Correspondence.

"Audi alteram partem."

THE DIFFERENTIATION OF HEART MURMURS IN SOLDIERS.

To the Editor of THE LANCET.

SIR,—Amongst the many problems in connexion with war illness presented for solution, few are more interesting and more difficult than the distinction between organic valvular defects and their counterpart, or mimicry, occurring in the course of functional heart derangement. The importance of a correct diagnosis can scarcely be over-estimated, and the difficulties the problem presents may be gauged by the fact that a large number of cases have reached the hospitals in this country with the diagnosis of V.D.H. (valvular disease of the heart), which long and careful observation and suitable treatment have proved to be functional. In the majority of these cases the diagnosis was presumably based upon the existence of a murmur, though no doubt other signs and symptoms were also taken into consideration.

The cause and detection of functional heart murmurs has interested me for many years, and my connexion with the Northumberland War Hospital has afforded me considerable fresh opportunity of investigating the subject as well as the nature of the so-called "soldier's heart" generally. But my object in writing this letter is to call attention to a method by which I believe functional murmurs can, as a rule, be distinguished from organic. I may say that in my experience a systolic bruit can be detected in the great majority of cases of functional derangement of the heart arising in some way out of war conditions, whether from strain, shell-shock, or other nervous causes. It is true these murmurs are not always present; at times they stop and remain absent for hours; they may be audible when lying and not when standing, or *vice versa*; they may diminish even to vanishing-point under examination; but frequent examinations will nearly always lead to their detection, and they are usually best heard towards the right of the apex, and especially when the patient is lying on his left side. They are not well conducted beyond the apex, and often cease when the patient draws and holds a long breath. The chief point, however, to which I wish to draw attention is the fact, which I regard as almost conclusive, that the functional apical murmur will at once become inaudible when the fingers of the observer holding the bell-piece of the binaural stethoscope press in the ribs upon the heart as the patient lies on his left side. It is well when examining the case to stand on the right side of the bed and stoop over the patient, and in this way the fingers of both hands can be employed to press in the ribs and interspace auscultated upon the heart; or the observer may be on the left side of the patient and an assistant directed to make the necessary pressure. In the case of organic murmurs—e.g., those of mitral regurgitation—the firmest pressure fails to render the bruit inaudible, and may intensify it.

I may mention incidentally that I have noticed whilst investigating heart murmurs in this way that pressure considerably modifies the presystolic bruit of mitral stenosis, for as the chest wall is being pressed in upon the apex the murmur becomes shortened and loses some of its rough character. It would seem that firm pressure renders inaudible sounds which are really due to chest-wall vibrations, and are therefore exocardiac in origin.

I am, Sir, yours faithfully,

Newcastle-on-Tyne, Oct. 24th, 1916.

DAVID DRUMMOND.

THE MANUFACTURE OF SALVARSAN PRODUCTS IN ENGLAND.

To the Editor of THE LANCET.

SIR,—Major Ernest Lane has drawn renewed attention in THE LANCET of Sept. 30th to his unfortunate experiences with kharsivan. We feel that it would be unfair to the firm of chemists which was so enterprising as to place this substance at the disposal of British medical men so soon after the beginning of the war if we were not to state our own experience, which has been very much more favourable than his.

We have used about 1400 doses of kharsivan and neo-kharsivan (nearly all the former), the injections having been given by one of us or under our supervision. In military cases we have followed the new Army regulations for the treatment of syphilis, and in civil and private practice we have usually given the full dose of 0.6 gramme to adult males and females alike. Our experience has been the same. We have seen no symptom which could possibly be considered as being due to arsenical poisoning, no rashes, no violent reactions, and, in short, nothing which could give either of us a single moment's uneasiness as to any of our patients. In most cases there are no symptoms of any sort, but in early syphilis there is usually a slight temperature reaction, rarely exceeding 100° F., but this almost always subsides in a few hours. There is often some slight gastric disturbance; anything more than this can usually be traced to a surreptitious meal before or after the injection. Often there is a sharp movement of the bowels, rarely diarrhoea. No patient has been kept in bed for more than one night owing to the severity of the symptoms.

Most of our patients have been young and otherwise healthy men, but in the civil practice of King's College Hospital and in private there have been numerous injections in older men and in females of all ages. One of us injected a man 70 years of age, who suffered from severe cystitis due to B.coli, without any unpleasant results. We make a routine examination of the urine in all cases, and regard even a slight trace of albumin, if probably of renal origin, as a contraindication. So far we have met with no other. In all cases the patients are prepared as for an operation, being given an aperient the previous night and kept in bed for about four hours without food before the injection. They stay in bed for the rest of the day, and are only given light food. We use water that has been distilled in the laboratories of the hospital under the supervision of one of us and autoclaved immediately afterwards. We take care that the vessel containing it is not opened, even momentarily, after sterilisation until it is required for use. We dissolve the drug in water which is nearly cold, and add about five or six drops of 15 per cent. caustic soda beyond the point required for complete re-solution of the precipitate. We never use a solution which has been prepared for more than half an hour, and prefer to use it as soon as it has been prepared.

We are, Sir, yours faithfully,

W. D'ESTE EMERY,

Captain, R.A.M.C. (T.),

JOHN EVERIDGE,

Captain, R.A.M.C. (T.).

Harley-street, W., Oct. 31st, 1916.

ENTEROCOCCUS IN THE URINE OF CONVALESCENT SOLDIERS.

To the Editor of THE LANCET.

SIR,—In an important paper in your issue of Oct. 7th attention is called by Major T. Houston and Captain J. M. McCloy to the importance of the enterococcus in "trench fever" and allied conditions. Certain observations made by us in the routine examination of the urine of soldiers convalescent from enteric fever, paratyphoid fever, and dysentery led us to the conclusion that military service abroad and perhaps the occurrence of lesions in the intestine were often followed by the invasion of the system by enterococci and by their excretion in the urine. In fact, urinary "enterococcic carriers" are very commonly met with among soldiers at command depôts and convalescent camps. Many of these "carriers" suffered from vague articular and myalgic pains, others had no symptoms whatever.

We find on consulting our records that in one series of 162 specimens examined 22 were found to contain enterococci. A number of these strains were tested as to their fermentative reactions, and we found that there was considerable variation among the individual strains, some having the characters of what we usually term in this country streptococcus faecalis, and as such generally fermenting mannite, others fermented glucose, lactose, and saccharose, but not mannite, whilst some had no action on any sugar, and in this respect corresponded with the description given by French bacteriologists, such as Macé, to the enterococcus. French writers¹ have recently shown that frequently the

¹ Sartory, Lasseur et Spillmann: Diplocoque dans le Sang des Suspects de Typhoïde, Compt. R. de la Soc. de Biolog., vol. lxxviii., p. 257 (1915), and Bourges, Lancelin et Joly in Compt. R. de la Soc. de Biolog., vol. lxxviii., p. 632. Also Lebrun et Portier, ibidem, p. 440.

enterococcus gives rise to a condition clinically resembling enteric fever, and that it is often associated with the *B. typhosus* in other cases.

It is evident, therefore, that the enterococcus plays an important rôle in infective processes, and the work of Major Houston and Captain McCloy would seem to show that many cases of "trench fever" are due to its activity. I think most observers will agree with their conclusion, which is very cautiously stated in the following words: "Our experience with the enterococcus appears to show that when the organism is found in urine it is frequently an infecting agent." In rheumatic conditions it is very common to get enterococci in the urine, and vaccines prepared from cultures are often very efficacious in treatment. Our own observations tend to show that subsequent to an acute infection enterococci continue to be found in the urine. There is evidently a sort of subinfection which, under certain conditions, may become acute.

We are, Sir, yours faithfully,

GEORGINA DARLING, M.B., D.P.H.,

W. JAMES WILSON, M.D., D.Sc.,

Captain, R.A.M.C. (T.F.); Specialist Sanitary
Officer, Belfast District.

Hygiene and Public Health Laboratory, Queen's
University, Belfast, Oct. 19th, 1916.

SOLDIERS AND VENEREAL DISEASES.

To the Editor of THE LANCET.

SIR,—During the past two years the Liverpool Medical Institution has distributed over 160,000 copies of pamphlets especially written in plain non-technical language for soldiers, warning them of the dangers and disabilities incurred by contracting these avoidable diseases. The Army authorities in Egypt have reprinted the tract for their own use. We desire to enlist your support by the insertion of this letter, and invite inquiries for specimen copies from commanding officers, medical officers, chaplains, social workers, and others interested in our soldiers, addressed to the Librarian, the Medical Institution, Liverpool.

I am, Sir, yours faithfully,

CHARLES J. MACALISTER,

Liverpool, Oct. 31st, 1916.

President.

THE ETHICAL STANDARDS OF PANEL PRACTICE.

To the Editor of THE LANCET.

SIR,—In Dr. Mitchell Bruce's address to students at the opening of the winter session the following passage occurs (*vide* THE LANCET, Oct. 21st):—

It is in this way surely that you have been brought to Charing Cross Hospital to-day—not, I am sure, for purely commercial ends, which it is to be feared have been promoted by the panel.

I presume the concluding word refers to National Health Insurance practice, and it strongly suggests, if it does not actually accuse, panel practitioners of lacking in the spirit of medicine which ought to inspire them—that they are tempted by the conditions of panel practice to dishonour their calling. This is an offensive remark, uttered *ex cathedra*, and I trust that the young students who will later on join a panel will not accept the view that panel practice does not claim as many conscientious doctors in its ranks as any other form of medical practice. The integrity of Dr. Bruce's excellent address is marred by this unfortunate reference, which I am sure is quite undeserved.

I am, Sir, yours faithfully,

Kensington, W., Oct. 24th, 1916.

O. ECCLES.

SPINAL ANÆSTHESIA IN ACUTE ABDOMEN.

To the Editor of THE LANCET.

SIR,—The advocates of the above method make no mention of the minor drawbacks, which probably appeal to the anaesthetist more than to the surgeon. Supposing one is dealing with a case in which there are acute suppuration and general peritonitis, surely the mere act of turning the patient on to his side cannot improve the condition; and if there is a large localised abscess on the verge of rupture before adhesions have been firmly developed, then this moving about might possibly tend to break them down. Another

objection is that though the superficial tissues are anaesthetised with ethyl chloride or hypodermic injection of novocaine there is still some pain caused when the needle is pushed through the deep tissues into the spinal canal, which gives rise to a certain amount of shock. There is always the drawback to a nervous patient that he is conscious of the progress of the operation, and when the peritoneum or mesentery is handled to any extent there is considerable discomfort. Lastly, anyone who has any experience of spinal anaesthesia is aware that a small proportion of cases show signs of collapse from the anaesthetic *per se*.

The most satisfactory anaesthesia in acute abdomen, in my experience, is obtained by giving the patient a hypodermic of morphine and atropine followed by gas and oxygen administered with some such apparatus as the Gwathmey, with or without the local injection of novocaine. If the latter is used then there ought to be no difficulty about getting complete relaxation, but even if it is not used the result is so good, in that there is almost complete freedom from shock, that the temporary inconvenience to the surgeon ought to be well compensated for by the advantage gained by the patient. The addition of a small quantity of ether or mixture makes very little difference as regards after-effects to the patient and helps the relaxation.

I am, Sir, yours faithfully,

HUGH R. PHILLIPS, M.D. Edin.,

Senior Anaesthetist, Italian Hospital; Anaesthetist to the King
George Hospital, Royal Flying Corps, and Endsleigh Palace
Hospital for Officers.

Dawson-place, W., Oct. 21st, 1916.

FALLOPIAN TUBE FOUND IN FEMORAL HERNIA.

To the Editor of THE LANCET.

SIR,—The following notes may be of interest in connexion with similar cases reported in THE LANCET of Oct. 21st and 28th:—

A woman while doing housework one afternoon was seized with a sudden severe pain in the lower part of the abdomen. She was about five months pregnant at the time, and thinking she was threatened with a miscarriage she sent for the midwife. The nurse gave her an enema, the bowels acted freely, and the pain lessened somewhat. She became worse later in the evening and I saw her about midnight. Her temperature was normal, pulse 102. Vaginal examination showed no signs of labour. The bowels had acted and she had not vomited, but she looked very distressed, and there was a slight rigidity in the lower part of the abdomen. She was a corpulent woman; she was not aware of the existence of a hernia, and it was only after careful examination that a small swelling no bigger than a walnut was found embedded, so to speak, in the fat of the right groin. It was dull on percussion, irreducible, and had no impulse on coughing; it was thought to be a strangulated femoral hernia containing a small piece of omentum. On opening the sac about a teaspoonful of turbid serum escaped. The only structure found in the sac was the fimbriated extremity of the Fallopian tube; it was intensely injected and of a dark purple colour. Doubts were entertained as to the vitality, so I excised it and closed up the femoral ring. She carried the foetus to full term, and was delivered of a healthy male child.

The points of interest are the presence of the Fallopian tube in a femoral hernia at the fifth month of pregnancy; the difficulty of exact diagnosis, the absence of vomiting, the movement of the bowels, the dull percussion note suggested omentum. The excision of the tube has apparently not interfered with subsequent conception, for since the operation, five years ago, she has given birth to two full-term children.—I am, Sir, yours faithfully,

J. F. DEVANE, M.D., F.R.C.S. Irel.,

Hon. Surgeon, Limerick County Infirmary, and
St. John's Hospital, Limerick.

Oct. 30th, 1916.

SKIAGRAMS OF GAS GANGRENE.

To the Editor of THE LANCET.

SIR,—In the report of my paper on Gas Gangrene in your issue of Oct. 28th (p. 754) an error appears. The French worker who had great experience with cases showing a fine striation believed that the *vibrio septique* was always found where that X ray appearance was seen. He recognised there were other appearances due to other organisms which were equally capable of giving rise to gas gangrene.

I am, Sir, yours faithfully,

Weymouth-street, W., Oct. 29th, 1916.

AGNES SAVILL.