times immediately and sometimes from days to years after the injury. It is difficult to find a case where extension has returned to the terminal joint. Some of these have had the appropriate plaster-of-Paris fixation, others have had operation, and one an arthrodesis. Others have had no treatment whatever, continuing at work, and the impression has been that the best result is in the latter class. All have had jobs where the residual dropping has not been likely to interfere with their skill to any appreciable extent, and the impression is that those who have carried on work, and where there has been no effort to correct the deformity, have quickly accommodated themselves to it.

Some idea may be reached of the economic factor from these two cases. A man was under treatment for one year for this condition in the little finger and lost some three months from work during this time. A woman injured at work on July 6, 1948, is still away from work—five months of treatment by plaster and operation. Incidentally, although a part-time worker averaging 35s. a week, she receives 45s. a week for an industrial injury, not because she is malingering but, it is suggested, as a result of over-enthusiastic treatment. These cases, by virtue of the form of the plastic fixation, are difficult to accommodate in work while under treatment.

While it is realized that this letter gives impressions and not statistics, it may be that it will stimulate discussion and inquiry into treatment given without thought to financial disability, and possibly without knowledge of the probable ultimate function. It would be desirable to carry out a planned investigation of this problem.—I am, etc.,

Birmingham. W. J. LLOYD.

Pre-suppurative Amoebic Hepatitis

SIR,—Dr. James T. Harold in his letter (Dec. 11, p. 1034) states that no recent record exists of an amoebic liver abscess in a patient who has never left this country. He (and others) may be interested to hear of a case in the Queen Elizabeth Hospital, Birmingham, at the present time. The patient had a large subphrenic abscess which was opened and drained. He gave a history of a fortnight's diarrhoea; proctoscopy led to the discovery of ulcerations of the rectum. A portion of ulcerated epithelium was removed and upon examination proved to contain cysts of *Entamoeba histolytica*. The patient has never been out of the country in his life, and for the last ten years has never even been out of Worcestershire, except to come to this hospital.

I owe my thanks to Mr. A. L. D'Abreu, whose patient he is, for allowing me to write this letter.

—I am, etc.,

Birmingham. FRANCIS LOWE.

Curare in the Treatment of Tetanus

SIR,—In view of the current interest in the treatment of tetanus with curare compounds the following brief case report may be of value.

A patient, a boy of 9, was admitted to hospital after a three days' history of trismus, with painful muscular spasms for twelve hours. On examination he showed marked trismus and a considerable degree of rigidity of the spine, especially marked in the cervical and upper thoracic region. Muscular tone was raised generally, and reflexes were brisk. Examination of the child was sufficient to provoke an attack of muscle spasm with typical "risus sardonicus" and acute pain in the cervical region.

Tetanus antitoxin (24,000 i.u. diluted with 10 ml. of pyrogen-free water) was administered intravenously at once and a further 30,000 i.u. given intramuscularly. The patient had been given 3,000 i.u. before admission to hospital without ill-effect, so chances of anaphylactic shock were considered negligible. At the same time sedative treatment was instituted by giving soluble phenobarbitone, gr. 1½ (0.1 g.) six-hourly, and 0.05 mg. *d*-tubocurarine chloride also six-hourly.

The following day the dose of 30,000 i.u. of antitoxin was repeated intramuscularly. The patient had had no further spasm and was able to swallow semi-solids without difficulty. Treatment with curare and soluble phenobarbitone was continued, and after three days the time interval between doses was lengthened until at the end of seven days the drugs were being given twelve-hourly. Treatment was then discontinued. Apart from a slight restriction of jaw movement the child felt well and was discharged one week later.

This case shows two points of interest. (1) The dose of curare compound used was so small that there was no danger of interfering with respiration, yet it was sufficient to abolish spasm in a fairly advanced case. (2) There was no obvious mode of entry found. The child's arms and legs showed a few healed scratches only, and no other wound was found. From this point of view it is interesting to note that a farm horse at the child's home contracted tetanus a year ago and was cured with tetanus antitoxin, suggesting a heavy implantation of the child's environment with the bacillus.—I am, etc.,

Barrow-in-Furness. ANNE L. BARLOW.

Anaesthesia in Ludwig's Angina

SIR,—The danger of intravenous anaesthesia for incision of acute inflammatory swellings of the neck has long been recognized, yet only recently a case was described to me which very nearly ended tragically.

A resident, called upon to give the anaesthetic to a case of Ludwig's angina, consulted the latest edition of a standard surgical textbook and found that intravenous anaesthesia was recommended as the method of choice. Accordingly he administered "pentothal." Breathing at once became obstructed and extreme cyanosis developed. The surgeon proceeded to perform tracheotomy, but after he had made the skin incision the anaesthetist managed to persuade an endotracheal tube past the obstruction into the trachea. This patient made a complete recovery, though only after twenty-four hours of delirium. Before operation, I am told, there was visible oedema in the floor of the mouth, and in this and in similar cases one might expect some oedema to be present in the pharyngeal wall and in the glottis without necessarily causing any symptoms of respiratory obstruction prior to anaesthesia.

The sequence of events in these cases would appear to start with laryngeal spasm. Pentothal is known to increase the laryngeal reflex, and the presence of oedema in the nearby tissues probably provides the exciting factor. Asphyxia resulting from this spasmodic occlusion of the larynx gives rise to venous engorgement of the head and neck, which increases the oedema and finally results in complete obstruction. Obstruction will still be complete even when the spasm of the larynx passes off, as it invariably does before death. It follows, therefore, that in the absence of tracheotomy or intubation the patient must die.

Anaesthesia for these cases must be non-irritating and not liable to give rise to laryngospasm. Cyclopropane or chloroform given with plenty of oxygen are the agents which best fulfil these requirements. It is scarcely necessary to add that instruments for tracheotomy should be ready in every case of this nature. It seems deplorable and very hard on young residents, not to mention patients, that such misguided advice should be perpetuated in recent editions of reputable surgical works.—I am, etc.,

Sutton, Surrey. JOHN H. WILLIS.

The M'Naghten Rules

SIR,—Dr. Henry Yellowlees (Dec. 11, 1948, p. 1034) has written without fear of offence, and I am sure that he will permit me to do the same. He has produced the usual stock arguments, for which I am most grateful since it allows me to show their flimsiness. It is surprising, for instance, to see the old one, so beloved of the cheap press, regarding "Law from Harley Street." Whether Dr. Yellowlees likes it or not, the law is dependent on medical opinion. First, the accused may be unfit to plead. How is that decided? On a doctor's opinion. Secondly, even if condemned to death, there is a proviso in the Criminal Lunatics Act, 1884 (Section 2, subsection IV), by which two or more legally qualified practitioners can be asked to examine the prisoner and inquire as to his insanity. So the law does come from Harley Street.

I am sorry that Dr. Yellowlees would hesitate to certify a patient who "stated that his father had been insane and that he himself had impulses to murder children." I am certain that no judge in chambers would allow an action for malpraxis against me if I certified a man for such impulses, and no commissioner in lunacy would dare to question such a certificate. The reasons for certification are that the patient is (1) dangerous to himself or others, or (2) in need of care and treatment. Most patients in need of treatment will go voluntarily to hospital, so in general patients are certified because they are dangerous.

This does not mean that they are dangerous all the time, but have brief impulses, potentially homicidal or suicidal, etc. *What is more contradictory than that a patient should be certifiable because he is dangerous and yet we should regard him as responsible if he kills anyone?* How a competent lawyer or psychiatrist can accept such a proposition is beyond my comprehension.

I am sure that Dr. Yellowlees has a wide legal acquaintance, but what a pity he never knew Lord Bramwell, who stated, "Nobody is hardly ever really mad enough to be within the definition of madness laid down by the judges' answers"; or Lord Chief Justice Coleridge, who said, "The judicial decisions on questions of insanity were bound by an old authority which, by the light of modern science, was altogether unsound and wrong." The young barristers I meet express uneasiness and dislike of the rules.

Dr. Yellowlees accuses me of expressing "a travesty of the facts." Well, let them speak for themselves. I cannot burden your columns with long lists of disputed cases, but to examine two recent ones: First, a young man whose father has been psychotic and who himself was always odd enters a hospital ward and removes a child he has never previously seen. He smashes it to death against a wall. Is this insane act regarded as a sign of mental disease and the man sent to Broadmoor? No, the M'Naghten rules are invoked and he is hanged. The other case is of a young man who has been an obvious psychopath since puberty. He has been in Borstal and thrice lost commissions in the Services. He is sexually abnormal—a sadist and handkerchief fetishist. He flogs a woman to death with a riding quirt. Then he cuts a girl to pieces. These senseless crimes are not regarded as signs of insanity, and the man is not sent to a criminal mental hospital. No, the M'Naghten rules are produced and he is hanged. If these men were sane, then my criterion of sanity is all awry.

May I state that I am not trying to interfere with the expert's duty to assist the court, but to persuade politicians to alter the law to something sensible, logical, and in accordance with modern psychiatry, when I suggest that legal and medical insanity should be regarded as identical? May I offer the hope that both Dr. Yellowlees and I shall live to see this accomplished?—I am, etc.,

London, W.1. CLIFFORD ALLEN.

Femoral Hernia

SIR,—I should like to express my agreement with Mr. Andrew G. Butters (Oct. 23, 1948, p. 743) in his advocacy of the low operation for femoral hernia, though one should always be prepared to use the high (Annandale) approach in the exceptional case. Thorough freeing of the neck of the sac, as he stresses, is very important to secure adequate reduction.

I think the best technique to use is that described long ago by Macewen,[1] who used a puckering stitch to transform the sac into a pad to block the upper end of the canal. Instead of the single strand he used I prefer to run a catgut suture up one side of the sac across the neck and down the other side. When this has been done the sac with its adherent fat is reduced into the abdomen, and with one finger blocking the femoral canal each end of the suture is pulled tight so that the sac is formed into a pad, and the ends of the stitch tied. A pull on the catgut will tell in the majority of cases that the canal is safely closed, in which case, when a local anaesthetic has been used, the patient may safely walk out of the theatre.

I am less inclined to agree with Mr. Butters's view that because a femoral hernia usually makes its appearance at the age of 50 years or later the majority of femoral sacs are acquired.

Some years ago I had charge of a woman of about 50 years of age who was admitted with a mass in the right iliac fossa and a recently acquired, rather tense right femoral hernia. The former was regarded as an appendix abscess and expectant treatment decided on. After about a week she became anxious to go home, but it was considered that the femoral hernia at least was a danger, and it was explored. At operation a thin sac was found to be filled with blood-stained fluid. The neck of the sac was so narrow that some persuasion was required to introduce a probe-ended dissector into the abdomen, and when this was done blood-stained fluid trickled from the abdomen. Laparotomy then revealed similar fluid in the abdomen and a fixed growth apparently arising from the right ovary. Such a sac could hardly have been acquired, and it is easy to imagine a congenital sac with a narrow neck remaining dormant till, with advancing years, loss of supporting fat in the femoral region allows a tongue of omentum to slip down and produce a hernia.

Incidentally, it may be mentioned here that a useful retractor for the suture or transfixion of the neck of funicular sacs may be devised from the common or kitchen four-pronged fork, the ends of the two medial prongs being bent away from the midline of the instrument to prevent their being entangled in the tissues. The instrument is slipped over the sac, and the assistant uses one hand to press it firmly against the abdomen while his other hand pulls the sac firmly forward. The abdominal contents are kept from entering the sac and the surrounding tissues clear of the surgeon's needle.—I am, etc.,

Birmingham. J. W. RIDDOCH.

REFERENCE

[1] *British Medical Journal*, 1887, **2**, 1263.

Nephritis in Textile Workers

SIR,—Dr. G. Herdan (Dec. 18, 1948, p. 1083) makes some statistical criticisms of my article on this subject (Nov. 15, 1947, p. 771), but I cannot agree with his conclusions. In the first place he suggests that my series of personal cases is not a representative sample of the population because it does not show deaths from nephritis or from malignant hypertension in the older age groups. Evidently Dr. Herdan is not very familiar with renal disease or he would know that both conditions are extremely rare over the age of 50. I do not remember ever seeing a case of malignant essential hypertension over the age of 60. Benign essential hypertension does not occur in my table because it does not cause death from renal disease. It is largely for these reasons that I am so certain that the Registrar-General's deaths from so-called nephritis are mostly not renal deaths at all.

I cannot agree either with Dr. Herdan's second point that deaths from nephritis in textile workers should be compared with deaths in the whole population rather than with deaths in social classes III and IV, from which textile workers are drawn. Surely if there were any increased incidence of nephritis due to occupation rather than social circumstances my comparison is the only one by which this could be shown?

Finally, I do not wish my statistical analysis to be taken as proving anything, as I clearly said in my conclusions. The whole paper was merely written to expose what is still the greatest fallacy of all statistical argument—namely, the facile assumption that the data from which the statistics have been compiled are sound.

The question of renal disease in textile workers is now being investigated in the field by Professor Lane's department, and I have no doubt we shall have the answer shortly.—I am, etc.,

Manchester. ROBERT PLATT.

Treatment of Simple Ganglion

SIR,—The present teaching on the subject of simple ganglia is inadequate, for in many cases a wrong diagnosis is made—e.g., fibroma, neuroma, osteoma, chondroma, bursa, and even sarcoma. In a few cases seen diagnostic *x* rays have been taken and, in some, unfavourable prognoses had been given. The condition is common in factory workers, steel workers, miners, etc., and there can be little doubt that heavy work and strain are aetiological factors.

The treatments usually advised in surgical textbooks are: (1) Do nothing in the hope of spontaneous disappearance. This is unsatisfactory, for if a patient comes to a doctor with a swelling he expects something to be done about it. (2) Hitting the swelling with a hard object such as a book. This is clumsy and possibly dangerous. In many cases—e.g., in the palm of the hand—it is often impracticable. This treatment should cease to find a place in modern textbooks. (3) Aspiration and injection of a sclerosing fluid. This is painful, disabling, and often unsuccessful. It is not to be advised. (4) Incision with a tenotome and expression of the contents. (5) Excision of the swelling. This is a major surgical procedure, necessitating a general anaesthetic, most careful asepsis, and subsequent rest. It