been made by our committee as to the methods or means by which the public may obtain the necessary disinfecting material, the fact that such materials are easily obtained at any chemist being in our opinion quite sufficient. The aim of the committee is solely the instruction of the public."

Mr. Walker has summed up our wishes in his sentence, "let each of the societies work along the line it has chosen." My society would welcome the teachers of moral prevention as allies working along another line towards the same goal, if they on their part would accept the alliance of the teachers of medical prevention and not waste valuable energy in opposition that is not only unnecessary but also hopeless as long as disinfectants are acknowledged to disinfect. As regards Mr. Walker's suggested meeting between the two societies, official correspondence between the presidents of the two societies with this object occurred not long after the foundation of our society in 1919. My society stated their willingness to meet the National Council in conference if the National Council would accept and endorse the principles and practice of immediate self-disinfection as one of the valuable methods of preventing venereal infection. This the National Council were unable to do, and therefore the conference fell through. Our offer to meet the National Council on these grounds has never been withdrawn.—I am, Sir, yours faithfully,

H. WANSEY BAYLY,

Honorary Secretary, Society for the Prevention
of Venereal Disease.

143, Harley-street, W., Feb. 12th, 1921.

CONGENITAL SYPHILIS AMONG THE NEWLY BORN.

To the Editor of THE LANCET.

SIR,—In your issue of Feb. 12th Dr. S. M. Ross and Dr. A. F. Wright, in an article under this heading, seem to quote me in support of their statement that an estimate of the amount of congenital syphilis among the newly born, based upon Wassermann reactions upon the umbilical cord serum, will be lower than is actually the case. This is the exact opposite of the impression I wished to convey in the paper they referred to. I showed that a positive Wassermann reaction at birth in most cases merely indicated that the mother had a positive reaction, which passed passively into the infant. If the infant was tested a short time after birth it was found to have a negative reaction. Thus a test of the umbilical cord serum cannot be taken as an indication of syphilis in the infant and estimates of incidence based upon such tests will be *much too high*.

Since my paper was published in 1915 I have seen this umbilical cord reaction quoted as evidence of the ravages of syphilis, and, further, such "syphilitic" infants have been "cured" with remarkable facility with salvarsan. It has always seemed to me that this test introduces a gross error into the work of infant welfare organisations so far as syphilis is concerned. No one can take exception to the conclusions of the present authors, but it is to be hoped that orators will not quote them as saying that 3.5 per cent. of infants are syphilitic.—I am, Sir, yours faithfully,

London Hospital, E., Feb. 11th, 1921.

P. FIELDS.

THE INDICATIONS FOR REMOVAL OF TONSILS.

To the Editor of THE LANCET.

SIR,—With reference to recent correspondence in THE LANCET on this subject, I am of opinion, after considerable experience, that the following conclusions are justified: 1. That in children practically all tonsils can be enucleated readily and easily with the guillotine. 2. That in adults they are better removed by a dissection operation. I personally use a McKenzie separator. Provided sufficient care is taken to hit the capsule the operation is easy. But in both cases a very great deal depends upon the skill of the anaesthetist. The latter should not only be able to control the patient's head, but he should know his operator's methods well enough as to reciprocate him.

I am, Sir, yours faithfully,

MACLEOD YEARSLEY.

Welbeck-street, Cavendish-square, W., Feb. 15th, 1921.

THE OPERATIVE TREATMENT OF PROLAPSE.

To the Editor of THE LANCET.

SIR,—I am surprised to find from Mr. A. H. Burgess's letter in THE LANCET last week that he is still using paraffin wax injections for prolapse. At one time the method was popular, but, as there were so many bad results from it, I thought it had been entirely discarded. I have never used it myself, not liking the idea of introducing a foreign mass into the pelvis, which cannot be removed. But I have seen the secondary results in quite a number of cases, and these included large pelvic abscesses, often months after the injection of the paraffin, and one of the worst tunnel strictures I ever saw. The stricture case proved to be hopeless, as the mass of paraffin wax prohibited all efforts to dilate the stricture, and the patient had to have a colostomy performed. The great objection to the wax treatment is that if anything goes wrong the mass cannot be removed.

I cannot understand Mr. Burgess's argument about primary union, as, surely, with primary union no adhesions are formed. My reason for using healing by granulation in these cases is that firm adhesions between the rectal and the pelvic walls are produced—the condition which is required to hold up the prolapse; stitching the rectum to the sacrum and pelvic wall is not possible, and this method has proved a very satisfactory alternative. If the surgeon is for some reason unable to stitch up a hernial ring, or otherwise to close the opening, he will find that leaving the wound to close by granulation is a satisfactory substitute, although, of course, inferior to stitching up the parts. All I claim is that where, as in the case of prolapse, stitching is useless, the method I employ is a very satisfactory substitute—and the value of an operation depends upon the results obtained. I have treated 32 cases by this method, with only one complete failure. I am surprised that Mr. Burgess has had no failures after paraffin wax injections, and should like to know his figures.—I am, Sir, yours faithfully,

J. P. LOCKHART-MUMMERY, F.R.C.S.

London, Feb. 15th, 1921.

THE DEVELOPMENT OF STUMPS.

To the Editor of THE LANCET.

SIR,—Many surgeons of the limb-fitting centres of the United Kingdom find, after performing a very successful amputation or re-amputation of a limb, that their patients, on being fitted with artificial limbs, fail utterly to carry them, either through muscular weakness, awkwardness, or shrinkage of the stump. The surgeon naturally turns to massage and stump exercises for a remedy. These exercises are usually carried out against resistance, and to a certain extent do some good, but it is necessary to call to one's aid the brain of the patient. I make a practice of asking the patient to concentrate his mind on the foot or hand, as the case may be, of the limb he has lost. He at first finds this mental concentration hard to acquire, but once it is established he can contract muscles at the end of his stump which would be impossible without mentally attaching to his limb the distal member which has been amputated. Take, for example, a below-the-knee amputation, upper third. If the patient is asked to extend his leg with the toes pointing to the ground, both vasti will be thrown into a far greater state of contraction than that obtained by the present faulty system of exercises. Now in this same amputation, if the patient is asked to flex and extend the foot at the ankle-joint, and also evert and invert the foot, the end of the stump will be seen dimpling owing to the action of the muscles brought into play by movements at the ankle-joint.

The advantage of this system of exercises will be quickly seen in the tone of the muscles and nourishment of the stump. In educating the patient in this remembrance of the distal end of the amputated limb, the tone and development of the muscles are retained. The strength of the voluntary muscles is fully doubled. The artificial limb becomes animate and equilibrium is established.—I am, Sir, yours faithfully,

M. DOCKRELL, L.R.C.P. & S. Irel.

Special Surgical Hospital, Blackrock, co. Dublin.
Ministry of Pensions.

Feb. 14th, 1921.