

midwifery, both as G.P. and consultant, I would say that there are still too many problems in obstetrics, without adding to them by "full medical induction" for any pregnant woman.—I am, etc.,

Bury St. Edmunds,  
Suffolk.

D. J. P. O'MEARA.

#### REFERENCE

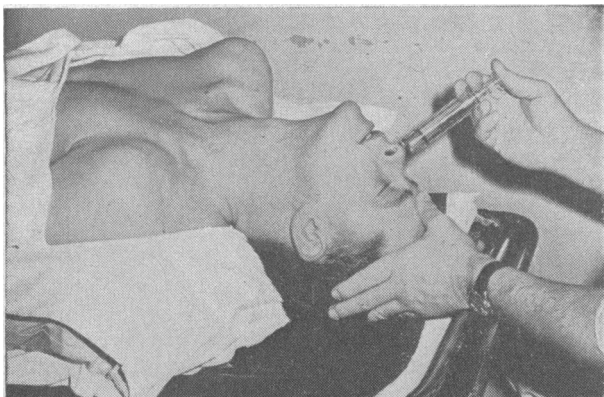
<sup>1</sup> Donald, I., *Practical Obstetric Problems*, 2nd ed., 1959. Lloyd-Luke, London.

### Anaesthetizing the Nose

SIR,—The nose is usually anaesthetized by spraying, by packing with ribbon gauze, or by applying the local anaesthetic agent on orange-sticks. Moffett<sup>1</sup> pointed out that these methods are not always satisfactory and proposed running the solution into the nose with the head in different positions. His method has a number of advantages, but takes 30 minutes to complete; it requires a lot of co-operation and some agility on the part of the patient, and a special needle for introducing the fluid. The following method has the same advantages but is quicker and simpler.

An appropriate dose (say 0.5 g. lignocaine) of local anaesthetic is made up in 40 ml. of warm water, to which 0.5 ml. adrenaline hydrochloride, B.P., may be added (1:80,000). Two pillows are placed under the patient's shoulders as he lies on a couch or operating table, so that his head hangs over them with the neck fully extended, the chin vertically above the external auditory meatus. The administrator sits at his head and instructs the patient to breathe through his mouth. Half the solution is now put in a medicine glass or syringe and poured into one nostril until it is full (see picture). As the level of the fluid reaches the external nares the patient may try to swallow, indicating that it has reached the soft palate at the back of the nose. The patient is reassured that this will not interfere with his breathing freely through his mouth and a firm hand on his forehead will prevent him involuntarily tipping the fluid into his pharynx. The second nostril is now filled and the nose held closed with finger and thumb to prevent him breathing through it. After three minutes the patient is given a swab in his right hand, sat up, and told to blow his nose and spit out any fluid in his throat. The quantity of fluid required varies greatly, as does the quantity recovered by the final manoeuvre. The entire mucosa of the nose will now remain anaesthetized for an hour or more. Other solutions besides anaesthetics may, of course, be applied to the nasal mucosa in the same way.

This method has been used over the past five years in about one hundred operations for submucous resection of the nose with complete satisfaction. Moffett claims four advantages for instilling a local anaesthetic solution into the nose: (1) The maximum quantity of drug used is known; (2) instillation is effective when the anatomy is abnormal; (3) no particular skill is required; and (4) the procedure is not painful. The present method has



three further advantages: (1) It only takes three minutes; (2) no movement of the patient is necessary once he is in position; and (3) no special apparatus is required.—We are, etc.,

Hillingdon Hospital,  
Uxbridge, Middlesex.

R. I. BODMAN.

F. BOYES-KORKIS.

#### REFERENCE

<sup>1</sup> Moffett, A. J., *Anaesthesia*, 1946, 1, 31.

### Hereditary Spherocytosis

SIR,—The results of Dr. A. C. Allison and his colleagues (December 17, 1960, p. 1766) on the analyses of phosphatides in the cells of hereditary spherocytosis are interesting. Three years ago I and my colleagues made similar analyses by the same chromatographic methods on six patients with this disease, and were unable to find any statistical differences between the component phosphatides of their red cells and those of normals. Dr. Allison and his colleagues do not give the separate results for each of the two patients whom they studied. It would be surprising to me if these were similar, since one of the two patients had had a splenectomy, and a consequence of this would be a difference in the mean ages of the two individuals' cell populations. It is, of course, known that the lipid content of red cells varies with cell age.

There are other difficulties to me in accepting their hypothesis of a causal relationship between the lysophosphatide content and the shape of the red cells as the primary genetical defect in this disease. In hereditary spherocytosis cell shape may vary from extreme spherocytosis to none detectable at all, yet in these two extreme states the haemolytic rates in the individuals may not differ. Furthermore, it has now been shown that the shape of hereditary spherocytic cells can be reverted towards normal by inducing a state of iron deficiency in affected individuals, but this does not alter the haemolytic rate. These findings suggest that any structural changes in red cells would not influence their vulnerability through altering their shape. I hope the authors will make further observations on a greater number of hereditary spherocytosis, particularly selecting some with differing cell shape.—I am, etc.,

T. A. J. PRANKERD.

University College Hospital Medical School,  
London W.C.1.

### White Mouse Medicine

SIR,—As a naturalist, I noted a mass-scale experiment in fat-deprivation between 1940 and 1950. During this period, particularly over the middle years and in western London and the Thames Valley, a large section of the populace were deprived of animal fats as thoroughly as a benevolent government could manage it. The principal beneficiaries of the experiment were elderly to middle-aged "white-collar workers"—such lower forms of life as clergymen, lawyers, doctors, schoolmasters and mistresses, and other under-privileged persons.

I had been working as a surgeon in London ever since I left the Army in 1920. I knew that there was such a thing as coronary disease, but I regarded it as a prerogative of the aged, and not a usual thing at that. As a student I had hardly heard of it—and my masters were Clifford Allbutt and Archibald Garrod. Until the war years it had made no impact on me as something that would kill or cripple friends and colleagues, often many years junior to me. For the moment I was a little startled to read "epidemic" in the letter of Dr. R. Mackarness (December 10, p. 1737), but looking

back on that period I remember my wife coming in again and again from meetings of the Medical Benevolent Fund with news of another young doctor who had died of coronary disease at an age to leave children, themselves of school age. This is a casual observation and impossible to support by statistics. But it deserves some comment. Of all people who went short of fats at that time, young and middle-aged doctors were prominent "white mice."

On general principles I heartily agree with Dr. R. W. Cockshut (December 10, p. 1738). Life is really getting too dangerous to live. La Rochefoucauld remarked about three hundred years ago that "the living strictly by rule for the preservation of health, is one of the most troublesome diseases that can be." The prospect of dragging out my remaining years on a diet of brown bread, whisky, and cod seems to me "*propter vitam vivendi perdere causas*."—I am, etc.,

London S.W.1.

F. W. WATKYN-THOMAS.

### Clients of Prostitutes

SIR,—I read your leading article on the above subject (December 17, p. 1794) with great interest. I do not think it is sufficiently appreciated that men who resort to prostitutes have not advanced beyond the adolescent "fantasy level" of sexual stimulation—which, of course, means that sexual desires are continually being whipped up by means of fantasy-thinking. Prostitutes, of course, realize this and endeavour to play their part in this fantasy world, a part which wives, as a rule, refuse to play, with the result that such men are frequently impotent with their wives, or have so outraged them that all intimacy between them has long since ceased. In the sexually matured man, sexual desire is integrated with and completely based upon the tender emotions, and is, as a consequence, infinitely more stable. In the absence of the expression of these emotions, the sexual life is left alone and comes to no harm.

Nor do I think it is sufficiently appreciated what a delicate plant the sexual instinct is and how easily it can be killed. Almost all prostitutes, of course, are completely frigid—view men who resort to them with loathing—but continue in the life for various characterological and economic reasons. And, of course, the promiscuous man or woman faces similar dangers from the way they use their sexual instinct. Sex expression divorced from the tender emotions is, as a rule, most unstable and most unsatisfying, and nearly all such men and women soon exhibit varying degrees of impotence or frigidity. It is the appearance of the latter which often drives these people to greater promiscuity, in the hope of achieving the sex union of their fantasy—a hope rarely fulfilled. And more tragically in the case of men, as I have seen, the unsatisfied sexual fantasy life may shift from prostitutes to criminal assaults on children.—I am, etc.,

Pinner.

ROBERT THOMPSON.

### Surgery of Appearance

SIR,—Fig. 3 in the article by Mr. Patrick Clarkson and Dr. David Stafford-Clark (December 17, p. 1768) shows, to my mind, not only a girl with underdeveloped breasts but also a girl with overdeveloped shoulders. Was any effort, in fact, made to assess the state of this girl's endocrine glands? Might not hormone therapy have cured her, where plastic surgery has only helped? I should very much like to know.—I am, etc.,

London N.W.4.

T. C. DANN.

## Obituary

Sir ERNEST FINCH, M.D., D.Sc., M.S., F.R.C.S.  
Hon.F.R.C.S.I.

Sir Ernest Finch, honorary lecturer on the history of medicine and formerly professor of surgery in the University of Sheffield, and a former vice-president of the Royal College of Surgeons, died on December 16 at the age of 76. For many years the leading surgeon in Sheffield, he was admired throughout the surgical world for his personal qualities and respected for his learning, experience, and devotion to his speciality.

Ernest Frederick Finch was born on September 2, 1884, and educated at the Commercial Travellers' Schools, Hatch End, near London. Gaining a scholarship to the University College of Sheffield in 1901, he graduated M.B., B.S. (with honours in pathology) at the University of London in 1906. For a year before this he had been working as a demonstrator of physiology in Sheffield, and had published papers in the *Transactions of the Physiological Society*. In 1908 he was granted the degrees of M.B., Ch.B. (*ad eundem*) by the new University of Sheffield. Proceeding M.D.(London) in 1909, he took the F.R.C.S. in 1911 and the degree of M.S. (London) in 1913. From 1907 to 1912 he was casualty officer, house-surgeon in various departments, and surgical registrar at Sheffield Royal Infirmary, to the staff of which he was elected in 1912 as honorary assistant surgeon. He also held the posts of demonstrator of applied anatomy and surgical pathology in the university.

During the first world war he served as a major in the R.A.M.C., first in France with the 3rd West Riding Field Ambulance (T.F.) and later with the 3rd Northern General Hospital. On his return to civilian life he joined the senior staff of his own famous teaching hospital in Sheffield, where by his skill, hard work, and attractive personality he soon made a great reputation and built up a large practice. From 1933 to 1944 he was professor of surgery in the university, and when he ceased to lecture on surgery he was appointed honorary lecturer on the history of medicine. On his retirement from the active staff of the Royal Infirmary he was appointed consulting surgeon, and, by the aid of subscriptions from his colleagues and former students, the Ernest Finch Medical Library was established in the Royal Infirmary. For the great work which he had done in Sheffield he was in 1951 honoured with a knighthood. In Sheffield itself his distinction as surgeon and citizen was recognized by his being elected a Trustee of the Sheffield Town Trust, and in 1953 the university conferred on him the honorary degree of D.Sc.

Sir Ernest Finch devoted much time to the work of the Royal College of Surgeons, on the council of which he served from 1941 to 1954. Elected a vice-president in 1949, he acted as senior vice-president in the following year. He delivered the Bradshaw lecture in 1951, the Vicary lecture in 1953, and in 1957 he gave the Hunterian oration, taking as his subject "The Influence of the Hunters on Medical Education." Before the Medical Society of London he gave the Lettsomian lectures in 1947, his subject being "Cancer, Yesterday, To-day, and To-morrow." He held many offices in medical organizations. He was a former president of the Association of Surgeons of Great Britain and Ireland,



[Elliott and Fry]