showing the obviously greater distance of the lung edge from the chest wall; and, incidentally, the presence and site of adhesions will be seen to greater advantage in the second.

The needle should accordingly be inserted during the natural pause which takes place at *the end of expiration*, thus obviating any risk of injury to the lung, which at this phase is *more out of reach*. There should be no sudden stab. The patient should be instructed to inspire, then expire, and then stop breathing. A Morland needle with a very sharp spear-headed point is next placed *on* the skin in the appropriate interspace and then, comparatively slowly and deliberately, pushed through skin and pleura. The following inspiration on the part of the patient will then show the maximum inspiratory swing on the manometer, the clip on which should be left open and air allowed to enter the pleural cavity at low pressure, thus avoiding air embolism, undue pull on any adhesions, and possibly subsequent pleural effusion.

Incidentally, it is worthy of note that after induction a puddle of fluid immediately collects at the bottom of the pleural space. This is not to be confused with the onset of pleural effusion; it is simply due to the new position taken up by the lymph, which, before induction, normally bathed the pleural surfaces, including the interlobes. This phenomenon can be observed on the *x*-ray screen or radiograph if the patient is examined immediately after induction, provided the mechanical diaphragm on the *x*-ray plant is sufficiently widely open to include the lowest depth of the costo-phrenic sinus.—I am, etc.,

Cambridge. W. PATON PHILIP.

SIR,—I read the correspondence on the humane A.P. refill with much interest. I entirely agree with the views expressed by Dr. C. F. Hawkins. I gave up the use of local anaesthetic after careful investigation of a considerable number of A.P. cases. A random sample of A.P. cases were selected at each refill session; one would be given a local anaesthetic and another no local. When this had been done over a period each patient at different times had a refill with and without anaesthetic. Only two patients expressed a desire to have a local anaesthetic before refills; the others preferred refills without a local anaesthetic. It is interesting to note that the two patients who preferred to have local anaesthetic before refills were given refills after sterile-water injections and declared that the refills were less painful than without a local anaesthetic. Owing to the prolonged nature of the treatment it is decidedly beneficial to the patient not to have injections of either cocaine or novocain before each refill; but if the patient expresses a desire to have a local anaesthetic I give it.

I do not believe that the danger of pleural shock in an established A.P. is greater when local analgesia is omitted. I have had only one case of pleural shock in an established A.P. case in a series of over 15,000 refills, and this occurred in a transfer with a history of several so-called fainting attacks after refills and to which no reference was made in the case notes on transfer. It is interesting to note that the same patient developed pleural shock following the development of pleural friction on re-expansion of the lung. I regard this as redux pleural shock.—I am, etc.,

H. P. FERNANDES,
Medical Superintendent.

Derbyshire Sanatorium, Chesterfield.

Latent Disease in Far East P.O.W.s

SIR,—The prisoners of war from the Far East are nearly all home by now and about to be demobilized. Many of them are suffering from diseases which may give them trouble in after-life. Stool examinations done on them by Sergt. Baptist, S.S.V.F., as prisoner of war, and later in Rangoon under the aegis of Lieut.-Col. G. A. Ransome, I.A.M.C., showed that about 40% had some intestinal parasite, 13% *Entamoeba histolytica*, 30% ankylostomiasis (by saline concentration), and a few cases of trichomonas and *Strongyloides stercoralis*. Examinations carried out on the troopship coming home showed 3% with enlarged livers. *Entamoeba histolytica* cysts were found in the stools of a high proportion of these. Anaemia due to hookworm is rather more rare but is present in an appreciable number. Deficiency neuroretinitis leading to reduced vision with central scotoma is particularly common among those who did not leave Singapore Island. Chronic malaria seems to have responded in most cases to the six-weeks prophylactic mepacrine course. Old tropical ulcer scars may become eczematized and break down. (The figures quoted here are rough computations and should not be taken too seriously.) Psychoneurotic manifestations are seen chiefly among the civilian internees, who had more attention from the Japanese Gestapo and worse food than the military.

I very much doubt whether the routine demobilization medical examination includes a microscopical stool examination, so it is probable that some of these cases will be coming into the hands of civilian doctors, especially in East Anglia, the soldier having been demobilized without the condition having been spotted while still in the Army. It is up to the medical practitioner to see that these men have a square deal as regards financial compensation for lost hours of work and pension.—I am, etc.,

Ealing, W.5. F. E. DE W. CAYLEY.

The Saline Infusion Bottle

SIR,—Since the blood transfusion services unanimously adopted the Medical Research Council's transfusion bottle for the supply of blood, plasma, and serum many hospitals have been led to use it for all intravenous solutions. In most large hospitals the various saline and dextrose saline solutions used for intravenous infusion are made up by the pharmacist and delivered sterile in M.R.C. bottles.

These bottles, however, are too small for the average routine saline infusion. Unlike blood, saline is commonly required in quantities of 10 or even 20 pints (over the course of several days), and the frequent changing of the one-pint bottle is inconvenient, especially at night. Moreover the washing, filling, sterilizing, and labelling of multiple small bottles give the pharmacist unnecessary work. It is perhaps not sufficiently realized that the expense of a saline infusion lies mainly in the handling of the bottles; the larger the bottles, the cheaper is the infusion. Even in sterilizing, where one would suppose that the autoclave would take only a certain volume of saline irrespective of its containers, the big bottle is still economical, for an autoclave with a capacity of 16 pint bottles will often take 10 of quart size. Anyone doubting these facts should examine the prices of the commercial article; the pint and the quart cost almost the same.

If the quart is the best size for saline, why is it not in general use? Unfortunately those patterns at present available differ from the standard in all their dimensions, so that their use entails the provision of two types of "giving set." This is the crucial point. To avoid it we require a companion to the standard blood bottle with the same size of mouth and same height, and a double capacity accommodated laterally. It seems that no such bottle is made. We have approached the United Glass Bottle Company (makers of the M.R.C. pattern), but they can offer nothing suitable from stock, and to begin manufacture would require an order for a larger number than any single hospital could use.

United effort is required. We find that the Medical Research Council is handing over its wartime responsibility in this field. We have heard, with some alarm, that this subject has been discussed recently among those who are particularly concerned with the organization of the blood transfusion services, and that there was such diversity of opinion that no decision could be reached. Perhaps some of the points of disagreement will appear in subsequent correspondence. For our own purposes we are in no doubt as to the type of bottle we require. We would place an order for it if, through the kindly medium of your *Journal*, we could find a few hospitals who would join us.—We are, etc.,

J. C. H. HANSON, Pharmacist.
T. C. BEARD, R.M.O.

Hertford County Hospital.

Subcutaneous Oxygen for Sciatica

SIR,—In your correspondence columns (Nov. 17, p. 703) Dr. H. Avery writes on the treatment of sciatica by subcutaneous injection of oxygen, and refers to a letter of mine (Oct. 20, p. 544). He used for the purpose an oxygen injector with bag reservoir supplied by the Sparklet Company. He "used this treatment when all others had failed . . . and had a large number of spectacular cures, until on one occasion (the needle having apparently slipped) my patient suddenly complained of pain over the heart and faintness; in fact he presented a com-