioned one case of femoral hernia. No follow-up was given. Savini<sup>3</sup> described the operation in 1921 and stated that it was a modification of the operation of G. Ruggi described in 1893. La Roque<sup>4</sup> wrote a paper in 1922 in which he described 12 cases with some follow-up, but he also opened the peritoneum. Henry's description<sup>5</sup> appeared in 1936. He made a very large incision, which few surgeons nowadays would advocate. He described a repair but thought it might be superfluous. He described one case which was bilateral, but gave no follow-up. I therefore think that if we are to designate operations by eponyms the priority here must go to that great scholar and surgeon, Cheate. It would appear that Cheate's paper went unnoticed. No doubt Professor Henry's great reputation as a surgeon-anatomist led to people taking more notice of his paper when it appeared.—I am, etc.,

Hull.

J. CLAPHAM COATES.

#### REFERENCES

- <sup>1</sup> Tait, L., *Brit. med. J.*, 1883, 2, 1118.  
<sup>2</sup> Cheate, G. L., *ibid.*, 1920, 2, 68.  
<sup>3</sup> Savini, C., *N.Y. med. J.*, 1921, 114, 451.  
<sup>4</sup> LaRoque, G. P., *Ann. Surg.*, 1922, 75, 110.  
<sup>5</sup> Henry, A. K., *Lancet*, 1936, 1, 531.

#### The Misnamed Stethoscope

SIR,—Dr. R. P. W. Kup writes (*Journal*, November 16, p. 1178) expressing doubts about electrocardiogram as the word for the end product of electrocardiography, and asks someone to elucidate. As one of the older generation who, until the moment of entering Cambridge, was brought up entirely on Latin and Greek—a circumstance for which, after recovery from initial shocks, I remain devoutly thankful—I will try to do as he requests. Electrocardiogram for the finished product is quite correct, for the Greek word *gramma* (γράμμα) is concrete, meaning the thing written or inscribed, while *graph(e)* (γραφή) means writing in the abstract or the art of writing. Electrocardiograph for the machine producing electrocardiograms is rather less correct, but we must not be too pedantic, and, as it is already compounded of three Greek words, "electrocardiograph" as an abbreviation for "electrocardiographic machine" is not the worst we have and is unlikely to have caused the batting of any eyelids among those of our masters who arrange these things to their delight. To incorporate the Greek *graptee* (γραπτήρ), a writer, or *grapheus* (γραφεὺς), an inscriber, would give an impossibly ugly result, and if we did do so someone would at once write and say that both words are masculine while a machine must be neuter. An electrograph is at least derivatively feminine, which entitles it to be uncertain and coy.

In the world of radiology we have suffered even more. I remember at a meeting a long time ago someone protested at the use of "radiograph" for the finished x-ray film, someone reminded him that the more correct "radiogram" had already been appropriated for a machine for making noises. He had to sit down and we have suffered ever since. "Skiagram," the inscription of a shadow, is both apt and correct, but has never been popular, presumably owing to its ugliness.—I am, etc.,

Bedford.

H. B. PADWICK.

SIR,—Dr. R. P. W. Kup's question (*Journal*, November 16, p. 1178) betrays once again the sadly felt absence of a classical education which these days, apparently, only very few aspiring medical men go through. The "graph" of

course, is the machine because it does the writing (γράφω, I write), and the "gram" is what it writes (τὸ γράμμα, the letter).—I am, etc.,

Sheffield, 3.

H. GRUNDMANN.

### Mongolism in a Twin

SIR,—Dr. J. V. Morris in his interesting article on mongolism in a twin (*Journal*, November 2, p. 1038) states that only 14 cases have been reported in the British literature since 1876, and he describes an additional case. He quotes Morris and MacGillivray<sup>1</sup> as saying that mongolism in one of twins is not so rare in British literature as had been suggested.

Dr. J. S. Happel, of Alresford, has kindly reminded me of twins born at home and transferred to the Royal Hampshire County Hospital, Winchester, on April 3, 1957. The second twin, a male, was clearly a mongol, markedly jaundiced, cyanosed, and breathless due to a pronounced heart defect, having bilateral cataracts, and weighing 3 lb. 15 oz. (1.8 kg.). He did surprisingly well, and at 5 months weighed 11 lb. 4 oz. (5.1 kg.), when he contracted an upper respiratory infection and died within a few days. The other twin was also a male and weighed 6 lb. 11 oz. (3 kg.) at birth. He is quite normal and now thriving and well. There were two placentas. The mother was aged 36, and was delivered of a normal child in 1954 and again in 1955. She had a miscarriage in 1956. No history of twinning in her own family or in her husband's family can be traced.

Drs. Nicholson and Keay<sup>2</sup> state that among dizygous pairs the great majority are discordant for mongolism, and they go on to report mongolism in both monozygous twins of opposite sex which they describe as unique in the literature.—I am, etc.,

Winchester.

GEORGE ORMISTON.

#### REFERENCES

- 1 Morris, J. V., and MacGillivray, R. C., *J. ment. Sci.*, 1953, 99, 557.
- 2 Nicholson, D. N., and Keay, A. J., *Arch. Dis. Childh.*, 1957, 32, 325.

### Cyanosis in Infancy

SIR,—Besides the causes mentioned in your annotation (*Journal*, November 2, p. 1045), cyanosis in infancy may be due to methaemoglobinaemia. This can be caused by feeds made up with water containing nitrates,<sup>1</sup> but the greatest number of cases reported in this country were due to the absorption of aniline from an ink used to mark the babies' napkins.<sup>2</sup> All those affected recovered, but in an American outbreak<sup>3</sup> 4 out of 17 died. The early recognition of cyanosis from this cause is therefore important, so that the source of the intoxication may be removed and treatment with ascorbic acid or methylene blue given if necessary.—I am, etc.,

Oxford.

K. W. LOVEL.

#### REFERENCES

- 1 Ewing, M. C., and Mayon-White, R. M., *Lancet*, 1951, 1, 931.
- 2 Howarth, B. E., *Lancet*, 1951, 1, 934.
- 3 Graubarth, J., Bloom, C. J., Coleman, F. C., Solomon, H. N., *J. Amer. med. Ass.*, 1945, 128, 1155.

### Splenectomy in Felty's Syndrome

SIR,—Drs. J. N. Blau and A. Willcox's advocacy of splenectomy in Felty's syndrome (*Journal*, November 9, p. 1094) prompts me to record an additional case.

Early in 1952 I was consulted by Dr. Meerapfel, of Sutton, about a woman of 56 who had had rheumatoid arthritis for 24 years. For the last two years a series of ulcers in her throat had caused a severe dysphagia. These additional symptoms had led her doctor to examine her blood, which had on each occasion showed a striking neutropenia. Her spleen was considerably enlarged, and, at my suggestion, she was admitted to hospital for splenectomy. This was performed on February 13, 1952, and was followed by an immediate and dramatic rise in the polymorph count, as follows:

Feb. 11.	Total W.B.C.	500	per	c.mm.,	polymorphs	5%
Feb. 13.	"	(pre-op.) 750	"	"	"	5%
	"	(post-op.) 4,600	"	"	"	77%
Feb. 14.	"	8,200	"	"	"	78%

After the operation the ulcers healed and did not recur. The rheumatoid arthritis was, of course, unaffected, but the advantage gained by splenectomy was, as your contributors say, impressive.—I am, etc.,

London, N.W.1.

C. P. PETCH.

### Conglutination of External Os

SIR,—I have recently had a most interesting obstetric experience, the like of which I had never seen before.

A young primigravida went into labour one morning two weeks before her expected date. Her pains were very slight, causing her very little inconvenience; when I examined her in the evening, I obtained the impression that the os was two fingers dilated. The following morning, after a night of slight pains, I examined her again, but this time could not make out the degree of dilatation. I asked Dr. J. M. McBride to see her, and, after examining her, he decided that the examination should be repeated under an anaesthetic and in good light. A self-retaining speculum was introduced, and we were surprised to see that there was no os at all, but merely a pin-hole opening through which blood could be seen oozing. At this stage the thought of caesarean section loomed very large, but Dr. McBride proceeded to enlarge the small opening until the head could be seen with the membranes intact. The patient was then left to come out of the anaesthetic in the hope that the artificial os would dilate. Nine hours later she delivered herself spontaneously of a 7 lb. (3 kg.) infant with very little trouble. Unfortunately, the delivery of the placenta was followed by a brisk haemorrhage, necessitating transfusion, but everything went well, and mother and child were able to go home on the ninth day, none the worse for the experience. Pelvic examination six weeks after delivery revealed, to my surprise, a completely normal cervix, with no evidence of laceration, and a perfectly normal parous os.

Having never encountered this anomaly before, I reviewed the textbooks and literature, and from my survey I feel satisfied that my case was one of atresia of the cervix or conglutination of the external orifice. Most textbooks give a description of this condition, but no figures as to its relative frequency, although Chassar Moir<sup>1</sup> states that "it is not so uncommon as compared with atresia of the internal os." In spite of this, my review has revealed only one reference to conglutination of the external os. This was in a report by G. F. Melody<sup>2</sup> in a paper entitled "The Obstructed Uterine Cervix." The following paragraph is reproduced verbatim.

In this rather unusual obstetrical complication the presenting part is well engaged in the pelvis, the cervix thin and effaced, and tightly stretched over the presenting part, and the os fails to dilate beyond a pin-point opening, the margins of which are rigid and sharp. This condition is more common in primiparas than in multiparas, but has been known to recur in succeeding pregnancies. The stenotic external os usually very promptly opens in response to digital insinuation; rarely Dührssen's multiple incisions are required.

I should be most interested to hear of similar cases, and to find out if this condition is as uncommon as the paucity of references in the literature would make one believe. I am very grateful to Dr. McBride for his skilful handling of the situation, and to Sister Camilus, of the St. Francis Nursing Home, for her calm efficiency in the emergency which followed the delivery of the placenta.—I am, etc.,

Glasgow, S.4.

M. SLUGLETT.

#### REFERENCES

- 1 Moir, J. C., *Munro Kerr's Operative Obstetrics*, 1956, 6th ed., p. 379.
- 2 Melody, G. F., *Surg. Gynec. Obstet.*, 1949, 88, 50.

### "Butcher's Thigh"

SIR,—As a result of a case of accidental stabbing of the thigh by a thin-bladed butcher's knife, which fortunately passed by the major vessels, our attention has been drawn to two similar accidents in young persons which were fatal before any surgical aid could be obtained. Questioning of the senior butchers in shops where these fatalities occurred, and in fact all the other butchers we have met in the last year, reveals a complete lack of knowledge of this injury and the first-aid measures which are necessary to prevent exsanguination. In fact a butchers' organization has been