Committee had been discontinued. He saw an urgent need for consultation between those who had given papers in deciding on the dietary standards which were necessary for adequate nutrition of the human subject. It was equally essential to discriminate between the rival claims of the various farm animals to share in such foodstuffs as were available.

LUNG ABSCESS

At a meeting of the Manchester Medical Society on Oct. 1 Mr. W. F. NICHOLSON, reading a paper on this subject, said that bronchial obstruction with secondary infection was the common cause of lung abscess. In normal health the cilia lining the bronchial tree kept the air passages free from organisms and debris. When ciliary action was impaired by trauma, infection, or growth, coughing was effective in preventing bronchial obstruction. When coughing was embarrassed by pain or anaesthesia or tenacious secretion, bronchial obstruction might occur.

An abscess due to bronchial embolism was peripheral in the lung, though it might not present on the costal surface. Because the subapical segment of the upper lobe and the apical segment of the lower lobe contained the most dependent bronchi in the lateral and supine positions respectively, these segments were most frequently affected, and consequently most inhalation abscesses presented on the costal surface of the lung corresponding to these segments. The upper-lobe abscess was common after operations on the upper respiratory tract, in which a lateral position was usually employed in the immediate post-operative period. Lower-lobe abscess was often due to abdominal operations, which were associated with a supine or Fowler's position. A putrid lung abscess was frequently undiagnosed because it was still not widely known that such an abscess could exist without foul sputum. When the abscess ruptured into the bronchial tree sputum would be present; but even before this happened there might be fetid breath.

Treatment was by drainage, either bronchial (postural) or external (by operation). In either case location of the lesion must be exact if treatment was to be rational. The responsibility of the physician in these cases was heavy. If he delayed external drainage, in many cases the disease spread to a diffuse suppurative pneumonia of a lobe, which would eventually require a lobectomy. Moreover, the immediate mortality of conservative treatment was considerable. Only by sharing the responsibility with a surgeon from the beginning could drainage be instituted promptly in cases which did not respond to medical measures. Chemotherapy and antibiotics were of value, but did not replace drainage. Bronchoscopy was of value in locating the broncho-pulmonary segment of the abscess, in improving bronchial drainage, and in excluding a foreign body or growth; as a curative measure it was of little more value than postural drainage. Surgical drainage would decrease mortality and morbidity.

At a meeting of the Liverpool Medical Institution on Oct. 23, with the president, Dr. H. Wallace-Jones, in the chair, Dr. R. Lipman read a case history illustrating psychogenic factors in dysmenorrhoea, menorrhagia, and *Mittelschmerz*. Mr. Barry McMurray reviewed the various lesions which may occur in sprained ankles.

The autumn number of *Biology and Human Affairs* (obtainable from the British Social Hygiene Council, Tavistock House North, Tavistock Square, London, W.C.1, 2s. 6d.) contains an interesting article by Prof. J. M. Mackintosh on "The Contribution of Science to Comfort in the Home." He comments on the delay between the discovery of knowledge and its application in the home—a popular topic of conversation among housewives after reading articles on the contributions that science could make to their comfort. He attributes it partly to the conservatism of builders, and to those people, often elderly, who choose designs for new houses for working people—"the cold, dead hand of a passing age presses too hard on an age that is coming to birth."

Correspondence

Anaesthesia for Head and Neck Surgery

SIR,—The article by Dr. J. G. Bourne (Oct. 25, p. 654) on the subject of thiopentone-nitrous-oxide-oxygen anaesthesia with curare for head and neck surgery will have been read with interest by all. May I trespass on your columns to say that my reaction was one of admiration for the obvious skill of the author? Following hard on this, however, I found myself asking, does this method in fact promote the well-being of the patient and constitute an advance in the degree of safety afforded to him, or does it rather represent an advance in the technical skill of the author? (For these two virtues, though usually so, are not invariably synonymous.) My doubts were increased when I saw that, in the five instances in which the advantages of the new method or the objections to the old were enumerated, on every occasion the time factor was given pride of place. The factors such as the degree of safety and the comfort or discomfort of the patient followed in (presumably) their due order. One cannot but gain the impression that the speed of the method constitutes its chief attraction in the author's estimate.

I also find it rather hard to agree with the statement that for procuring the initial relaxation for intubation there is no agent as safe as curare. I have yet to see the figures that will convince me that the dangers of a few ounces of ether are greater than those of 20 mg. of curare. The amount of ether required for a blind intubation (and in the majority of head and neck cases a nasal tube is as good as an oral) is not very large. If the head is not moved, anaesthesia can be maintained with a minimum trickle; and if it is possible to turn off the ether 10–15 minutes before the end, then the degree of post-operative nausea is but reasonably transient in most cases. That the degree of relaxation afforded by this method should be cited as one of its virtues caused me a mild degree of surprise, for I have worked with Continental as well as English surgeons (through circumstance rather than choice), and have never been asked, during a head-and-neck operation, for a degree of relaxation that would necessitate the giving of 20 mg. of curare.

Surely one of the advantages of curare is that it provides where needed a degree of relaxation that could otherwise only be brought about by some form of nerve block or the use of toxic amounts of the inhalational agents. Is, then, the method described by the author a logical outcome of this; or is it a very skilled demonstration of cracking a medium-sized walnut with an out-size sledge-hammer?—I am, etc.,

London, W.8.

G. C. STEEL.

SIR,—I read with interest Dr. J. G. Bourne's article (Oct. 25, p. 654), and my purpose in commenting is to inquire rather than to criticize. Under "Method" the sequence enumerated appears to me to be capable of improvement both in the safety factor and in time. Would it not be better to adopt the technique for curare advised by Dr. Gray, of Liverpool, and to give the injections in the following order? (1) Test injection of "tubarine," 5 mg. (one-third average induction dose); (2) wait for four minutes to observe its effect, from which to judge the total injection dosage advisable, and then inject this—say, a further 10 mg.; (3) immediately give in a separate vein an intravenous barbiturate in adequate dosage.

By this time the patient will be ready for laryngoscopy, "cocainization," and intubation. Then N_2O-O_2 may be continued, with a further relay of barbiturate if necessary at a later stage. By this there is not only a safer control of curare but also a saving of time, as the effect of both the tubarine and barbiturate synchronize.—I am, etc.,

Barton-on-Sea, Hants.

HAROLD C. J. BALL.

All the Vitamins

SIR,—When you published Dr. Leslie J. Harris's article (Nov. 1, p. 681) in reply to a simply worded request in "Any Questions?" one expected a simple reply, giving the answer in words which the average doctor could understand. I wonder if the reader who sent that question is satisfied by Dr. Harris's