craft" by the institution of simple lecture demonstrations for both parents, these being developed as a part of the antenatal service. This interest can be further developed in hospital in the case of a mother with a difficult or premature infant by making her responsible, under supervision, for the entire care of her baby during the additional period of hospital stay allowed for the infant to become established. The hospital almoner also is of great assistance in the welfare of both mother and infant. It is our practice to have the home circumstances of each case investigated by the almoner during the lying-in period, and to be satisfied that sufficient home help and reasonable home conditions exist before discharging the mother and infant from hospital. Although Dr. Lewis states that the liaison obtained by notifying the Health Department of such an infant's discharge and requesting an early visit from the health visitor is ineffective, we have found that, in practice, by ensuring a home visit on the day following discharge, the continuity of supervision of the mother as to the care of her infant is preserved with reassuring results.

We feel, therefore, that the major responsibility in the establishment of small, difficult, or premature babies after birth lies primarily with the maternity unit, and that such a unit must be fully satisfied, when such infants are discharged home, that they are fit to withstand the less suitable conditions in the average household, and that in addition their mothers must be fit, at least physically, to look after them.—We are, etc.,

I. M. HARKNESS.
J. B. COCHRANE.

Nottingham.

"Anaesthesia" or "Analgesia"?

SIR,—Dr. F. W. Roberts in his letter (Dec. 28, 1946, p. 1007) raises two points to which I feel I must reply in self-defence. First, he states that "novocain" and other local anaesthetic agents do not abolish touch, deep pressure, and thermal sensibility, and are therefore true analgesics. I believe that they abolish all these and are therefore true anaesthetics, which is the base of the reasoning that appears faulty. Authority for this may be found in any textbook, and I would quote Langton Hewer's *Recent Advances in Anaesthesia and Analgesia*, fifth edition, p. 143, where reference to the literature is given. Secondly, if I had meant intravenous anaesthesia I would have said so. Reference to the slow drip infusion of dilute procaine in glucose saline is given on p. 139 of the same work.

Whether analgesia is an ugly word is of course purely a matter of opinion. It is much more frequently written than spoken, which suggests that others besides myself find it so; and I have not yet heard of its being used as a girl's name, which is a touching tribute to the beauty of the word anaesthesia. As a matter of fact, I find from Liddell and Scott that there is no distinction between the words in Greek, although the adjective derived from analgesia was used to mean "very painful." This might be held by some to justify the use of the word to describe the occasional nerve block which does not "come off."—I am, etc.,

Colchester.

J. N. FELL.

Abacterial Pyuria

SIR,—Dr. D. P. Wheatley (Nov. 30, 1946, p. 837) brought attention to the fact that no mention had been made of penicillin in the treatment of abacterial pyuria. I have treated several of these cases with large doses of penicillin (over 1 million units) and can record only a temporary slight improvement followed immediately by relapse on cessation of penicillin administration. In contradistinction to Capt. Fieldsend, R.A.M.C., I have always found evidence of prostatic infection with the presence of pus cells and a lessened lecithin content in prostatic beads.

Search for the *Trichomonas vaginalis* has been negative on each occasion despite repeated examination for the same. I have always regarded these cases as infection of the bladder trigone by simple extension from a posterior urethritis and prostatitis. Two cases gave a history of non-specific urethritis, for which high urethral lavage had been administered.

I have treated several of these patients with intravenous neoarsphenamine, and, while recording an improvement and later clearing up in the majority, must submit that some

responded only to long-term hospitalization and rest. I should like to add that all were subjected to complete pathological and physical investigation to exclude other causes, and only in the end labelled "abacterial pyuria."—I am, etc.,

Chester.

F. LANCELEY,
Major, R.A.M.C.

Pre-operative Blood Transfusion

SIR,—Many surgeons have wisely adopted the pre-operative blood transfusion to hasten recovery and to minimize the risks attendant upon operation in the anaemic subject. It would seem, however, that some of these surgeons, or their house-surgeons, are unnecessarily delaying the giving of these transfusions until almost the immediate pre-operative period. I would suggest that such a delay, except in a case of active haemorrhage, is not in the best interests of patient or surgeon.

My reasons for making this suggestion will be obvious to all surgeons, but for those who would appear to have overlooked them I append the following: (a) Even under the best conditions a transfusion may be followed by a reaction. This complication is always undesirable, but especially so just before an operation. Even in the absence of reaction a transfusion places a considerable physical and mental strain upon the patient. (b) Attention has recently been drawn in your columns to the value of adequate nutrition during the week or two preceding operation. Anorexia, a frequent accompaniment of chronic anaemia, is often not overcome until the anaemia has been satisfactorily treated. Moreover, it is surely desirable that the patient should be given the advantages ensuing from improved oxygenation of vital organs for a greater period than the 24 hours or less before a major surgical ordeal.

For these reasons I would plead that the transfusion of surgical cases complicated by anaemia should be undertaken at least one week prior to operation. It may be objected that the adoption of such a measure is quite impracticable because of the shortage of hospital beds. It would seem probable, however, that the increased time spent in hospital during this preparatory period would be counterbalanced by the hastening of recovery following the operation. In some instances it may be of value to admit the patient for two or three days only for the transfusion, and then to re-admit for the actual operation.—I am, etc.,

Bristol.

GEOFFREY H. TOVEY.

Conservative Treatment of Perforated Ulcer

SIR,—I was interested in the summation and verdict on the above given in the annotation in the *Journal* of Dec. 21, 1946 (p. 950). During the past three years I have been investigating these cases from the radiological and clinical aspect, and in a paper to the Faculty of Radiologists in June, 1945, I suggested, in view of the observations to date, that the conservative line of treatment should be given a fair trial. The idea was ridiculed at the time and it was with considerable difficulty that some of my surgical colleagues were persuaded to try the method. The investigations were on the acute abdomen with particular reference to the presence of free gas in the peritoneal cavity.

The radiological detection of free gas in the uppermost dependent portion spells only one thing—a perforation somewhere in the gastrointestinal tract. The subdiaphragmatic gas gives us a fairly accurate estimate of the degree of gas-leak and consequently an idea of the size of the perforation. I would be interested to know the views of surgeons as to the value attached to the presence of free gas in the diagnosis of perforation and if they have utilized the volume of gas present as an index of the degree of leak and size of perforation. Assuming there is a gas-leak in the majority of perforations, it would appear to me that the estimation of volume would be of assistance in determining the suitability of the case for conservative treatment or otherwise. The gas may vary from a millimetre to a couple of inches (5 cm.), and a check can be made during the first few hours as to increase or otherwise. Unfortunately there is at present no method of indicating the stoppage of leak, but we can at least indicate any increase. The gas is absorbed slowly and may take, according to the volume, anything from five to fourteen days. The direct or scout x-ray examination should be helpful not only in assessing the degree of leak but also in the differentiation between intra- and retro-