illness was obtained. He worked as a light machinist at a lathe in a nearby factory. He was married and had a family of four sons. No familial history of any ailments was obtained.

FIG. 1.—Standard leads taken at 11 a.m. Normal.

FIG. 2.—Standard leads taken at 11.15 a.m. The tracings show ventricular complexes which vary in size and which are deformed, the appearances being those of ventricular tachycardia or ? flutter. Rate 330 a minute.

FIG. 3.—Standard leads taken at 2.15 p.m. Normal.

Little of significance was found in the various systems, but examination of the cardiovascular system revealed: pulse, 70, regular, good volume and tone, arterial wall normal; blood pressure 150/100; apex beat displaced slightly downwards and outwards; a soft systolic murmur audible over the apex. Fundi: early silver wiring and tortuosity of the vessels.

Investigations.—Hb, 110%; white cells, 9,000; E.S.R., 19 mm./hour. W.R. and Kahn test negative. Urine normal. Chest x-ray examination showed no active disease in the lung fields; slight tenting of the right diaphragm was due to a minimal adhesion; the heart shadow was normal. Electrocardiograms were taken (1) before exercise (Fig. 1); (2) after exercise which caused a typical attack of retrosternal pain with sweating and coldness; the symptoms were relieved by inhalations of amyl nitrite (Fig. 2); and (3) 3½ hours after exercise (Fig. 3).

Trinitrin tablets for individual attacks, and quinidine sulphate, 6 gr. (0.4 g.) three times daily, have been given since. Up to the time of writing the patient managed fairly well, although he still had occasional tightness of the chest.

COMMENT

Schwartz (1942) describes three phases in the production of ventricular fibrillation—ventricular tachycardia proceeding to multifocal ectopic beats and eventual establishment of ventricular fibrillation. The ectopic beat prior to the run of tachycardia (initial premature beat) bears a constant relationship to the preceding ventricular complex, and all such beats appear to be identical in form and direction.

Runs of ventricular tachycardia are thought to originate from an irritable ventricular focus, and are the precursor of fibrillation.

Wetherbee *et al.* (1952) published tracings showing ventricular tachycardia following quinidine therapy in six cases of auricular fibrillation. Schwartz *et al.* (1953) showed tracings of transient ventricular fibrillation following quinidine therapy in cases of atrioventricular dissociation. A case of complete heart block described by Gresham (1952) gave rise to a series of electrocardiograms showing, at first, runs of ventricular tachycardia but, terminally, evidence of ventricular flutter and fibrillation.

The case described would appear to be in the first phase described by Schwartz in the production of ventricular fibrillation, and it is interesting to postulate an irritable ventricular focus arising from recurring relative ischaemia of a patch of ventricular musculature.

I wish to express my sincere thanks to Dr. Robert Mowbray for his constant help and permission to publish this case. I would also like to thank both the secretarial staff and members of the E.E.G. department, Dryburn Hospital, for their valuable assistance.

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Grafting of Finger-nails

The restoration by grafting of lost or congenitally absent finger-nails is a subject upon which very little has been written. After carrying out a series of experiments it may be of interest to record that in suitable cases either the whole or part of the toe-nail can be transferred to the finger or thumb.

Apart from the disfigurement associated with absence of a nail, there is often a considerable reduction in function in the finger-tip. The normal nail acts as a support to the highly sensitive pulp, and without this counter-pressure the finer qualities of tactile appreciation are blurred. In the index finger or thumb this may be a very real disability in fine work.

The example shown here is the hand of a girl aged 8 in whom the middle finger showed congenital absence of a nail associated with brachydactyly (fusion of the distal and middle phalanges). Part of the great toe-nail with its

Restoration of middle finger-nail by free grafting of part of a toe-nail. One year after operation.

germinal matrix was implanted on the finger, and one year after the operation is seen growing normally. The donor toe-nail has also regenerated and causes her no discomfort.

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