was given intravenously. After the usual muscular twitching complete relaxation occurred within a minute, and a full-sized cuffed Magill's tube was passed with the greatest ease. The cuff was then inflated, and, as natural respiration had ceased, intermittent positive pressure was given, using 80% nitrous oxide and 20% oxygen with no adjuvant.

The operation proceeded uneventfully, and 42 minutes later, just as the surgeon finished, the patient took his first spontaneous breath, and within a minute was moving his head and trying to expel the tube. The cuff was accordingly deflated, the tube removed, and the patient then immediately sat up and started talking rationally. He was returned to bed and suffered no ill effects.

The salient features of this case are that premedication was light, and that he had a minimal dose of thiopentone and pure nitrous oxide and oxygen after a minute amount of preliminary trileone.

It therefore seems certain that the prolonged apnoea was due to succinylcholine. I have no suggestions to make on the reason for this, but in the present state of our knowledge it must be confessed that the length of time during which this relaxant acts appears to be quite uncertain, and it is interesting to speculate on what would have happened if a succinylcholine drip had been given with the intention of maintaining a constant depth of relaxation, or if the dose recommended by the makers for a "large adult" had been used, which is 200 mg.—I am, etc.,

London, E.C.1.

C. LANGTON HEWER.

Mental Disease a Symptom of Physical Defect

SIR,—Much stress has been laid of late on what is called, erroneously, I think, psychosomatic medicine, and also on the psychogenic causation of not only mental disease but also of many frank physical diseases, and it has given to many a false idea of the prominence of the mental state in the aetiology of disease.

I do not believe there is any such thing as mental disease *per se*, but that it is the symptom of a physical disease, defect, or dysfunction. The psychogenists and psychoanalysts, I know, will not agree with this view, but surely to work on the premise that one of the most obvious manifestations of a disease is the disease is similar to considering Addison's disease or jaundice from the dermatological aspect alone. To what, I wonder, would they have ascribed the cause of dementia paralytica before Noguchi demonstrated its specific cause in 1913? Would the third stage with its lalling speech have been considered to be due to an infantile fixation? I cannot follow the reasoning that it is possible to have a disease of an abstract quantity. One does not have a disease of any of the senses but rather of the organ of the particular sense, and the disease is manifest by a defect of function just as an encephalopathy or an endocrine dysfunction may cause a mental abnormality. Heredity as a cause of mental disease is universally accepted; as an abstract quality cannot be inherited of itself, surely this denotes a physical basis for mental disease?

Lest the rather fatuous criticism be levelled at me again that I am ignoring the existence of a mind, let me say that I believe the mind to be something more beautiful than the cesspool which some would have us believe it with its Oedipus and Electra complexes and the very suggestion that even the infant psyche is driven by a desire for incest and murder.

In conclusion, Sir, may I say that I agree with your leading article (November 10, 1951, p. 1136) in which you declare "psychosomatic" to be "an unnecessary term and the sooner it is dropped from the current medical literature the better"? If, however, some term be necessary in its stead, I would suggest "somatopsychic" as being more logical.—I am, etc.,

Cork,

MICHAEL J. KENNEFICK.

Explosion during Anaesthesia

SIR,—I was interested to see Dr. G. M. Wyant (April 19, p. 870) raise the question, "What was the explosive?" in the case reported in the *Journal* of January 19 (p. 168). He suggests an explosive residue in the machine powerful

enough to cause a violent explosion, occurring in this case in the patient's gullet and stomach. I submit that there is another source for the explosive—namely, the patient's bowel. I have personally witnessed the ignition of *downward* flatus by a subject (not myself) who held a lighted match close to his anus (a thin pair of cloth shorts intervening) and was able to produce flatus which ignited and burnt with a momentary blue flame, presumably the product of intestinal fermentation. I have been unable to demonstrate that such inflammable gas can be found in the stomach, but this is clearly a theoretical possibility. It is even possible that such a gas might be spontaneously combustible, as marsh gas causes the will-o'-the-wisp, and that such an occurrence might explain the recent explosion and others.

Until this matter is clarified, I think it unwise to give oxygen under pressure to relaxed patients unless through a cuffed endotracheal tube. The safe and easy method of artificial respiration by thoracic compression will suffice to carry a patient through the early stages of a modern anaesthetic without the machine being connected at all until the tube is in position.—I am, etc.,

Paignton, Devon.

J. F. BURDON.

Sponge-rubber Collar for Cervical Disk Lesions

SIR,—It is generally agreed that operative measures have little place in the treatment of intervertebral disk lesions in the cervical spine. Conservative measures, however, whose aim is to provide rest and protection to the affected joints, present special difficulties in this region. The hard and unyielding nature of cervical collars made of leather or "perspex" tends to produce discomfort or pain over bony prominences. As a result, the wearers will tend to hold themselves away from contact with the collar. Thus, although the collar will prevent movements, it will often fail to give the necessary rest and support. In fact many patients will not tolerate such an appliance.

For the last few years I have been using a collar cut from sponge-rubber sheeting, $\frac{1}{2}$ in. (1.25 cm.) thick. The accompanying sketch shows the shape and size of the piece required for the average case. The collar is wrapped round the neck, the ends overlapping in front, a notch being cut out of the underlap, as shown, to accommodate the thyroid cartilage and prevent discomfort in swallowing. It is held in place by a crêpe bandage or fitted with some form of buckle.

AVERAGE LENGTH 24"
DEPTH AT BACK 6"

This type of collar has been found to be effective in practice and to have the following merits:

- (1) There need be no delay in instituting treatment while awaiting the manufacture of a surgical appliance.
- (2) It is cheap.
- (3) In these days of red tape it avoids the delays involved before a general practitioner can get any surgical appliance ordered for one of his patients. He can make and fit such a collar in his own surgery in a few minutes—at least as a first-aid measure while awaiting a specialist opinion.
- (4) Although it does not provide such efficient immobilization, it gives better rest and protection than a surgical appliance, for the patient can relax into it without discomfort.
- (5) It is more easily tolerated for use at night.

—I am, etc.,

London, S.E.1.

T. T. STAMM.

Effect of Sulphonamides on Mortality

SIR,—I was very interested to read a letter entitled "Cost of Treatment" by Dr. R. McL. Todd (March 8, p. 546). During the early part of the war I was deputy medical superintendent at Alder Hey Children's Hospital, Liverpool, prior to the formation of the Liverpool University Department of Child Health, and at that time I prepared statistics