Western ideas. But the more severe cases approach the character of intestinal obstruction, with marked distension, shock, and even vomiting of intestinal contents, though sudden relief may come after repeated large slow enemata or even without treatment.

Indian patients refuse operation as often as not, and of those whose condition justified a diagnosis of obstruction by all ordinary standards a surprising number (about one-fifth of the total) recovered after one, two, or even three large slow enemata. One patient was so ill that he died a few minutes after a third enema had produced a copious watery motion. At necropsy it was evident that a volvulus had existed and become unwound. The affected loop was increasingly congested as one traced it downwards, with many ecchymoses, especially on the anti-mesenteric border. The congestion ceased abruptly at the lower end, and on the root of the mesentery was a deep groove where the bowel had crossed it. This is exactly the picture found at operation after relieving the severer cases of volvulus of the small intestine. In another obstruction case I found what I believed to be a later stage of the same picture. A year after a severe "colic" attack I found a large loop bound down at both ends to a scarred and thickened mesentery. Here the damage must have been greater, for at the scarred upper end was a stricture which had brought the patient to the operating table.

It is remarkable that both "colic" cases and those of volvulus nearly always gave a history of a large meal of coarse, indigestible food—badly ground millet, half-cooked grain, or certain green leaves (gunyan), all of which have the reputation of giving colic. From a search of such literature as was then available to me I gathered that volvulus of the ileum was not uncommon in Southern Russia, where the poorer classes consume large quantities of millet and other coarse grains. From these facts I believe that volvulus of the small intestine is not unusual in races whose food leaves a large indigestible residue (Indians excrete twice as much faeces as Europeans), and that spontaneous resolution is quite common.

I am in complete agreement with Major Salisbury Woods's picture of the loop folding over and then swinging free again, and I agree that in early cases when congestion is slight the appearances are so puzzling that the condition is easily overlooked. Eventually I learnt to recognize the volvulus by sweeping a finger round among the intestines in the right lower quadrant of the abdomen when it encountered a band of resistance. It was, I suppose, the pedicle of the volvulus; at any rate there was something going back to the lower part of the root of the mesentery which did not slip away before the finger as it should.

In these Indian cases the volvulus involves several, even many, feet of the ileum, and it is quite difficult to be sure when the reduction is complete without more manipulation than one likes. The affected coils contain little gas and may be very heavy with liquid contents and undigested food, which may account for the production of the volvulus.—I am, etc.,

R. C. McWATTERS,
Military Hospital, Penshurst. Lieut.-Col., I.M.S. (ret.).

Operation for Varicose Veins

SIR,—Mr. Harold Dodd (Oct. 13, p. 510) has done a great service in calling attention to the importance and difficulties of this subject. His statement in which he advocates that a "pool" of information is necessary brings out the fact that there is no 100% cure for varicose veins, and that, furthermore, there are many and varied opinions and techniques being practised by those interested in this fascinating subject. Most of us will agree that the operation is one which calls for the greatest care, and should be treated as a major surgical procedure. Economic conditions and the shortage of beds necessitate in many instances the use of out-patient procedure. However, even though this may be a necessity, such operations should be performed in a major theatre with all facilities for absolute sterility and for expert assistance. My attention has been called recently to certain tragedies which might have been avoided had these points been better appreciated. To mention a few: sepsis, sloughing from sclerosant injections, emboli, tearing of the femoral vein, and even ligature of the femoral artery, have occurred in the hands of qualified practitioners. The fetish of a minute incision performed in a poorly equipped out-patient theatre should be discarded.

Again, the use and abuse of sclerosants at *the time of the operation* is a subject which calls for further investigation. There are two schools of thought in this matter. Should both legs be dealt with at the same operation, or should the operation come into line, say, with that of double hernia, in which I believe the practice of dealing with one side at a time to be the usual procedure?

There are countless other "differences of opinion," and there seems to be but little correlation of the late results following the various and varied techniques. Mr. Dodd's letter will have been a great service if it serves to call together those of us who are struggling with this problem of the vagaries of the varix.—I am, etc.,

London, W.1. R. R. FOOTE.

Nerve Injuries in Children

SIR,—I should like to thank Mr. St. Clair Strange and Mr. Zachary (Oct. 20, p. 545) for their letters correcting the obvious mathematical error in my article of Oct. 6. The figures should have read 15 mm. a week and not 15 mm. a day. This is in line with Mr. Zachary's figure of 2.1 mm. a day.

Although 2.1 mm. a day does not appear to be a great increase upon the oft-quoted figure of 1.0 to 1.5 mm. a day for the rate of recovery in an adult, it is in my opinion much greater than the figures suggest.

The rate of recovery of nerve injuries in adults is very rarely as rapid as 1.0 mm. a day. In fact, the rate of recovery in adults in our own cases and those of other surgeons, which we are treating, is disappointingly slow.

The case referred to in my article of Oct. 6 was seen in May, 1944, in the out-patient department of the Royal National Orthopaedic Hospital, Great Portland Street, and was operated upon two weeks later. Both before operation and twelve weeks after operation she was also examined by my colleague, Mr. Donald Norris. The patient, Miss P., is now employed in the telephone exchange of the Royal National Orthopaedic Hospital, Stanmore, and is most co-operative in demonstrating her result to anyone who may be interested.—I am, etc.,

Royal National Orthopaedic Hospital. E. HAMBLY.

Caffeine and Peptic Ulcer

SIR,—Your annotator ends his article (Oct. 13, p. 504) with these words: ". . . at least an adequate justification for eliminating caffeine-containing beverages from the diet of ulcer patients." Why not put it in plain English? Ulcer patients are not to be allowed tea or coffee. Now the cup of tea is an institution without which no charlady, Service man or woman, private or colonel would complete a day's work. Tea was one of the few luxuries that Lord Woolton maintained during the blackest period of the Battle of the Atlantic. It fetches an enormous price in the "black market" on the Continent.

What is the evidence for its denial to the ulcer patient? An American youth who perforated after drinking 150 bottles of coca-cola; a resistant duodenal ulcer in a patient who was a coca-cola addict; experiments on cats which show they develop engorgement of the gastric mucosa after the injection of 250 mg. of caffeine sodium benzoate (the equivalent weight for weight of an average man drinking 50 cups of tea). It is difficult enough to persuade an ulcer patient to stick to a regime, but to deny him tea and coffee on these grounds will undermine any faith he may have in his doctor.—I am, etc.,

R.A.F. Station, Keevil, Wilts. J. S. ASTBURY.

Epidemic Diarrhoea and Vomiting

SIR,—We have read the very interesting paper on epidemic diarrhoea and vomiting, etc., by Drs. George Brown, G. J. Crawford, and Lois Stent (Oct. 20, p. 524), and think that our experiences during an outbreak in July, 1945, in this hospital might be of interest to your readers.

This hospital has a population of about 2,000 patients and resident staff, but the outbreak was practically restricted to female staff and patients. Altogether about 130 out of a female population of 1,300 became ill. This is all the more remarkable as one of the female wards with a morbidity of about 25% lies within the "male side" of the hospital. This is a female infirmary ward, and the patients are not much in contact with other patients. We could