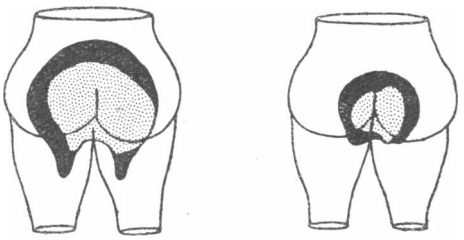
stand. His unit M.O. reported normal power and movement of the limbs, but had to catheterize him for retention of urine. Examination on May 29 showed a symmetrical area of anaesthesia involving S 3, S 4, and S 5, with partial affection of S 2, though maximal stimuli were felt over the latter area. There was no dissociated anaesthesia. Abdominal and cremasteric reflexes were present.



May 29, 1945. July 22, 1945

Diagrams showing anaesthetic and hypo-aesthetic areas in Case 2. Stippled area = anaesthetic; black area = hypo-aesthetic.

Knee-jerks were present, ankle-jerks absent, and plantar responses flexor. Lumbar puncture revealed clear fluid under a pressure of 135 mm. C.S.F. There was no block or any increase in cells, protein, or pigment. Skiagrams showed no fracture of the spine. Cystometry was not carried out. On May 29 suprapubic cystotomy was performed. By June 4 the hypo-aesthetic area of S 2 had largely disappeared, and there was no dissociation. On June 9 sensation began to return in the anaesthetic area, and the anal sphincter was functioning. On July 22 muscular tone was normal; no loss of power was detected. Knee-jerks were present, ankle-jerks absent, and plantar responses flexor. Bulbocavernosus and anal reflexes were negative. Erection was absent. Sensation: Cotton-wool touch well appreciated over all areas except immediately around the anus. Sensitivity to pinprick all over S 2, S 3, and S 4, but well-defined hypo-aesthesia over this area. Loss of sensation over the immediate perianal region. Hot and cold sensation poorly appreciated over S 2, S 3, and S 4, covering an area slightly more extensive than that hypo-aesthetic to pinprick. Protopathic heat appreciated over this area. There was blunting of pinprick sensation and poor appreciation of heat over the sacral areas of the scrotum and penis, with a clear-cut change to normal when the lumbar areas were reached. No urine had yet passed per vias naturales. Since war moves doctors on and patients back, it was improbable at the time of writing that this man could be followed much further, but it will be seen from the diagram that there has been considerable improvement over a period of time comparable to that during which the first case was observed.

Discussion

It only remains to call attention to the fact that, as the anaesthesia resolves in Case 2, its dissociation, not apparent during the first few weeks of recovery, is reminiscent of the sensory loss seen in cases of syringomyelia. This suggests to us that the essential morbid anatomy consists of a haemorrhage into the grey matter of the conus medullaris.

Medical Memoranda

Perforated Duodenal Ulcer at the Age of 12

The following case is of interest in view of the age of the patient and the absence of any previous dyspeptic symptoms.

CASE HISTORY

The patient, a girl aged 12, was admitted to hospital on Nov. 15 complaining of severe generalized abdominal pain of two hours' duration accompanied by repeated vomiting and nausea. There were no urinary symptoms and the child had had a normal motion that morning.

On examination she was obviously suffering from a moderate degree of shock. The tongue was slightly coated and there was generalized tenderness, maximal just below and to the left of the umbilicus, with marked guarding in all quadrants. There was no abdominal hyperaesthesia, and on rectal examination she was tender on the left side, both anteriorly and posteriorly. The patient was treated for shock, and after four hours was considered fit for operation.

The abdomen was opened through a right paramedian incision and thin yellowish-brown fluid was found in the lower peritoneal cavity. A small perforation of the anterior wall of duodenum 1/16 in. (1.6 mm.) in diameter was discovered from which bile-stained fluid was oozing. Induration around the perforation suggested the presence of a duodenal ulcer. The wound was sutured in two layers and closed with suprapubic drainage.

The child made an uninterrupted recovery, and was given six weeks' in-patient medical treatment, including dieting, antispasmodics, and antacids, before discharge. No dyspeptic symptoms were complained of before or after the operation.

My thanks are due to Dr. R. R. M. Porter, senior honorary surgeon to the Southport Infirmary, who performed the operation, for permission to publish this case.

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Technique for Use in the Guillotine Operation

The guillotine operation in recent years has largely fallen into disfavour among E.N.T. surgeons for the very good reason that, while it was possible to be certain of a full view unobscured by blood in attacking the first tonsil, the operator's success in dealing with the second was often rendered extremely difficult—not to say impossible—by haemorrhage filling the pharynx from the bed of the first tonsil. A technique which I have followed for some considerable period eliminates this difficulty.

It is, of course, a truism that each case must be examined to make certain that the tonsil is of the infantile pedunculated type and not of the adult type in which the lower pole blends insensibly with the lymphoid tissue on the lateral pharyngeal wall and the back of the tongue. In the latter case it is impossible to engage the guillotine, and the method should be dissection. In cases suitable for the guillotine operation, which in my opinion form the great majority of infantile cases, the following technique is adopted.

METHOD

The patient is premedicated with "seconal" (dosage appropriate for age and weight) and 1/100 gr. (0.65 mg.) of atropine by mouth one hour before operation. Premedication carried out in this way entirely eliminates psychological trauma, and there is, in fact, no need for the child to know that an operation has taken place, as a skilled anaesthetist can induce without the patient realizing what is happening. Induction is by ethyl chloride followed by open ether, anaesthesia being carried to the top of the first plane of the third stage.

A tonsil gag is inserted and a final view of the field taken by means of a right-angled spatula. The surgeon then has available two matched guillotines of suitable size. It is essential for the success of this technique that the guillotines used should be so blunt that there is no fear of their cutting through the tissues when they are closed; the tonsils are thus completely snared, and are removed by digital dissection with the first finger of the left hand pressing the lateral pharyngeal wall away from the tonsil, and not by tearing the tonsil off the lateral pharyngeal wall by traction with the guillotine. Having selected the size required, he then stands at the head of the table, the anaesthetist steadying the head while standing to the left, and at the same time controlling the gag. The operator engages the guillotine on the left tonsil, closes it, the handle then being handed to an assistant, who presses the guillotine as much to the left as is possible. The surgeon then takes the other guillotine, changes his position to the right-hand side of the patient, and proceeds to guillotine the right tonsil in the usual way, removing it completely. His assistant then hands to him the first guillotine, which is engaged on the left tonsil, and he then proceeds to complete its enucleation. By this time the patient should be coming round from the anaesthetic, and the adenoids are then removed.

In my experience this makes the operation extremely easy; there is no hurry or rush to attack the second tonsil, and it is surprising, but true, that there is plenty of room in even a very young child's mouth for two guillotines to be *in situ* together. The teaching of the operation to a house-surgeon is also much easier, as the surgeon himself has entire control of the situation during the operation, which is, of course, impossible by the usual technique, because if the learner has failed with the second tonsil the mouth is then a pool of blood, the patient is coming round from the anaesthetic, and it is practically impossible for the surgeon to correct the mistake made by the operator. I now carry out this technique exclusively. In my hands I find that the disadvantages of the guillotine operation are eliminated. One can by this method be as certain of removing both tonsils completely as one is when carrying out the dissection operation.

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