dangerous slow dissection with unsafe ligatures and stitches is tending to replace the swift and safe guillotine, which certainly needs a knack to handle it properly.

The usual type of Heath, Sluder, or Ballenger instrument has a business-end too bulky to turn easily in the mouth, and therefore I have had my set of three sizes ground down to shorten the oral ends by from 5 to 7 mm. off the rear shoulders of both the blade and grooved-recessed shafts, so that the knack is more easily acquired and performed.

Having captured the tonsil by pushing on the anterior pillar so that a dimple appears, while closing slowly the blunt blade deep to the capsule, and with the tonsil hooked towards the surgeon, the tonsil is then shoved down towards the larynx, sliding it off its bed—the final wrench is supplied by snapping off the lower tail of the tonsil over the index finger, which has done the pushing-through. Then the La Force adenotome is used with semi-blunt blade, and the Eustachian adenoid strips are cleared with semi-blunt small curette. Finally inspect with forehead lamp through the opened blades of a Collins pile-clamp, which (very seldom) is needed to snap off a tag or two. All this is done with the patient's head hanging over the well-shaped and padded end of the table, and then the patient is instantly turned prone and cold-sponged over the face and awakened to cry and get rid of blood-tinged mucus.

With Sir William Hill at St. Mary's Hospital in 1913–14 we tried many methods and abandoned in turn snare, dissection, sharp guillotine, and a double blade Elphick crushing guillotine: all had either immediate or reactionary bleeding to follow. In over 15,000 cases since then I have never had a report of bleeding by using my method, with only 5 ml. of ethyl chloride by closed-bag anaesthesia.—I am, etc.,

Bishop's Stortford, Herts. R. A. R. Wallace.

Temporal Arteritis

Sir,—We must heed Dr. B. T. Horton's remarks from America about this treacherous disease (8 January, p. 105). It is certain, as he suspects, that there are also hundreds of older people in England who have been blinded by cranial arteritis.

I reported[1] an annual incidence of seven per million of bilateral blindness of sudden onset due to vascular disease in patients over the age of 55 years who lived in the county of Middlesex. Though retrospective diagnosis was not possible in all these patients many had been blinded by temporal arteritis. Possibly upwards of 350 elderly people are so blinded every year in Great Britain, while in a similar number the sight of but one eye may be lost. If appropriate therapy using corticotrophin or steroids is commenced within a few hours of the onset of blindness the chance of recovery of some vision is great. No improvement, however, can be expected without this treatment.—I am, etc.,

Gerald Parsons-Smith.
Charing Cross Hospital, London W.C.2.

Reference
1 Parsons-Smith, B. G., *Brit. J. Ophthal.*, 1959, **43**, 204.

Pyelonephritis in Childhood

Sir,—Recent surveys reported in your columns, such as that of Smellie and associates,[1] have shown that the greatest incidence of urinary infection in childhood involves the very young, and that chronic atrophic pyelonephritis with its potential for progressive renal destruction is a disease largely originating in young children.[2] When serious renal damage occurs in a child with urinary infection it is usually found to be present at the first examination, and seldom develops under the physician's eyes.[3] What are the factors that encourage such early advance of disease in a minority of those stricken? We know that vesico-ureteric reflux is a regular accompaniment of this severe type of disease,[4] but in older children this anomaly may be borne without inflicting renal damage, and even sometimes without accompanying pyelonephritis.[3]

Two special characteristics of very young children may be important, though seldom mentioned in discussion of the subject; these are nocturnal voiding and recumbency. In the horizontal position reflux will surely exert more forcible effects upon the kidney than when upright, and infected urine entering the pelvis of a recumbent kidney will not be subject to gravity that otherwise would assist its return to the bladder. More important in that majority of children whose reflux occurs mainly on voiding is the effect of repeated micturition in bed, again facilitating the upward surge of infected material, and contributing to its prolonged contact with renal tissue in dependent calices.

Learning to walk and gaining control of the bladder by night would both seem to be important stages in freeing the kidneys from the worst effects of contact with infected bladder contents. These developmental stages are normally not completed until the third year of life. How important are these factors in the genesis of destructive renal disease at this time, and only at this time? An imperfect but possibly not irrelevant analogy is provided by oesophageal hiatus hernia, where the severe complication of ulceration leading on to stricture never begins after the child's recumbent life is over.—I am, etc.,

Warwick Hospital, Warwick. M. E. MacGregor.

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1 Smellie, J. M., Hodson, C. J., Edwards, D., and Normand, I. C. S., *Brit. med. J.*, 1964, **2**, 1222.
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3 Persky, L., *J. Urol. (Baltimore)*, 1965, **94**, 20.
4 Williams, D. I., and Eckstein, H. B., *Brit. J. Urol.*, 1965, **37**, 13.
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Respiratory Syncytial Virus Infection in Childhood

Sir,—In their paper on epidemic bronchiolitis in the *B.M.J.* (8 January, p. 83) Dr. C. M. B. Field and his colleagues state that we have reported[1] that in respiratory syncytial (R.S.) virus infection the virus isolation rate is low and that there is no serological response to infection in about half the cases. This is a misreading of our paper, as we reported the isolation rate and serological response to R.S. virus *not* in R.S. virus infections but in a series of various acute respiratory illnesses of children admitted to hospital during an epidemic of bronchiolitis. A high proportion of our series of 42 children showed laboratory evidence of R.S. virus infection. Thus, of paired sera from the total 42, 20 (47%) showed rising titres of complement-fixing antibody to R.S. virus. Throat swabs from 29 of the children yielded R.S. virus in 8 (28%) cases; seven of these eight also had rising antibody titres.—We are, etc.,

Constance A. C. Ross.
E. J. Stott.
Regional Virus Laboratory, Ruchill Hospital, Glasgow N.W.

Reference
1 Ross, C. A. C., Stott, E. J., McMichael, S., and Crowther, I. A., *Arch. ges. Virusforsch.*, 1964, **14**, 553.

Resuscitation of the Apparently Dead

Sir,—The following case makes me wonder how long one should really persist in one's efforts to revive the apparently dead.

Yesterday I was called by a midwife to a confinement. On arrival I found the baby, weight 5½ lb. (2.4 kg.), born and seemingly dead—bluish-grey in colour, flaccid musculature, chest-cage collapsed, no heart beats or respiratory sounds. The midwife had been trying artificial respiration and also aspiration via a catheter for over 10 minutes.

Without thinking I did cardiac massage through the abdominal wall, and at first mouth-to-mouth breathing followed after a time by artificial respiration by direct compression of the chest cage, while the midwife did direct breathing into the infant's lungs via an endotracheal catheter. After about 20 minutes we were just about to give up when we noticed a slight change in the facial colour, and so continued for another 15 minutes, by which time the heart had recommenced to beat, followed by respiration and a little later the infant cried.

When fully crying and breathing normally the infant was placed in an oxygen cot and transferred to hospital.

I told the parents to thank God for the miracle, but the thought that occurred to me was that if on arrival I had accepted what was obvious death I would have had my first stillbirth in 30 years of domiciliary midwifery.

So I ask when is a human being dead?—I am, etc.,

London E.8. J. Zeitlin.

Diagnosis of Hysteria

Sir,—The recent articles and correspondence on hysteria depicting the entity and usefulness of the concept have on the whole taken a fairly limited range of meaning for the word. Unfortunately, this word or the word hysterical are used in many different ways, and this should be recognized.

(1) The word is used to describe a symptom which may be in the physical or psychiatric sphere, and the essential feature of the symptom is that it results in the "primary gain," which is the loss of anxiety. The man with the paralysed arm no longer has to face the anxiety-provoking situation in battle or at work. Because of his loss of anxiety the patient may show *belle indifférence*. The presence of this symptom or a number of them may constitute the hysterical illness, and, given sufficient stress, this type of illness may occur in any type of personality.

(2) The use of hysterical symptoms (at an unconscious level) to obtain further benefits