

and the canal was drained. The child was discharged healed on the tenth day, and has remained well since, having passed through an attack of pertussis without any sign of reherniation.—I am, etc.,

Minehead.

H. B. WALKER.

SIR,—I was very interested in the case described by Dr. T. E. Winckworth (*Journal*, September 5, p. 567), because I have on two occasions seen a similar condition associated with femoral hernia.

Two years ago, while I was working with the late Mr. W. E. Tanner, he operated on a woman for a femoral hernia which had recently become tender. At operation the sac was found to contain the tip of the appendix, which was considerably swollen and congested. There were early signs of inflammation, but the congestion was considered to be secondary to the impaction of the appendix in the neck of the sac. Curiously, exactly one week later, I personally operated on an identical case in a woman. I have not, however, heard of any similar cases.

With regard to the occurrence of the normal appendix in a hernial sac, I recently found one in the sac of an inguinal hernia in a small child.—I am, etc.,

Birmingham.

D. G. MAURICE.

Possible Sequel of Treating Infants in the Erect Posture

SIR,—I was interested to read Professor John Craig's reference (*Journal*, July 11, p. 98) to flattening of the head noticed in infants nursed in an upright posture. At this hospital a similar condition has been present in three cases of cardiochaliasia or hiatus hernia nursed in a "chair." In one child the flattening was marked during the period of treatment, but at the age of 2½ years the shape and measurements of his head seem to have reverted to normal. He has not required any form of therapy since he was a year old.—I am, etc.,

Pontypridd.

W. DAVIES.

Pain of Transurethral Manipulations

SIR,—As a urologist, I heartily agree with your two correspondents, Dr. E. C. Atkinson (*Journal*, August 22, p. 440) and Mr. H. Calvert Dales (*Journal*, September 5, p. 567). May I put in a plea for the use of smaller instruments as well as lignocaine ("xylocaine") and/or general anaesthesia?

In my clinic I use a 16 French viewing cystoscope, which I had specially made. This is only three-quarters the size of the 21 French cystoscope generally used. For double catheterizing I use either an 18 or 21 French American Brown Bueger instead of the 23 French double catheterizing cystoscope in general use, some of which in practice tend to be even larger than the listed scale. For anyone who is accustomed to endoscopy these smaller instruments give an adequate view, and I am sure contribute considerably to the comfort of the patient, both during the procedure and afterwards.—I am, etc.,

Luton.

HENRY CLARKE.

SIR,—I am glad that Dr. E. C. Atkinson (*Journal*, August 22, p. 440) has raised the question of anaesthesia for transurethral instrumentation. It is a matter of astonishment to me that even now some surgeons pass instruments per urethram without any anaesthetic at all. I think that there is a tendency to decry local surface analgesics as useless because they are never given a chance. I have seen surgeons use a local analgesic, and immediately start to operate. Mr. Lang Stevenson waits for ten minutes, and Mr. Winsbury-White for five minutes (*Journal*, September 19, p. 674). I am sure it would surprise many readers to know how long five minutes' waiting means. If checked by a watch it is very much longer than one thinks.

For many years I have followed the advice of my colleague, the late Mr. Douglas Crow, who was in charge of the throat department at the Royal Sussex County Hospital. He used to teach that after anaesthetizing a patient with a

local analgesic one should treat another patient, and after that return to the patient one has anaesthetized—by then the analgesic will have taken effect. I am sure that, if adequate time were allowed, local analgesics would be more effective, and Mr. Crow's simple method ensures this.

No surface analgesic will anaesthetize the deep structures, and gentleness is still necessary. I have had patients attending my out-patient clinic for years for dilatation of a stricture under a local analgesic, who have occasionally had to submit to this treatment without an analgesic when I have been away, and they tell me the local analgesic makes a very great difference. I follow the technique of the late Canny Ryall, but, having had a few alarms with cocaine, for many years now I have used 1/1,000 cinchocaine ("nupercaine") with good effect and no untoward results.—I am, etc.,

Hove.

H. J. MCCURRICH.

Neonatal Asphyxia

SIR,—Your annotation (*Journal*, August 8, p. 328) and the correspondence on this subject have prompted me to quote an article describing a resuscitation trolley that was photographed and produced in the *Journal of Obstetrics and Gynaecology of the British Empire* (1949, 56, 1044).

This referred to a resuscitation trolley the purpose of which was to facilitate the passage of an endotracheal tube so that a newborn baby might be insufflated with oxygen and respirations established. Since this time in the last 3½ years this trolley has been present at every caesarean section (215) and forceps delivery, and a large percentage of the babies have required this method of resuscitation consisting purely of the rhythmic insufflation of the lungs through an endotracheal tube with oxygen controlled at the correct pressure with a water manometer. No other method of resuscitation has been used, and no drugs of any kind have been administered to a baby to stimulate respiration.

With the use of a resuscitation trolley as described it soon becomes practicable for an anaesthetist or obstetrician to pass an endotracheal tube in any sized baby, and with the use of a water manometer no injury to the baby will occur by too great a pressure of oxygen being applied to the baby's lungs.—I am, etc.,

Workington, Cumberland.

JAMES B. JOYCE.

SIR,—I am grateful to Mr. W. G. Mills (*Journal*, September 19, p. 675) for writing that my "arguments are sound" and that my "practice can be shown to give dramatic results by anyone who takes the trouble to try," but I cannot claim the special skill with which he credits me in giving intracardiac injections. They are, in fact, simplicity itself in infants.

All that is required is a hypodermic syringe with a 1-in. (2.5-cm.) needle of fairly fine bore—a No. 15 or 16 is suitable. This is inserted about 3–4 cm. internal to and superior to the position of the normal apex beat, and slight suction is applied from time to time as it is inserted the last half of its length. Immediately blood appears in the syringe the desired dose of "cardiazol" ephedrine is injected. If by any chance the ventricular cavity is not struck the first time it is only a matter of seconds to have another try. The fine needle cannot possibly do any damage, though it is possible that it and the injection of 0.5 ml. of fluid into the cavity might stimulate a contraction in a heart which had practically ceased to beat.

The great advantage of the method is that it is certain. The dosage does not depend on or get lost in the peripheral circulation before it reaches the heart, and, if by any chance the result is not, as Mr. Mills says, "dramatic" owing to the heart having ceased to beat, I have in one case found that firm alternating pressure on the thorax apparently initiated enough circulation to take the blood to the brain and make the baby breathe. In such cases milking the umbilical cord would have been useless, and of course all oxygenating methods—such as that mentioned by Dr. David Morris (p. 675)—depend on the existence of quite a reasonable peripheral circulation. I am glad to see that quite a few textbooks now suggest intracardiac injections. The great