testing the corneal reflex and thereby destroying the corneal epithelium. There is a third cause, in which the anaesthetic is merely a contributory factor. It is this. We know that, normally, the eye is protected from infection by the secretion of tears. Under general anaesthesia there is not only diminished secretion but separation of the lids. Should this occur in a patient suffering from chronic dacryocystitis it is inevitable that the conjunctiva will be reinfected from the chronic focus, and that an acute conjunctivitis will result. Obviously, under all circumstances, the eye should be protected from undue drying.

The object of this letter is not to labour points already fully appreciated by professional anaesthetists, but to suggest that the prime function of works on anaesthesia is the instruction of students, and not the provision of books of reference for competent anaesthetists. This being so, it is to be deprecated that there should be a conspiracy of silence in regard to a preventable condition involving so much post-anaesthetic suffering.—I am, etc.,

Birmingham, Oct. 16th. L. T. Clarke.

Dental Deformities

Sir,—While not denying that thumb sucking or any persistent pressure may produce dental deformities, I desire to say that the cases illustrated in the *British Medical Journal* of October 12th (p. 670) appear to me much more likely to be caused by congenital syphilis. If my view is correct rhagades will be found if looked for. The angles of the mouth will show " vaccination " scars, and the edges of the lips will show areas where the red margin has been dermised into white skin.—I am, etc.,

Dublin, Oct. 14th. Robert H. Woods.

Radiological Grouping of Arthritis

Sir,—In your review of the publication entitled *Radiological Atlas of Chronic Rheumatic Arthritis* (*The Hand*) it is stated that climacteric arthritis cannot be placed satisfactorily in any of the four groups mentioned.

I should like to point out that this is rather the fault of the clinical differentiation than the method of radiological grouping. By this I mean that of two cases clinically diagnosed as climacteric arthritis one will show typical radiographic changes of rheumatoid arthritis and the other osteophytic formation and loss of cartilage associated with osteo-arthritis. I am therefore led to conclude that there are no changes to be detected radiographically that can be said to be characteristic of climacteric arthritis.—I am, etc.,

London, W.1, Oct. 14th. S. Gilbert Scott.

Circumcision

Sir,—While avoiding the pros and cons of circumcision in male infants and children, I should like to express my entire agreement with the view taken by Dr. C. E. Gautier-Smith (*Journal*, October 5th, p. 692)—that manipulative surgery should find no place in the treatment of phimosis and allied conditions.

The operation of circumcision, anaesthetic apart, is attended with very few risks. Haemorrhage should be very rare if the fraenal vessels are first tied before any incision is made and a simple tourniquet is applied at the root of the organ (inch jaconet folded in three and held firmly in Spencer Wells forceps) ; a clean cut with scalpel is made, taking care not to remove too much foreskin—that is, flaying the glans penis. Redundant mucous membrane having been cut away, two lateral and one dorsal catgut sutures (Halstead) are inserted ; a dressing applied, such as gauze impregnated with tinct. benz. co., does quite well. It is understood that the tourniquet is first released to make sure there is no oozing before applying the gauze. Primary healing should be the rule, as soiling of the wound is prevented.

Some of my colleagues have informed me that where necessary they sometimes do a circumcision on a newborn infant while awaiting the arrival of the placenta, with gratifying results. Of this line of treatment I myself have no experience. It has this merit, however, that there is no anaesthetic risk, and it is done at a time when an infant can best tolerate trauma ; but personally I would consider it a somewhat hurried proceeding.—I am, etc.,

S. A. Montgomery, M.B., B.Ch.

Bournemouth, Oct. 14th.

Sir,—With regard to your correspondence on circumcision the following case may be of interest.

My son, now aged 6, was born with a long, tight foreskin. As I was against circumcision at the time, he was left uncircumcised. When he was 6 months old I noticed that he continually handled his penis. A colleague found adhesions, which he freed, and since then the foreskin has been pushed back every night at bath time and the parts thoroughly washed. There has been no recurrence of the handling on his part except on one or two occasions when the nightly washing has been omitted and there has been some slight local inflammation. The boy now does the washing himself as a matter of routine, which falls in place with the cleaning of ears, teeth, etc.

The points I wish to stress are: (*a*) it is really difficult to keep the parts clean in the uncircumcised, and (*b*) regular pushing back of the foreskin and washing does not always conduce to masturbation, whereas dirty, itching parts do. I hesitate to have the boy circumcised now because I think it quite likely that a psychological trauma may result from the operation at this age. I know of at least one case, where a boy of 4 years, one of twins, was circumcised, in which the operation undoubtedly was a great shock, and this may have far-reaching results. With regard to what Dr. H. M. Hanschell says of the preference of the copulating woman for the circumcised male: this may be due to the fact that the glans is less sensitive after circumcision in infancy and that therefore coitus can be prolonged. If this is the explanation it is an argument in favour of circumcision which should not be overlooked. Ejaculatio praecox with its concomitant unhappiness to both partners is common enough to call for investigation.—I am, etc.,

Suffolk, October 5th. W. M. C.

Sir,—My own personal experience leads me to echo Dr. D. W. Walker's advice in your issue of October 12th, although my experience is admittedly trivial in comparison.

My elder brother and myself both required this attention at school age ; two of my friends required it when medical students ; recently an official in my town hall, with two grown-up children, had to absent himself for circumcision—a very uncomfortable kind of operation for an adult apart from the inevitable ribaldry as to change of faith and so on which ensues among the easily amused. I was foolish enough myself to listen to the advice of one of our maternity and child welfare staff who stretched the prepuce of my elder son, with the result that he required at school age the operation he should have had as an infant.

It is too bad that boys should suffer discomfort or be subjected to an operation at school age or later which should be carried out in infancy.—I am, etc.,

October 14th. M.D., D.P.H.

Sir,—I suggest that all male children should be circumcised. This is "against nature," but that is exactly the reason why it should be done. Nature intends that the adolescent male shall copulate as often and as promiscuously as possible, and to that end covers the sensitive glans so that it shall be ever ready to receive stimuli. Civilization, on the contrary, requires chastity, and the glans of the circumcised rapidly assumes a leathery texture less sensitive than skin. Thus the adolescent has his attention drawn to his penis much less often. I am convinced that masturbation is much less common in the circumcised. With these considerations in view it does not seem apt to argue that "God knows best how to make little boys."—I am, etc.,

Hendon, N.W., Oct. 9th. R. W. Cockshut.

Cerebral Haemorrhage and Thrombosis

Sir,—I am much obliged to Dr. R. T. Cooke (*Journal*, October 12th, p. 702) for pointing out the slip which I made in regard to the way the tongue was protruded; it was, of course, pushed over to the paralysed side. My point, however, was that here we had a case apparently of cerebral embolism in which, after a few days of almost complete hemiplegia, the symptoms disappeared with dramatic suddenness. That it was due to embolism and not due to haemorrhage was indicated by the fact that the blood pressure was low and that there was not an undue amount present of fibrotic or calcareous changes in the arteries. I remember seeing a similar case several years ago in a child of approximately 14 months, where, after an attack of convulsions, hemiplegic symptoms supervened. These cleared up twenty-four hours later, after the administration of a dose of calomel, some castor oil, and a hot bath.—I am, etc.,

Ramsey, Isle of Man, Oct. 12th. E. G. Fenton.

Registration of Opticians

Sir,—What exactly has the ophthalmic surgeon to fear from the sight-testing optician? The suggestions made by Mr. Tibbles and "G.P. Oculist" would only result in division between ophthalmic surgeons and medical refractionists. We are agreed that the claims of the optician to refract cannot be disputed except upon the ground that his examination is incomplete, owing to inadequate knowledge of the eye as a living structure and a part of the body liable to show early signs of serious disease. Every private refraction done by a surgeon carries an implicit guarantee that the eyes are structurally sound. In hospital practice the surgeons' time is saved by delegated responsibility and repeated examinations. This wastes the time of the patient. The National Eye Service attempts to meet this difficulty by providing an intermediate service. The dispensing optician admits our claims, and his duty is to see that his materials, workmanship, and fitting are better than those of his sight-testing colleague. This symbiosis will not work upon a price-cutting basis, and the suggestions made by "G.P. Oculist" would reduce ophthalmic practice to a business of "working out" refractions at so much per head. It would not profit the undergraduate to learn detailed refraction work, but many ophthalmic house-surgeons master it rapidly in hospitals where they have to do this work. Such appointments could be increased.

The refraction is only an incident in the routine examination of the eyes. A presbyopic citizen can never be prevented from buying a magnifying glass any more than he can be prevented from consulting a bone-setter about his tennis-elbow. He cannot be compelled to go to a medical clinic or to a "fully qualified" and "State registered" sight-testing "ophthalmic optician." If his society gives him a grant based upon an inferior scheme to that of his friends the remedy lies in his own hands, and our duty is to make certain that the National Eye Service is a better scheme. It would not improve on the lines suggested by your correspondents.—I am, etc.,

Glasgow, Oct. 7th. W. J. B. Riddell.

Sir,—The registration of opticians is a minor detail compared with the further lowering of fees suggested by "G.P. Oculist" in the *Journal* of October 5th (p. 644), which he seems to think will result in more work. Years ago, when I was on the Ophthalmic Benefit Committee, I warned members then that lowering the fee, from the then guinea standard paid by the approved societies, would not help, because there is only a limited amount of ophthalmic work to be done for each individual during his lifetime, and I have yet to see that cheap work brings more, as it does not even bring more cheap work. More medical men should take up refraction work, and as a large number of people visit sight-testing opticians first there is no sense in quarrelling with what is an established fact, so that it is better to co-operate with them. They, at least, do not expect a doctor to see a patient for the absurd fee that our own profession has cut it down to in the last few years, as a fee once reduced can never be raised again. Since a third of the population come under the Insurance Act this lowering of fees has been a very serious thing for every eye surgeon, and if they wish to extinguish themselves totally they had better lower them still further. Many societies run their own clinics, and one secretary of the biggest approved society told me they had no intention of paying a guinea for these insured people when the sight-testing optician will do it for five shillings. As it is a question of money and not sentiment with them the sooner the ophthalmic surgeons face these facts the better, instead of our trying to mix sentiment and business. The public will, however, always pay for a thing well done, so it is better for us to make the best arrangements we can as regards remuneration, either through existing channels or by private arrangements between patient and doctor.—I am, etc.,

London, W.1, Oct. 8th. Sydney Tibbles.

Pay Beds for Middle-class Patients

Sir,—In view of the approaching financial reconstruction of the London Clinic and Nursing Home, it is not untimely to offer some observations on the future of this important undertaking.

The originators of the scheme at its inception had in mind the creation of an institution which would give middle-class patients, for a moderate fee, a standard of comfort and privacy similar to that obtainable at a good nursing home, combined with the modern facilities for diagnosis and treatment such as are available to poor patients at the large voluntary hospitals. Undoubtedly the equipment and standards of comfort obtainable at the London Clinic fulfil these desiderata, but unfortunately the fees are *not* moderate and, generally speaking, are beyond the reach of the class of patient for whom it was originally intended.