Arnott) feels so strongly about this matter that the students are not taught the administration of N_2O but are trained very thoroughly in the use of local anaesthesia. He teaches that the use of open anaesthesia for dental or oral surgery is indefensible.—I am, etc.,

London, S.W.2. DONALD J. RITCHIE.

Gallamine Triethiodide and E.C.T.

SIR,—The papers by Drs. O. S. Thompson and A. Norton (April 21, p. 857) and by Drs. R. H. F. Smith and D. L. C. Thomas (April 21, p. 860), together with other recent contributions to the literature, suggest that the use of E.C.T. can be extended to relieve cases that would otherwise go untreated. The question arises now whether all E.C.T. should be modified by a curarizing agent or whether only selected cases should be so treated. My own experience at this hospital may be of help. In the past three years I have treated some 50 cases, the early ones with D-tubocurarine hydrochloride, the later ones with decamethonium iodide (C10), and the most recent cases with gallamine triethiodide. In all cases premedication has been with thiopentone, and atropine 1/75 gr. (0.8 mg.) has been given with the curarizing agent. Over half the cases treated suffered from cardiovascular disease—e.g., hypertension, cardiovascular degeneration, and mitral stenosis. Three of these had had a slight hemiplegia previously, one following an earlier course of E.C.T. Of the remainder, in 10 cases there had been a previous fracture of the dorsal spine and the rest suffered from diverse conditions, including rheumatoid arthritis and recent abdominal operation. The oldest patient treated was aged 81 years. It is worth reporting that hemiplegia is not rare following unmodified E.C.T. and that its results may be more disabling than crush fracture of the dorsal vertebrae.

My experience confirms the main findings of the authors, and I feel that gallamine triethiodide will come to be the drug of choice in this hospital. One must question, however, the practice of using curarizing drugs as a routine. If one takes care that the patient is treated on a hard mattress placed on fracture boards with a firm pillow under the thoracic spine, the number of dorsal crush fractures occurring is very low, although in my opinion it is the commonest complication of unmodified E.C.T. Fortunately all these cases get better, but as there is some risk of litigation they are obviously best avoided. Cases of cardiovascular disease carry more risk to the patient in the shape of cardiac failure or even rupture and cerebral haemorrhage. In this mental hospital many thousands of treatments are given each year, including a large number of treatments to out-patients. It would be impracticable, and in my view unnecessary, to give all these patients a curarizing agent.

I have found that the symptoms and signs of crush fractures of the dorsal vertebrae occur more commonly in out-patients. There is therefore a great need in the average out-patient department for an agent which will produce softening of the fit in young muscular patients but which does not require the time-consuming additions of thiopentone and insufflation with oxygen. In my view neither D-tubocurarine chloride, C10, nor gallamine triethiodide should be used unless an adequate closed-circuit resuscitation apparatus is available. I have used "myanesin" (10 ml. of 10% solution) with fair success for this purpose. It has the additional advantages that it relaxes the patient comfortably before the electrodes are placed in position and that recovery is rapid and complete afterwards. Its chief disadvantage is that it may cause considerable and sometimes painful thrombosis of the veins.

E.C.T. is one of the safest treatments in the field of psychiatry, and it is therefore up to us to keep it safe—and simple, so that we can use it in patients' homes and in less well equipped hospitals. I would therefore continue to advance a plea for careful selection of cases and for curarization to be carried out only in the presence of adequate equipment for administering oxygen to an apnoeic patient.—I am, etc.,

Warlingham Park Hospital, Surrey. R. A. SANDISON.

POINTS FROM LETTERS

Living Locked Twins

Dr. O. Ll. LANDER (Plymouth) writes: The following case of locked twins is of interest, since both babies are born alive only once in approximately 670,000 births. The patient was a tall, broad woman (I.S. 11½ in., I.C. 12½ in., E.C. 9 in.) aged 28, pregnant for the second time, having been delivered normally of a 7-lb. baby five years previously. At the 37th week twins were suspected, a breech leading, and the patient was sent for *x*-ray examination on the following day. Before the result was available labour started at 10 p.m. and membranes ruptured at 12.30 a.m. The midwife arrived at the patient's home at 2 a.m., found toes presenting at the vulva, and sent immediately for medical aid. The breech (L.S.A.) came down very slowly and an episiotomy was done. In spite of good expulsive efforts with strong contractions progress continued to be slow until the baby was born as far as the scapulae. There was no further advance, and pressure on the after-coming head had no effect. The baby was by then attempting to breathe, so an internal examination was made. This revealed that the head of a second foetus was presented below, and preventing the descent of, the head of the first, the chins being impacted. The babies were firmly wedged in the capacious pelvis (R.O.P. and L.S.A.). Trilene and gas-and-air were being self-administered throughout, and during the relaxation of the uterus and the voluntary muscles both heads were pushed above the pelvic brim and separated. This allowed the first baby to descend, and it was then delivered without difficulty at 5 a.m. This baby, a boy of 4 lb., shocked and white, was handed to the sister, who laid it gently on its side in a warm blanket with its head low and cleared the air passages; it responded with no further treatment. Ten minutes later, after spontaneous rupture of a second bag of waters, the other twin, a girl of 5 lb., was delivered by a second nurse. This baby was lusty at birth. . . . In this case the pelvis was exceptionally large and the two babies could enter it together. The slow descent of a small baby from a very large mother might have led to a suspicion of some abnormality, because the contractions and bearing-down were strong.

Adder Bites

Dr. C. A. E. I. BROWNLEE (Stirlingshire) writes: In the summer of 1934 I saw two cases of adder bites. Both were aged about 14. The girl I did not see till a week or 10 days after she had been bitten, but even then she still had a swollen and slightly tender finger. The boy I saw within half an hour of his being bitten. He had obtained a piece of cord which he used as a tourniquet. The fang-marks, on the right little finger, were quite easily seen, so they were opened up, and potassium permanganate crystals rubbed in, after which the patient was taken home and put to bed. . . . Apart from the swelling and oedema, which travelled slowly up the arm as far as the shoulder, and as slowly receded, and the subsequent bruising, the only other noteworthy points were a mild rise of temperature (99° F.—37.2° C.) and slight delirium on one or two nights. Recovery was complete in 8 to 10 days, apart from slight tenderness, which lasted for some little time longer, of the bitten finger.

Flat Feet

Dr. E. MOORHEAD (Winnipeg) writes: My daughter aged 7 had flat feet, and had been under the care of a leading orthopaedic surgeon for a long period. Plates broke, exercises aroused no enthusiasm, and a tendon transplantation was declined. My family spent a year in Hastings in the early part of the first war. On returning from France at the end of 1916, I was delighted to find that the flat feet were cured. As no treatment had been carried on, I could only reason that it was due to running about on the beach barefoot. When the tender feet came in contact with shingle or a sharp bit of shell, there was a sudden tightening of the intrinsic muscles of the feet, with consequent development. When I returned to Canada I suggested to the surgeon that his young patients should play barefoot in his gymnasium, and that dried split peas should be sprinkled on the floor. I have no evidence that a trial of this was made.

Correction

Dr. J. V. GARRETT writes: The second sentence of the second paragraph of my letter "Eosinophils and Blood Clotting" (July 21, p. 176) should read: "De Takats has reported that the eosinopenia after operation . . . if eosinophilia occurs subsequently."