seen on the examining finger. Proctoscopy showed reddened mucosa overlying the prostate; no orifice was seen, but some pus was present in the rectum.

By the tenth day after admission there was no pus in the rectum or any evidence of proctitis. On the fourteenth day the patient was discharged. He had then had, in the ward, a total of 8,400,000 units of procaine penicillin, 3,500,000 units of aqueous penicillin, and 84 g. of sulphatriad.

The patient continued to improve after discharge from hospital. After 12 weeks, rectal examination showed no abnormality apart from slight prominence and firmness of the right prostatic lobe. Prostatic fluid was normal, and the patient had gained 28 lb. (12.7 kg.) in weight. In early February, 1950, 16 weeks after rupture of the abscess, the prostate was normal on rectal examination.

COMMENT

At the time of rupture the urine was clear, suggesting that the abscess was not draining per urethram, and that, owing to this natural localization, subsequent fistula would be unlikely. It is at this stage that surgical drainage into the rectum may even be the treatment of choice.

In this case the large dosage of penicillin and sulphonamides would appear to have controlled the initial infection and prevented a proctitis subsequent to rupture.

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REFERENCES

- Attwater, H. L. (1948). In H. P. Winsbury-White's *Textbook of Genito-Urinary Surgery*, p. 658. Edinburgh.
Bailey, Hamilton, and Love, R. J. McNeill (1948). *A Short Practice of Surgery*, p. 567. London.
Burke, E. T. (1940). *Venereal Diseases*, p. 380. London.
McLachlan, A. E. W. (1947). *Handbook of Diagnosis and Treatment of Venereal Diseases*, p. 268. Edinburgh.
Marshall, J. (1944). *The Venereal Diseases*, p. 36. London.
Riches, E. W. (1950). In Carling and Ross's *British Surgical Practice*, 7, p. 137. London.
Romanis, W. H. C., and Mitchiner, P. H. (1948). *The Science and Practice of Surgery*, p. 856. London.
Wakeley, C. P. G., and Hunter, J. B. (1943). In Rose and Carless's *Manual of Surgery*, p. 1494. London.
Willcox, R. R. (1950). *A Textbook of Venereal Diseases*, p. 48. London.

Testing for Serratus Anterior Weakness

In testing for paralysis of the serratus anterior the patient is often asked to raise the arms forward or to push against a wall. These tests will demonstrate weakness if total paralysis of the serratus anterior is present, as the scapula will wing on any effort involving abduction or flexion of the arms. I have observed, however, that, in many cases in which only partial paralysis is present, if these tests are applied the winging of the scapula may unconsciously be so successfully disguised by the patient as to be almost non-existent.

If this ability on the part of the patient to mask weakness is not recognized the muscle may be passed as normal, when, in fact, partial paralysis is present. I found that by instructing the patient to adduct the scapulae before performing the test this ability to disguise winging was lost, and any weakness present immediately became apparent. This is because adduction of the scapulae will relax, by reciprocal inhibition, the abductors of the scapulae, of which the serratus is one, and, being relaxed, the serratus becomes weaker.

Figs. 1-4, photographs of a case of partial paralysis of the serratus anterior, illustrate this ability to disguise weakness and how it may be shown up by adduction of the scapulae before performing the test.

In Fig. 1 the patient, without any previous instruction, has been asked to raise his arms forward. In Fig. 2 he is

FIG. 1

FIG. 2

FIG. 1.—Patient with arms raised forward. FIG. 2.—Patient pushing against a wall. Very little winging is apparent.

FIG. 3

FIG. 4

FIG. 3.—Patient pushing against a wall, having first adducted scapulae. Gross winging. The whole scapula has come away from the chest wall, and fingers may easily be inserted under the vertebral border. (There is also paralysis of lower trapezius.) FIG. 4.—Same patient as in Figs. 1, 2, and 3, showing amount of abduction possible.

pushing against a wall. He performs these tests with a slightly rounded back and with the scapulae wide apart. In neither case are there signs of much weakness in the serratus anterior. However, when the patient was instructed to adduct the scapulae before pushing against the wall, the result was as shown in Fig. 3. Weakness immediately becomes apparent.

In the best test for serratus weakness—flexion of the arms under resistance—weakness cannot be disguised.

Fig. 4 shows the amount of abduction a patient may accomplish by trick movements in spite of the presence of extensive paresis. This abduction can be carried out with scarcely any interruption in the rhythm of the movement.

I am indebted to Mr. C. H. Hembrow, of Melbourne, for the explanation of the observation that adduction prior to movement will show up weakness.

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