Bipp

SIR,—While the times are surgically quiet I should like to draw the attention of all who are connected with war surgery to a paste which was used with marked success during the war of 1914–18, the so-called bipp. I saw this used myself with unfailing regularity and almost never-failing success. One of the leading consultant Army surgeons during that war gave to me the opinion that of all the antiseptics used at home or in France none had so great a value.

The process, briefly, is: (1) a clean dissection of the damaged and infected tissues; (2) a liberal smearing or filling up with bipp. The wound granulates from below upwards and needs no further dressing, thus saving an immense amount of pain and nursing labour.

We must learn from the lessons of the past; a substance whose value proved so remarkable after four years of unprecedented surgical experience must come again into the field of operative surgery. For the sake of those who would put to the test this pain-saving invention I submit the formula given to me; the formula in which 25 per cent. paraffin was used as a basis was not so successful.

Bismuth subgallate	4 ounces
Iodoform	8 „
Liquid glucose	or q.s. 3¼ „
Balsam of Peru	4 drachms

Fiat pasta.

I trust that this method of dealing with wounds will be given a thorough trial during this war.—I am, etc.,

Folkestone, Nov. 27. AUSTIN PRIESTMAN.

Injection Treatment of Hernia

SIR,—Mr. A. Simpson-Smith (*Journal*, November 18, p. 990) remarks that the difficulties of injection treatment of inguinal hernia have compelled many surgeons to give up this procedure. That in skilled hands it can be entirely satisfactory I have had ample confirmation. I have seen many cases treated by Surgeon Commander St. G. B. D. Gray, R.N.V.R. (now on active service). The results were excellent. There is no doubt in my mind which form of treatment I would plump for if I had a hernia.—I am, etc.,

London, W.1, Nov. 28. A. ERNEST SAWDAY.

Treatment of Varicose Ulcers

SIR,—Being in charge of a very large varicose vein and ulcer clinic I was naturally interested in the letter from Dr. J. R. A. Davies appearing in your issue of November 25 (p. 1060). I should like to make the following comments.

In my experience true varicose ulcers are seldom multiple and are never associated with deep abscesses that need opening. Dr. Davies (in the one case he describes) attributes the spread of the *Staph. aureus* infection (to parts of the body remote from the legs) to "the damming-up of foul stinking septic discharges." After a careful study of his report it would appear that there is nothing upon which one could base his assertion of the spread of the infection from the legs to other parts of the body; it would appear at least equally probable that the boils and abscesses broke out everywhere (axillae, groins, and legs) as a manifestation of the one general infection, and that it was this infection that caused the temperature and general illness and not the occlusive dressings.

In such a case as is described Dr. Davies obviously adopted the correct treatment. I do, however, most seriously join issue with him when he condemns the modern miraculously successful treatment of varicose ulceration (by the tight binding up of the whole foot, ulcer, and leg with elastic adhesive bandages) merely because this treatment had been applied unsuccessfully to one isolated case which, on the face of it, was not one of true varicose ulceration, but one of multiple body abscesses, including the legs.

Every ulcer seen on a leg is not necessarily varicose. A Wassermann is often helpful (even in real varicose ulceration); and, when indicated, concomitant anti-syphilitic treatment is instituted. Even, however, in cases of syphilitic ulcers the elastoplast treatment is a valuable adjuvant. At my own clinic the tight "occlusive" bandaging up of ulcerated legs leads to regular cure. Large ulcers can be "expedited" by the placing over them of pieces of specially prepared sponge rubber. It is frequently our practice first of all to put cod-liver oil into the ulcer cavity under the sponge rubber. In other cases, if there be much purulent discharge, the ulcer is first filled with calomel powder or T.C.P. powder.

I write this "answer" to Dr. Davies in no sense of carping criticism, but merely because one cannot allow to pass unchallenged destructive criticism of a treatment that has brought rapid cure of untold pain and suffering to countless thousands throughout this country. After all, this "occlusive" tight bandaging treatment is on the same lines as the most successful "occlusive" method of treating compound fractures by the Winnett-Orr method.—I am, etc.,

Liverpool, 1, Nov. 30. STUART MCAUSLAND, M.D.

Virtues of Brown Bread

SIR,—A very few years ago a letter advocating whole-meal bread would have provoked a lively and somewhat acrid discussion on the respective merits of white and whole-meal. This is no longer the case. Professor Geoffrey Taylor's letter (November 18, p. 1022) has so far been allowed to pass without comment. Your own annotation of August 5 (p. 289) was a masterly presentation of the large mass of experimental evidence that you had accumulated, proving the great superiority of whole-meal over white judged by every criterion. Your exposition aroused no response whatever apart from my own letter, which you were good enough to publish on August 19 (p. 426). The reason must, I think, be that the superiority of whole-meal is no longer in dispute. Why then are we still a white-bread-eating nation? And why do thousands of medical men themselves eat white bread although they know it to be inferior to whole-meal?

The remedy I suggested in my letter was for all medical men (*a*) to advise their patients to eat whole-meal bread, and (*b*) to insist on being supplied with whole-meal for their own use. Professor Geoffrey Taylor's suggestion is that the British Medical Association should urge the Government to legislate to encourage, if not to compel, the universal eating of whole-meal instead of white bread. This would be an ideal plan, but it might take some time to mature; meanwhile I would plead with the medical profession to adopt my suggestion, which, of course, is an obvious and not a new one.—I am, etc.,

London, W.1, Nov. 25. ALFRED C. JORDAN.

SIR,—With all the prominence given to food and its rationing it is surprising that so little attention has been accorded to brown bread in the dietary. It is an important source of the accessory food principle vitamin B_1, so advantageous for the healthy functioning of nervous and unstriped muscle tissue, while for many persons it has an actual relish not obtaining in white bread.

In Italy since the beginning of totalitarianism brown bread is compulsorily supplied by the bakeries, for it is recognized there that not only is the quality enhanced but the quantity is also increased—seven loaves in place of six for the same quantity of grain. In England a "colour prejudice" is apparently extended to food, especially among the poor and uninformed.—I am, etc.,

Netley, Nov. 26. ARTHUR KING.

Oestrogens: Natural and Synthetic

SIR,—Your statement in the *Journal* of November 25 (p. 1048) that no differences have been observed between the actions of the natural oestrogenic hormones and the synthetic product (stilboestrol) fails to take into account the recently published findings of two Dutch workers (Duyvené de Wit, J. J., and Bretschneider, L. H., *Klin. Wschr.*, 1939, **18**, 1423),