TABLE OF RESULTS OF EXPERIMENTS ON GUINEA-PIGS TO DETERMINE THE ANTISCORBUTIC PROPERTIES OF LEMON-JUICE EXPOSED TO VARYING DEGREES OF HEAT.

No.	Weight in grammes	Diet.	Course.	Result.	Gain or loss of weight.	Scurvy signs.	Duration (days).
32	250	Lemon-juice boiled 5 minutes. 1/5 tablet = 4'4 c.cm.	Paralysis of hind legs and 26-day signs.	D. 29th day.	Nil.	Hæmorrhages, subcutaneous and intestinal. Sp. large and hæmorrhagic.	29
33	340	" "	Steady growth.	R.	Gain 100.	Nil.	80
34	270	" "	" "	R.	Gain 160.	Nil.	91
35	300	" "	" "	R.	Gain 120.	Nil.	91
36	340	Lemon-juice boiled 5 min. 1/10 tablet = 2'2 c.cm.	" "	R.	Gain 110.	Nil.	91
37	350	" "	" "	R.	Gain 180.	Nil.	91
41	300	Deacidified lemon-juice boiled 5 min. 10 c.cm.	" "	R.	Gain 130.	Nil.	90
42	340	Lemon-juice heated at 58° C. for 45 min. 1/5 tablet.	" "	R.	Gain 170.	Nil.	93
43	270	" "	" "	R.	Gain 160.	Nil.	93
44	340	" "	Practically no growth for 6 weeks, then rapid fall.	D.	Loss 90.	None definite beyond emaciation.	67
45	240	" "	Steady growth.	R.	Gain 160.	Nil.	93
46	290	1/10 tablet of above.	Steady growth for 9 weeks, then rapid fall; normal diet on 67th day.	Final re-recovery.	Gain 20.	Stiff joints and paralysis of hindquarters.	93
47	240	" "	Steady rise.	R.	Gain 160.	Nil.	93
40	280	Control; basal diet only.	Began to lose weight 22nd day; rapid fall.	D.	Loss 120.	Blood, bones, and joints.	39
48	260	" "	Began to lose weight 24th day; rapid fall.	D.	Loss 50.	Hæmorrhage; fragile bones; large joints.	41
39	300	Basal diet, plus 1 c.cm. fresh blood.	Steady loss of weight from 20th day.	D.	Loss 80.	" "	39
38	250	" "	Scurvy signs on 27th day; put on cabbage 36th day; rapid recovery.	Final re-recovery.	Gain 100.	Face-ache; painful joints; diarrhœa; ophthalmia.	64

D., died. R., recovery. Sp., suprarenal.

Conclusions.

(1) The concentrated lemon-juice will keep well in concentrated juice or tablet form.

(2) Boiling the lemon-juice for five minutes does not appreciably diminish the antiscorbutic property.

(3) Heating for three-quarters of an hour at 58° C. diminishes it to a more marked degree. The equivalent of 2'2 c.cm. in one animal gave complete protection; 4'4 c.cm. completely protected three out of four.

Note.—In an annotation on this paper (THE LANCET, Oct. 23rd, p. 863) the question was raised of the utilisation,

for its antiscorbutic content, of the magma from the manufacture of citric acid by precipitation with chalk. In my previous paper (May 22nd, 1920) the deacidified juice mentioned in para. 2, p. 1104 (and in first series above), and which added to an otherwise scorbutic diet prevented scurvy in guinea-pigs and enabled normal growth to proceed, was prepared in such a manner. To the fresh juice precipitated calcium carbonate was added in excess, the mixture brought just to the boil and filtered; the filtrate gave the deacidified juice used.

Clinical Notes :
MEDICAL, SURGICAL, OBSTETRICAL, AND
THERAPEUTICAL.

A SIMPLE METHOD OF TONSILLECTOMY.
BY SIR JOHN O'CONOR, K.B.E., M.A., M.D.T.C.D.,
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I WOULD like to invite attention to a simple and effective method for removing tonsils and adenoids.

Ether is given by the open method and the patient is placed in a supine position on the operating table, with the head semi-extended over a medium-sized circular sand cushion, held firmly fixed in a vertical position between the hands of an assistant standing behind the head of the table. Another assistant, standing on the right side, introduces a Doyen's mouth-gag and maintains it in situ. The operator, standing on the left side, passes Mackenzie's tonsillotome of suitable size towards back of pharynx, at the same time gliding his left index finger downwards alongside of instrument to guide it into position so that it may encircle the left tonsil—this is combined with a gentle inward push of the handle which fixes the ring against the lateral pharyngeal wall below the projecting tonsil. The guillotine is then pressed home and the tonsil removed. The assistant at once removes the gag, he and the operator change sides, and the same procedure is repeated on the right side, after which the operator passes his right index finger behind the palate in quest of adenoids, which, if present, are at once removed by a curette. The gag is then removed, and the patient's head and shoulders are dropped, momentarily, over side of table to facilitate ejection of blood.

The essentials of this method are rigid maintenance of the head in the vertical position, and the intelligent assistance of the left index finger.

A CASE OF
TRANSPOSITION OF CÆCUM, APPENDIX,
AND COLON,
WITH ABSENCE OF THE SIGMOID FLEXURE.
BY VINCENT J. GLOVER, M.D. LIVERP., M.B., CH.B. VICT.

THE operation which is here described was recently performed upon a patient who first consulted me some six months previously.

At that time he suffered from pain which began on the right side, skirting the lower angle of the scapula, and radiating round the flank towards the umbilicus; shortly it became intense and localised midway between the umbilicus and McBurney's spot. Vomiting of green bilious fluid occurred; I found no temperature and no other symptom upon examination of the abdomen beyond marked tenderness on palpation over the region of McBurney's spot and along a line extending from it half-way to the umbilicus. After a few days' rest and appropriate treatment the patient resumed his occupation, taking a light diet. I formed the opinion that he had had an appendicular attack, although I was not quite satisfied, suspecting the presence of gall-stones. A similar attack supervened after three weeks' interval, and upon the occurrence of a third I consulted with Dr. A. Gordon Gullan, who inclined to the view that there was some gall-bladder trouble, and probably some appendicular disease. The patient was dieted and treated, and recovered rapidly, but another attack followed, and I decided to operate.

The abdomen was opened by the rectal-sheath method. There were extensive adhesions of the small intestine. The condition evidenced several attacks of localised peritonitis. During search for the appendix a loop of small intestine presented itself; as the latter was brought through the abdominal incision a circular ulcer perforated, but was rapidly dealt with. Passing the hand into the left iliac fossa one felt the bladder with an enlarged prostate drawn over towards it by adhesions to bowel, and by adhesions of bowel to parietal peritoneum. These were separated, and the bladder resumed its normal position. Searching for the appendix I then found that there was a complete transposition of the large bowel. The ileum ended in the cæcum on the left side of the abdomen, the cæcum being continued up on the left side as the ascending colon, passing into the transverse colon, and thus descending on the right side as the descending colon. At the level of the iliac crest the descending colon passed at an acute angle to the centre of the brim of the true pelvis to descend as the rectum. A remarkable feature was the absence of the sigmoid flexure. I examined the gall-bladder, and cystic, hepatic, and bile-ducts and found no evidence of gall-stones. There was no transposition of any other abdominal organs. The patient at no time had a temperature during his attacks.

Recovery after the operation has been rapid. The facts here stated will be corroborated by Dr. Douglas P. Blair and Dr. J. Dunn, who were present at the operation.

A CASE OF

NERVE SUTURE WITH IMMEDIATE RETURN OF SENSATION.

BY WILLIAM ROBERTSON, M.D. GLASG.

THE reference in THE LANCET of July 24th to denervated muscle recalls a case I had to deal with some time ago, of which the following is a brief clinical account:—

In 1897 a boy, aged 11, fell from his pony, sustaining a compound fracture of the left humerus near the elbow. The boy cried out and a kaffir pulled the injured arm rather roughly. The sharp edge of the fractured humerus could be easily seen in the wound. No attention at the moment was paid to the innervation of the arm owing to the extensive wound in front of the joint and the setting of the fracture. The limb was put up in rectangular splints. The wound healed rapidly and early movement could be practised. It was soon noticed that atrophy of the forearm and hand was too extreme to have been caused by the mere splinting of the limb, and sensation was bad in the fingers. One night the forefinger came accidentally in the candle and was burned without the patient being aware of it. After the wound was healed the bone united and the joint was mobile. An incision was made over the median nerve some distance above the site of the fracture. Abundant cicatricial tissue was met with enveloping the nerve. After freeing the nerve from this the sheath was found to be intact, but on running the finger along a gap was observed indicating the complete severance of the nerve within its sheath, the gap measuring perhaps 2 or 3 mm. The sheath was cut through the gap, and when the two cut ends of the nerve were examined each surface was found covered with small oval bodies, the repair material of a severed nerve. No formed tissue existed between the ends of the nerve. The repair material was shredded off down to normal nerve fibre, and the two ends of the nerve were sutured through with fine silk. In opposing the ends the proper alignment of the nerve was observed. The nerve sheath was carefully stitched up. When the boy came out of chloroform, or shortly afterwards, with an exclamation of surprise he told me he could feel his fingers. He could also discern articles placed between fingers and thumb.

The wound healed by first intention. The splint was continued and for a few weeks gentle daily movement of the elbow-joint was all that was attempted. To the integrity of the nerve sheath is to be attributed the early functioning of the nerve cells. The arm since the operation has given no trouble and is now perfect in function and strength. No doubt the nerve was severed inside its sheath by the rough pulling on the arm at the time of the accident.

Mossel Bay, South Africa.

LITERARY INTELLIGENCE.—Messrs. W. Heinemann (Medical Books), Ltd., will shortly publish a new work on "Gout, Its Etiology, Pathology, Course and Treatment," by Dr. Ll. Jones Llewellyn, to contain a section on Ocular Disease by Dr. W. M. Beaumont.

COMPLAINTS AGAINST AN INSURANCE MEDICAL OFFICER.—Complaints were recently made by two patients against a panel doctor in Devonshire, and the report of the committee of inquiry, which was held at Okehampton, was forwarded to the Ministry of Health. Dr. Addison has replied that he is not satisfied that the continuance of the medical officer referred to would be prejudicial to the efficiency of the medical service of the insured, and consequently will take no further action in the matter. One of the complainants was ordered to pay 2 guineas towards the costs of the medical practitioner, but as the other complainant was deceased no order would be made.

Medical Societies.

ROYAL SOCIETY OF MEDICINE.

SECTION OF OBSTETRICS AND GYNÆCOLOGY.

A MEETING of this section of the Royal Society of Medicine was held on Nov. 4th, Professor HENRY BRIGGS, the President, being in the chair.

Dr. J. D. BARRIS and Dr. M. DONALDSON presented a short communication on

Acute Inversion of the Uterus: Treatment by Blood Transfusion and Late Replacement.

Dr. Barris said that the patient, a housewife, aged 34, had been admitted to hospital on August 12th on account of collapse and hæmorrhage following labour.

She had been married for six years and twice pregnant; the first pregnancy had ended in miscarriage at the third month, September, 1914, and the second in labour at term, October, 1916, when she was delivered of a 10lb. child without difficulty. The present labour, which was conducted by a midwife, began at 3 A.M. and a child weighing 7 lb. was born at 6.5 A.M. on August 12th, the perineum being torn incompletely. The placenta did not come away spontaneously, and after two hours the midwife delivered it by expression, at the same time pulling on the cord. Profuse hæmorrhage followed and the patient "felt something come down." On her admission to hospital at 5 P.M. she appeared blanched and collapsed. Temp. 98° F., pulse 120. A swelling, identified as the uterus, was found rising to 4½ in. above the pubes, and in the position of the fundus a distinct cup-shaped depression could be felt. The vagina contained much fresh blood and blood clot. The fundus uteri could be felt projecting through the external os and lying just inside the vaginal orifice, and a diagnosis of acute inversion was made. It was decided to treat the patient for collapse and hæmorrhage and to postpone the replacement of the uterus. Pituitrin, 1 c.cm., was injected hypodermically and a hot vaginal douche was given. Two days later the red cells numbered 1,800,000 and blood transfusion was attempted (citrate method), but owing to a fault in the apparatus only 100 c.cm. could be introduced. The patient continued to bleed and on August 27th the red cells numbered only 1,200,000. 600 c.cm. of blood were transfused on Sept. 3rd, and the number of red corpuscles rose to 2,570,000 on Sept. 4th. Local sepsis, evident within three days of admission, was treated by means of Carrel's tubes inserted into the vagina, using a solution containing 1 in 4000 pot. permang. and 1 per cent. sod. sulph. The irrigation was continuous, and so regulated that if the pads were changed every three hours the bed remained dry. On August 18th, during micturition, the fundus became completely inverted and protruded from the vulva. Considerable shock ensued, and the fundus was wrapped in sterile gauze but not replaced. Three hours later it was irrigated with saline and pushed back into the vagina. Reposition of the uterus, which had involuted well, was carried out on Sept. 29th by means of Aveling's repositor, and was complete within 19 hours of its application. The repositor was removed from the uterine cavity after five minutes' gentle traction. On Oct. 4th patient appeared in good health; the fundus was normal in situation and contour, and no bleeding had occurred.

Dr. Barris added that the case presented several points of interest. It was an addition to those recently described by Dr. Herbert Spencer,¹ and it emphasised the value of late reposition of the uterus, as practised by him. The case also illustrated the value of blood transfusion in marked anæmia. The third point of interest was the demonstration that Carrel's tubes could be used for sepsis during the puerperium with no discomfort to the patient.

Discussion on Latent Syphilis during Pregnancy.

Papers on this subject were read by Dr. R. A. HENDRY, Dr. AMAND ROUTH, and Mr. JOHN ADAMS. These are published in full in this issue of THE LANCET.

In the course of the discussion Mr. CHARLES GIBBS said that his 25 years' experience in charge of women and children at the London Lock Hospital had shown him how deplorable was the gross neglect in the treatment of syphilis in pregnant women until the last few years. A poor woman suffering the double burden of pregnancy and the disease could not gain admission

¹ THE LANCET, 1919, ii., 877.