febrile convulsions are extremely rare in the newborn. What is meant by "febrile convulsions"? Do we really know enough about the cause of the first seizure in any patient to be so precise about treatment? Are we so advanced in understanding the mode of action of anticonvulsant drugs to use them at the time of the first seizure, whatever its cause might have been?—I am, etc.,

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Injury by Thermometer

SIR,—It is indeed gratifying to note that in most countries greater attention is now being given to the prevention of accidents in the home. The following is an account of how a thermometer caused a potentially serious accidental injury to the author through the agency of children in the home.

On the afternoon of 26 July 1964 I was feeling a bit out of sorts, and while lying in bed requested my wife to procure a thermometer for me, which I carefully positioned under my tongue on to the left side of the midline. My son aged 3 and daughter aged about 1½ years were playing on an adjacent bed near mine. The boy tickled the little girl, who laughingly crossed over to my bed and lost her balance. She fell flat on my face while the thermometer was under the tongue, with the result that the thermometer was hammered through the soft tissues of the floor of the mouth in down-and-out direction. The smooth bulb of the thermometer tore through the tissues and probably the bulb struck against the medial side of the left mandibular ramus, causing the constricted neck of the bulb to break from the thermometer body. I had only a feeling of discomfort under my tongue and immediately withdrew the thermometer from the mouth. I noticed that the thermometer was broken with the bulb missing and presumed that the impact would have caused the bulb to get smashed and to spill the contained mercury in the oral cavity. I simultaneously felt that fluid was accumulating in the mouth, and found blood welling in my oral cavity from under the tongue. By the time my wife rushed to get some ice cubes from the refrigerator I had, within seconds, already spat four mouthfuls of fresh blood. I did not know how to stop the terrifying bleeding and in the moments of confusion started fumbling for my facial arteries in an unsuccessful attempt to compress these. (In retrospect I now believe that this procedure would have been largely ineffective as the bleeding source would certainly have been proximal to the site of compression.) Local haemostasis was ultimately achieved by the ice cubes. I was now conscious of a dull ache on the left side, which I subjectively localized in the neighbourhood of the left submandibular region. It made me almost certain that the glass bulb along with the mercury had been buried in the floor of the mouth. A careful scrutiny of the spat pool of blood lent support to my hypothesis.

My wife made a quick telephone call to a surgeon colleague, who arrived within fifteen minutes. No foreign body could be seen or felt, so it was decided to make a skiagraphic examination. This revealed the

presence of the glass bulb with the contained mercury (see Fig.) lying obliquely above the left submandibular region. An emergency operation under general anaesthesia was

The broken mercury bulb is seen lying obliquely on the medial side of the mandibular ramus, with the markers near the central incisors.

decided upon to get an adequate exposure. The portal of entry could be spotted after a careful search. The route of the bulb was tracked and since the mercury was still contained in the intact bulb it could be rather easily detected. The jagged end of the bulb

at its fractured neck was carefully disentangled from the adjoining tissue. By pressing the blunt distal end the bulb was successfully made to retrace the route it had taken at the time of entry. A catgut stitch was applied and a piece of gauze packing was put on it. Needless to add that I made an uneventful recovery.

I am grateful to Dr. S. P. Srivastava, Dr. K. S. Bhargava, Dr. B. D. Sharma, and Dr. N. R. Gupta, who took active personal interest in getting me well.

—I am, etc.,

S. K. DIKSHIT.

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Endarterectomy or Grafting

SIR,—Professor W. T. Irvine and his colleagues (1 May, p. 1147) state that an adequate saphenous vein for use as a graft was often not present in their patients, and that endarterectomy is to be preferred to bypass grafting if the occluded segment is of limited length. We have found it possible to use the saphenous vein as a full-length femoro-popliteal by-pass graft in 8 out of 10 limbs in which grafting was attempted during the last year. The initial success was 100%, with one early failure and no late failures to date. Although the vein often looks too small in calibre initially, it has usually proved adequate after mobilization and distension with saline. We have been increasingly impressed with the superior long-term performance of vein grafts, especially in patients with poor calf vessels.

Professor Irvine and his colleagues do not define what they mean by an occluded segment of limited length. We now feel that endarterectomy should usually be reserved for occluded segments of not more than 3 in. (7.5 cm.) in length, occurring in an otherwise relatively healthy artery. We agree that the arterial incision should always be closed with a vein patch.—I am, etc.,

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Carpal Tunnel Syndrome

SIR,—Although splinting or injections of hydrocortisone may produce some improvement in the symptoms of carpal tunnel syndrome, only a division of the transverse carpal ligament can be relied on to effect an immediate relief of the pain. Most surgeons carry out the operation under general anaesthesia, making a long incision to expose the whole of the transverse carpal ligament. Usually the patient is admitted to the hospital ward for this.

In the last 32 cases the author has divided the transverse carpal ligament subcutaneously. A local anaesthetic was used, and the patient

was treated entirely as an out-patient. The technique of this method is as follows:

About 7 ml. of 2% Xylocaine with Hyalase (lignocaine with hyaluronidase) is injected just above the wrist and along the transverse carpal ligament. This injection is given after a pneumatic tourniquet has been applied. When done this way anaesthesia is instantaneous and the operation can be started at once. A half-inch (12.7 mm.) transverse incision is made in the crease just above the transverse carpal ligament. The palmaris longus tendon is identified and a Smillie's cartilage knife is inserted with one horn above

and one deep to the tendon. The tendon guides the knife to the upper edge of the transverse carpal ligament. The knife is then pushed into the palm and can be felt cutting the fibrous ligament. In following the plane of the ligament the knife is held at about 20° to the skin surface.

The whole operation, including injection of local anaesthetic and the insertion of two stitches, can be completed without haste in under three minutes.

Although most of the operations were done using a Smillie's knife, this instrument proved a little large and clumsy for this purpose and so a special knife based on the same principle was recently designed (Fig. 1). The knife is 7½ in. long (19.6 cm.) and ¼ in. (6.4 mm.) wide at its cutting edge. The depth can be gauged by inch markings on the upper edge of the neck, and pushing the knife in 1½ in. (3.77 cm.) is enough to cut through all the transverse ligament. The instrument is manufactured by Thackrays Ltd., Leeds.

Of the 32 cases done by this simple ligament-slitting technique under local anaesthesia, all were immediately relieved of their pain. A few developed ecchymosis in the palm but no palmar haematoma of any significance was encountered. Two cases developed a recurrence of symptoms within a few weeks. One of them had an open operation done and the transverse carpal ligament appeared to have re-formed and showed marked thickening. It was excised. In the second case a cure was gradually effected after several injections of hydrocortisone.—I am, etc.,

JAMES PATRICK.

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Stilboestrol in Reiter's Disease

SIR,—I should like to question the significance of the preliminary communication by Dr. S. M. Laird and his colleagues on the use of stilboestrol in Reiter's disease (10 April, p. 970).

The course of Reiter's disease is very variable. It may clear spontaneously in a few weeks or persist for many months. It is doubtful if any conclusions can be drawn from the fact that the mean duration of the illness in the ten patients treated with stilboestrol was 17.5 weeks compared with 24.8 to 26.3 weeks in the 54 cases not given this treatment, particularly when in this centre the average mean duration of the illness in 75 patients was 15 weeks. However, I look forward with interest to the results of the control trial which these authors are carrying out. Stilboestrol in higher dosage (5 mg. daily) was tried in a number of patients at this centre five years ago and proved to be valueless.—I am, etc.,

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W. FOWLER.

Syphilis as Acute Neurological Illness

SIR,—In their interesting paper on "Neurosphilis" (Dr. J. H. Wetherill and others, 1 May, p. 1157) the authors remind us of the formidable diagnostic difficulties, as illustrated by their four cases.

My own modest experience encompasses two similarly misdiagnosed patients (described elsewhere¹), who presented in general practice. Both appeared to be suffering from cerebral space-occupying lesions, and in both headache was a prominent symptom, as in the authors' Case No. 4.

One, a West Indian male, aged 41, had bilateral papilloedema on first attendance. Eventually he was saved from ventriculography in the nick of time when his positive serology became known.

The other, a European male aged 62, was seen shortly after he had suffered a seizure in his bath. He was stuporose and exhibited signs of marked bilateral upper-motor-neurone disturbance. His wife provided the history of recent increasingly severe headache and progressive dementia in this patient. He had a carotid angiogram and was scheduled for a ventriculogram before his routine serology provided the clue.

Neither patient bore any helpful stigmata, nor did careful questioning at a later date elicit a relevant history in either instance.

All credit then to August von Wassermann!

—I am, etc.,

London W.11.

KLAUS HEYMANN.

REFERENCE

- Heymann, K. G., *J. Coll. gen. Practit.*, 1963, 6, 341.

SIR,—I read with great interest the paper by Dr. J. H. Wetherill and others (1 May, p. 1157) and would like to add a brief record of the disease presenting with raised intracranial pressure.

A 24-year-old unmarried man was recently admitted with a six weeks' history of severe headaches and frequent vomiting. A few weeks after the onset he developed diplopia and slight left-sided deafness, together with a skin eruption. On examination he had severe bilateral papilloedema with haemorrhages and exudates, minimal bilateral VIth nerve palsy, and slight left-sided perceptive deafness. He was also a little unsteady in walking heel to toe along a straight line. There was a symmetrical red-brown, non-irritant papular scaling eruption in front of both ears and on his limbs. He also had an intermittent pyrexia. Although a posterior fossa lesion seemed probable, the rash and temperature raised other possibilities. The blood W.R. was found to be strongly positive, and so a careful lumbar puncture was undertaken. This revealed a high pressure with the presence of 312 mg./100 ml. protein, 185 lymphocytes, and 127 polymorphs per c.mm. of C.S.F., coupled with a positive W.R.

The patient has just finished a full course of penicillin, his symptoms have disappeared, and the papilloedema is resolving.

Another patient, a young woman of 25, was referred to a neurosurgical department for headaches and papilloedema. Ventriculography was carried out and showed no abnormality of the ventricular system. The ventricular C.S.F. was normal, including negative W.R., but the blood serology was not examined. Six years later papilloedema was still present. The presence of a positive blood W.R. on this occasion led to lumbar puncture and examination of the lumbar C.S.F. with findings comparable with that in the first patient. Full recovery followed a course of penicillin.

These cases show that meningeal syphilis can still present like a cerebral tumour. The importance of the second case is that if only the ventricular C.S.F. is examined the diagnosis may be missed—I presume because the C.S.F. is being obtained near its source from the choroid plexus. It would seem there is still a place for the examination of the blood

W.R. and in rare cases of papilloedema, despite neurosurgeons' protests, for lumbar puncture.

I would like to thank Dr. Raymond Hierons for permission to describe these cases.

—I am, etc.,

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MARK RAKE.

Punch-drunk Syndrome

SIR,—Dr. J. L. Blonstein (1 May, p. 1191) challenges Dr. McDonald Critchley to produce three cases of the punch-drunk syndrome. I can certainly furnish details of one. I wonder, however, if this is the important point at issue in the controversy. The syndrome represents the most extreme example of neurological damage which can result from boxing and in consequence occurs infrequently; to argue from this that the sport is without serious risk is manifestly absurd.

I have no doubt that Dr. Blonstein carries out a careful clinical examination on all his boxers. I doubt if he has the time or facilities to do a great deal more. Unfortunately, unless he does he is unlikely to detect anything other than a gross lesion. During an amateur career a boxer may well be knocked unconscious ten times. He is certainly likely to receive many heavy blows to the head. I have yet to be convinced that this does not produce cerebral damage, and until Dr. Blonstein produces a carefully controlled study, using as his tools techniques a little more sophisticated than a patellar hammer, I shall remain unconvinced.

It is the right of every Englishman to be knocked silly in the name of sport if he so wishes. I do not think the medical profession has the right to reassure him that he can do it with impunity.—I am, etc.,

Powick Hospital,
Near Worcester.

J. WARBURTON.

Mediastinoscopy and Radiotherapy

SIR,—It has long been appreciated by thoracic surgeons that negative radiology of the mediastinum does not exclude extensive intrathoracic invasion of nodes from bronchial carcinoma. Although "air" mediastinoscopy with tomograms may show up mediastinal nodes, mediastinoscopy is advantageous, as it enables a biopsy to be taken. The preliminary communication made by Mr. H. C. Nohl-Oser (1 May, p. 1167) will be welcomed by radiotherapists for three reasons:

- (1) A biopsy will be more often available.
- (2) Small metal marker seeds can be placed in the node stations. This will make possible more accurate delivery of radiation.
- (3) It may encourage thoracic surgeons to do mediastinoscopy more frequently, have a histological section from a substantially sized node (tiny ones are often negative), and in positive cases defer resection until radiotherapy has been given. It may also lead to a further trial of pre-operative radiation in this country, which from the information below seems warranted, especially as an improved resectability rate is claimed.¹

It is vital to spare the normal lung from high dosage which is concentrated at the root and in the mediastinum. Such is the practice of my friends at the Universities of