Correspondence.

"Audi alteram partem."

THE CONSTITUTION OF THE PRISON COMMISSION.

To the Editor of THE LANCET.

SIR,—With reference to your leading article on the Prison Commission in your last issue I beg to be allowed to state the following facts.

On the occasion of my retirement from the office of Commissioner of Prisons last February I had the honour to be asked by the Home Secretary whether I would continue my services, in so far as they were of a medical nature, for a term of five years. On my acceptance of this proposal Lord Gladstone appointed me medical adviser to the Prison Commissioners, and also Director of Convict Prisons, with a seat and voice at the Prisons Board such as I have had ever since my first appointment as Commissioner.

The medical work which now devolves upon me is the same, both in nature and quantity, as that which I have always hitherto carried out. This work occupied in the past little more than one-sixth of the time I devoted to my official duties; it now occupies about two half-days a week, besides causing a fluctuating amount of correspondence. Having now, however, more time at my own disposal, I am able to give voluntarily more attention to any important general question that may arise affecting the medical side of prison work.

I am, Sir, yours faithfully,

Portland-place, W., May 2nd, 1910.

H. B. DONKIN.

* * We are glad to learn that Dr. Donkin's position at the Prisons Board in respect of seat and voice is unaltered. We are sure that the Board for the time being gains by receiving medical services from him, while he is unfettered by other official duties. But we regret the exclusion from the Board of a full Commissioner who is also a medical man.—ED. L.

MR. LITTLEWOOD'S METHOD OF PERFORMING THE INTERSCAPULO-THORACIC AMPUTATION.

To the Editor of THE LANCET.

SIR,—The interest which will be aroused by Mr. C. B. Lockwood's paper in THE LANCET of April 30th upon amputations at the hip and shoulder induces me to draw attention to a method of performing the interscapulo-thoracic amputation which owes its inception to my colleague, Mr. H. Littlewood. Instead of carrying out the amputation from the front and tying the vessels as soon as the clavicle has been divided, Mr. Littlewood performed the operation from behind and divided the vessels last. Shortly described, the operation was begun by the usual skin incisions and division of the clavicle. Then the operator, standing behind the patient, reflected the posterior flap sufficiently to expose the muscles inserted into the posterior border of the scapula. These muscles were raised upon the finger and divided with scissors, and near the upper angle the posterior scapular artery was divided and clipped at once. As the scapula was dragged away from the thorax by the assistant, who held the arm, the trapezius was put on the stretch and divided, the omohyoid was cut, and the suprascapular vessels were secured, before division, as they ran to the notch. The large nerves and the vessels now stood out as a big cord. The former were divided, and as they started apart the white artery was exposed for a considerable length. It was divided between two clips, and then the vein was exposed and similarly dealt with. A few cuts of the knife severed the pectorales major and minor, the latissimus dorsi, and the serratus magnus, and completed the amputation.

There can, I think, be no question that performed in this way the interscapulo-thoracic amputation is a much simpler operation than that associated with Berger's name. The real difficulty of Berger's operation lies in the preliminary ligature of the vessels after division of the clavicle.

In a muscular or a short-necked patient they may lie at a considerable depth, and before they are satisfactorily exposed a good deal of bleeding may take place. Moreover, the position of the vein in front of the artery may add very considerably to the difficulty of tying the artery first; whilst if the axilla is filled up by a large tumour pressing forwards the pectorals and increasing the vascularity of the soft parts in the neighbourhood—a not uncommon condition where this amputation is called for—the difficulty becomes formidable.¹ But by Mr. Littlewood's method there is no difficulty in dealing with the vessels. They present themselves to the operator in the right order without any need for careful dissection and at the close of an operation which except for the skin incision might almost be considered bloodless. I have had experience of both methods and the amount of blood lost in the posterior operation is decidedly less than in the anterior.

Another point that has a bearing upon the shock is the time occupied. Mr. Littlewood's method is much more speedy. Roughly, I would say that it takes half or at most two-thirds of the time required for a Berger's amputation. I have always been astonished at the small amount of shock that follows this big amputation. Of the four cases I have had, in not one was there the least need for transfusion, and of the three that were done for growth the rapidity of recovery after the operation was striking. No doubt this is due, as Mr. Lockwood points out, to prevention of loss of blood, but this object is just as well secured by Mr. Littlewood's method as by M. Berger's. To those who have tried both plans the posterior operation will, I feel sure, be much preferred, and I have very little doubt that in due time it will become the operation of choice. Mr. Littlewood has shown so little disposition to publish much of his good work that I have sought his permission to rescue this little portion of it from oblivion—partly from a feeling of loyalty to a friend, and partly because there are many surgeons who I am sure will be glad to know of it.

I am, Sir, yours faithfully,

Leeds, May 2nd, 1910.

R. LAWFORD KNAGGS.

A DISCLAIMER.

To the Editor of THE LANCET.

SIR,—In THE LANCET of Oct. 12th, 1907, pp. 1011 *et seq.*, an article was published on a surgical instrument types of which have been in universal use for some 30 years or more. The article dealt with my attempt to construct an instrument which should combine the advantages of most of the types then in use. Although the matter is an experimental one, and consequently certain small but essential measurements in my instrument have since been altered chiefly at the representation of friends, the main type remains the same, and the original makers (A) have now stamped its measurements and design for purposes of reproduction by means of certain bosses and templates in their possession. In the experimental stages of the work they devoted much time, skill, patience and money to the subject for which they might reasonably expect some return. Now the originator of any instrument in surgery does not by the etiquette of his profession patent his invention, neither does he make a penny out of it. He places it at the disposal of the profession and if they back him up in the matter, as to a large extent they do and as I think they should do, they will insist on having the actual article made by the original maker, thereby enabling him to recoup himself. Unless this is done there is no incentive to progress, because it is a losing game from the instrument maker's point of view. At the same time it is recognised that the surgeon should not advertise the firm of instrument makers. The question arises, "Can the originator's name under these circumstances be regarded as a trade description or can it not?" If the design is registered or patented I believe it can, and as such it could be infringed, but if not, I believe, strictly speaking, it cannot.

It has come to my knowledge that recently another large and respected firm of instrument makers (B) have sent a traveller round the West of England, and doubtless by now to other districts too, showing an instrument with my name

¹ Vide a most instructing footnote, Jacobson and Rowlands's Operations of Surgery, vol. i., p. 225.