If the circumstances preclude an estimate of one half, then 6 ft. (1.8 m.) can be considered safe to remove. Except when the small bowel is shortened by disease it is rarely less than 15 ft. (4.6 m.) in length.

In the more extensive resections it should be possible to estimate the length of the remaining bowel. To leave 8 to 10 ft. (2.4 to 3 m.) is ample, and the taking of the slightest risk in order to leave more cannot be justified, while 5 ft. (1.5 m.) or less may be enough for subsequent good health.

Tetany should be watched for as a possible post-operative complication.

The general tendency is for health and weight to improve, and for diarrhoea to lessen, with the passage of time.

Extensive resections give better results than one might expect, and should not be allowed to fail through being insufficiently radical.

Summary

Extensive resections of the small intestine are discussed and an attempt is made to give some guidance on how much can be removed in certain circumstances. Emphasis is placed on the proportion of the whole removed, and the amount left behind, in determining the result, rather than on the actual length resected. Two new cases are reported in which the result was satisfactory ten years and one year after a resection of the order of 70%. In each of them some 4 to 5 ft. (1.2 to 1.5 m.) of small intestine remained.

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At the Royal Society of Tropical Medicine, on December 13, Dr. D. B. Jelliffe, senior lecturer in medicine, University College, Ibadan, Nigeria, speaking on the African child, described a form of infective gangrene of the mouth which differs from cancrum oris, since it infects the bones. This terrible and destructive disease, which may strip the tissues from half the side of the face, can be cured by penicillin if taken early, but, although in such cases a remarkable degree of replacement of lost tissue takes place, there is usually gross permanent disfigurement. The aetiology is not clear, but infection and malnutrition must both be important. The newborn baby may have to share his mother's (or grandmother's) milk with a brother 2 or 3 years old, and the milk may be thin, though often unexpectedly rich in protein. Congenital syphilis and relapsing fever are common, and congenital deformities, appearing with a frequency about that observed in Europe, lead not rarely to a fatal bronchopneumonia. The estimated infant mortality rate in Nigeria is somewhere between 300 and 500 per 1,000 live births.

ORCHITIS IN BORNHOLM DISEASE

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In the light of the reported widespread outbreak of Bornholm disease in this country an account of its occurrence in a family and in a contact may be of interest, since epididymo-orchitis figures prominently as a complication.

That Bornholm disease may affect several members of a family is well known. Dabney (1888) describes a family of six children, five of whom had the disease; Payne and Armstrong (1923) cite a family of ten, all developing symptoms, within a fortnight; and further examples are given by Pickles (1933), Sylvest (1934), and Howard (1938).

The incidence of orchitis differs markedly in the various epidemics. Sylvest (1934) gives a good account of epidemic myalgia. He states that orchitis was first described as a complication by Bacher in 1896. He reviews the literature and reports 93 personal cases, only one of which had orchitis. Jamieson and Prinsley (1947) describe orchitis as the commonest complication of an outbreak at Aden. It affected 12 out of 30 male cases and was usually unilateral. Orchitis appeared between the 8th and 36th days. The duration of pain and swelling was two to six days, but in one case it was ten days. Huss (1934) states that in the Swedish epidemic of 1931 the incidence of orchitis was 50 in 884 cases. He quotes three further outbreaks with orchitis, notably one at Håby in 1931 in which an epidemic of "benign orchitis" was followed by typical myalgia. On the other hand, Scadding (1946), giving an account of an outbreak in the Middle East, makes no mention of orchitis in his cases. We can find no direct reference to this complication occurring in members of a family.

Case 1

A 52-year-old officer was taken ill on September 17, 1951, just after returning from a three-weeks holiday with his family in Devonshire. (Cases of Bornholm disease had occurred in the locality but had not been associated with orchitis.) He felt shivery and unwell and ached all over. His temperature was 103° F. (39.4° C.). Pain in the left side of the chest appeared on the 20th, and next day had spread across the front to the right. This was severe on moving or deep breathing. He was treated at home by his family doctor. On October 3 he returned to work, but aching pain started in the left testicle and lasted for 48 hours. On October 6 the pain had appeared in the right testicle, and by the 9th discomfort was acute and the organ had become swollen. On October 12 the pain across the chest returned, pleuritic in type and more severe on the right side. Next day he was admitted to hospital. His past history included the usual childhood ailments, mumps, paratyphoid, and malaria.

On examination there was no fever, but he was in some discomfort, complaining of pain in the right side of the chest and in the right shoulder. There was diminished movement of the right lower chest and at the right base air entry was

diminished. Pleural friction was heard over a small area below the right nipple. The blood pressure was 220/140. The right testis and epididymis were swollen and acutely tender. On routine examination the urine was normal. The leucocytes numbered 6,700 (polymorphonuclears 53%, lymphocytes 46%, eosinophils 1%). A chest film showed some tenting of the right leaf of the diaphragm, together with some haziness of outline. Serum agglutinations were negative for leptospira, typhoid, and brucella groups. Specimens of serum were sent to the Virus Reference Laboratory, Colindale, for tests against the Cocksackie virus. The chest pains had practically gone by October 17, although the right testicle and epididymis were still swollen but not tender. All abnormal signs had passed off by October 20, and the patient was discharged fit on the 22nd.

The family consisted of his wife and three sons. One, aged 22, on September 4 complained of indigestion and a rash, thought to be due to something he had eaten. He recovered in four days, but on September 14 he became ill again with fever, shivering, and pain in the shoulder and over the left lower ribs on deep breathing, sneezing, or coughing. Towards the end of his illness he had pain in both testicles, the left beginning first and becoming swollen. His illness lasted 14 days in all.

The second, aged 19, was taken ill on September 14 with headache, malaise, and pains over the lower ribs on both sides. Headache and photophobia were severe and his fever continued until the 27th. Towards the end of his illness pain developed in both testicles.

The third, aged 15, became ill on September 12 with nausea, malaise, and aching pains across the front of the chest. He had fever for a few days but made a rapid recovery. There was no testicular pain or any suggestion of orchitis.

The wife had a sore throat, beginning about the middle of September, but she remained well otherwise.

Case 2

A middle-aged officer had been closely associated with Case 1 since the latter returned from his holiday. On October 1 he became ill with fever, sore throat, and cough. There was no pain in the chest. Pyrexia and malaise lasted for one day only, but on October 4 he complained of pain and swelling of the right testicle. He was seen as an out-patient on the 8th, when the right testis was found to be normal but the epididymis was enlarged and tender. On the 10th there was a definite orchitis. Intermittent testicular pain and swelling persisted. Considerable enlargement and much tenderness of the testis and epididymis continued until October 24. From then onwards symptoms resolved.

Summary

The importance of orchitis as a complication of Bornholm disease is stressed.

This cause should be considered in cases of epididymo-orchitis of undetermined aetiology, particularly if the condition appears in epidemic form.

Orchitis should be looked for in cases of Bornholm disease, especially in the second week.

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"TRIGGER-THUMB" SIMULATING PARALYSIS

A REPORT OF TWO CASES

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Recently two patients have been seen who appeared at first to have an isolated paralysis of the flexor pollicis longus.

Case 1

A housewife aged 53 suddenly noticed that she was unable to flex the terminal joint of her left thumb. She had not had any previous symptoms in the thumb, and her only other complaint was of some acroparaesthesiae in both hands. When first seen, some months later, the only detectable abnormality was loss of active flexion at the terminal joint of the thumb, though passively it appeared full, with some springy resistance at the limit. Faradic stimulation of the flexor pollicis longus produced a flicker of movement at the terminal joint.

General medical examination and an x-ray film of the thumb showed no abnormality. A tentative diagnosis of "hysterical paralysis" was made, and treatment by faradic stimulation and by attempts to re-establish active movement was begun.

The patient tried hard to achieve movement for about three weeks, and then suddenly she found that, with great effort and with pain felt in the anterior metacarpo-phalangeal region of the thumb, she was able actively to flex the terminal joint through a full range, but that it then became fixed in flexion and could not be straightened except passively, when a palpable click was noticeable at the site of pain. It was now evident that the diagnosis was "trigger-thumb" involving the flexor pollicis longus, and that the obstruction to movement which was occurring at the level of the metacarpo-phalangeal joint had been partly overcome.

Incision of the tendon sheath was advised, but during the usual long delay before admission the patient continued to practise flexing her thumb, and this gradually became easier and less painful, and eventually spontaneous recovery occurred, so that no disability remained. When seen 18 months later she complained only of odd twinges of discomfort in her thumb, but no catching. There was full painless active movement of the interphalangeal joint. Slight enlargement was palpable in the line of the sheath and tendon of flexor pollicis longus at metacarpo-phalangeal joint level, and a slight click was noticeable here on active flexion-extension of the terminal thumb-joint.

Case 2

A housewife aged 55 suddenly found that she was unable to flex the terminal joint of her left thumb. When seen at another hospital, where a diagnosis of hysterical paralysis was made, she was referred to a psychiatrist, who was unable to find any evidence of psychological disturbance. When seen at this hospital some weeks later she was still apparently unable to bend the tip of her thumb, and her only other complaint was of slight acroparaesthesiae in the left hand. On going into her history in more detail it was found that the onset of the condition occurred when she woke up one morning with the thumb flexed at the terminal joint and had had to pull it straight. Subsequently she had been unable to bend it at this joint, except on two occasions