erythroblastotic babies. Each mother willingly donated 300 ml. of blood, and from this the temporary storage and addition of the appropriate serum, has enabled us to continue Rh groupings and to increase our stocks of anti-Rh serum far beyond our own requirements.

The main objection to this routine Rh testing has been said to be the small amount of high-titre serum available. I cannot help feeling that this is wrong. We have in our refrigerators enough Rh serum to group many scores of antenatal and blood donors, and there is no reason why the hospital, and, what is more important, the sensitization of Rh-negative mothers by Rh-positive blood transfusion will be avoided and the appropriate blood for the erythroblastotic baby and the Rh-negative obstetric haemorrhage case will always be available and ready for immediate use.—I am, etc.,

R. A. ZEITLIN,
Medical Superintendent.
St. Mary's Hospital, Portsmouth.

The Incision for Appendicectomy

SIR,—May I be permitted to express my concurrence with the views of Mr. R. H. Franklin (April 13 p. 585) on the subject of the incision for appendicectomy, with one important exception. This is in regard to his hard-and-fast distinction between McBurney's and Rutherford Morison's incisions. I have found advantage in making my skin incision for a gridiron nearer to the umbilicus, suitable for all hospitals. This incision can be readily and rapidly extended upwards and laterally by splitting the external oblique and cutting through internal oblique and transversus abdominis muscles—i.e., converted into a Rutherford Morison. In my experience this expedient is seldom necessary. Hence a patient with acute appendicitis can be given the benefits of short convalescence and minimal peritoneal scar in the majority of cases.

Thus in a series of 100 cases of acute appendicitis operated on in 1944 and 1945 I used the paramedian incision on 31 occasions and the gridiron incision on 69. In only 5 of the 69 cases did I find it necessary to extend the incision as a Rutherford Morison. It is perhaps pertinent to add that in order to avoid expanding the incision, in 2 cases the appendix was removed by retrograde dissection.—I am, etc.,

BRIAN WEBBER.

Operation for Varicose Veins

SIR,—In pursuance of the policy of pooling information about the operation of simultaneous ligature and injection of varicose veins I beg to report three cases.

First, almost every patient under my care after this procedure has a temperature of 98 and 100°F. (36.7 and 37.8°C.) for two to four days afterwards. This in spite of a technique such as I would use for a cartilage, a hernia, or thyroid. I think it must be due to the extensive chemical phlebitis that follows. It is recommended by a large proportion of the policy of keeping patients under observation for three to four days after the operation, although they are got up for toilet purposes from the evening of the day of operation.

In the use of saturated common salt solution for injection I have had four patients who have had small areas of skin necrosis, two at the apex of Scarpa's triangle, one at the junction of the lower and middle thirds of the thigh, and the third patient had an area of dead skin the size of a florin at the back of the calf after ligature and injection of the external saphenous vein. In three cases separation and healing followed uneventfully; in the fourth case the skin necrosis was noted at the end of the operation, so the skin was immediately excised and sutured with primary healing. The practical lesson from this is to spread the injection evenly throughout the length of the varicose vein traversed by the special olive-headed needle (Down Bros.), which I introduce into the vein. It is a rare complication, but it may be advisable to discontinue the use of this fluid. I am watching the results carefully. It has always followed the retrograde injection and never when the insertion has been from the foot in support of the policy I advocated.

Lastly, I have to report a death in my clinic. A spinal analgesic, which was carefully given, did not work. This was supplemented by a general anaesthetic; collapse occurred during the operation, and the patient, a young man in his twenties, died in the ward half an hour later. The post-mortem showed a well-developed thymus gland. I would make two observations on this: first, that a local or general anaesthetic is the most suitable for this procedure—I do not think a spinal analgesic advisable. Secondly, the operation is a major one and will probably always carry a small mortality. Therefore we must evaluate it correctly to the profession and to the public.

I have recently heard of the report in the daily press of the inquest on a patient who died during an operation for varicose veins, due to the injection of methylated spirit instead of saturated common salt. In future I am using this solution coloured sea blue with indigo carmine to avoid such an error, while concentrated glucose is being tinted with congo red.—I am, etc.,

HAROLD DODD.


Hospitals for the Aged and Infirm

SIR.—Dr. Mungo Park's letter (April 6, p. 549) is a welcome plea for hospitals for the aged and sick, a subject which is so often treated as a stepchild. During the war many hospitals have admitted a very large number of patients with senile dementia, many of them of the simple dementing type who have no real need for special psychiatric treatment. The shortage of suitable accommodation elsewhere has resulted in their being transferred to the mental hospitals, which have provided the only portal of entry through their ever-open doors, even though the overcrowding is deplorable, often being as much as 25% over the already inadequate peacetime accommodation. Much more could be done for senile cases if a constructive policy was followed in which there was a proper means of sorting, initial observation, and specialized care in institutions meant for the purpose. Most of the cases could well be nursed in converted Army camps, such as Dr. Mungo Park has suggested. There is, however, the opportunity for the use of far larger units than those of fifty beds he mentions, as this would not give adequate classification, which is just as essential among the senile states as in other kinds of hospitals.

Making an analysis of 411 fairly recently admitted elderly cases which we are at present investigating, we were able to divide them into four diagnostic groups: (1) the simple dementing, (2) the confused, (3) the affecive, and (4) the paralysed. From this it was found that the affective group, which was often accessible to conclusive treatment, offered the greatest recovery and discharge rate—namely, 49%—and the death rate recruited mainly from the senile confusional states, roughly 78% of this type dying within one year of admission. Further investigation into our case material revealed that of the 411 patients 135 have been discharged, 155 died in our hospital, and the rest remained with us as chronic material. Out of these latter cases approximately 28% need psychiatric environment; the rest do not.

These figures are suggestive of two needs: (1) that there is an increased need for special psychiatric hospitals for the aged where, with proper treatment, in a number of cases rehabilitation can be achieved, (2) that the senile state, as Dr. Park suggested, is not infrequent where the simple dementing type of seniles who are in no need of special psychiatric treatment could be looked after. The consideration of these two suggestions may offer better opportunities for the treatment of the elderly patients.—We are, etc.,

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F. REITMAN.

Spontaneous Hypoglycaemia

SIR,—The communication by Dr. N. G. Hubert and Mr. R. J. McNeil Love describing a case of hypoglycaemia complicated by hypoglycaemia in the Journal of April 20 (p. 603) invites comment and criticism. In this communication we are not given sufficient details with regard to the "attacks," including the one which was witnessed in hospital on Sept. 7, 1942, to be