last five and a half years at the Infants Hospital, Vincent Square, were forwarded to me. Arranged in the months during which they were performed, they occur thus: January, 5; February, 4; March, 1; April, 2; May, 2; June, 2; July, 1; August, 1; September, 2; October, 4; November, 8; December, 8. That is, thirty cases were operated on in the months October to March and ten from April to September. A congenital disease would hardly show a seasonal incidence like this. No doubt there are large and small meatuses as there are large and small noses, but it is not necessary to describe this difference as a congenital disease, especially as the condition responds to the same treatment as does the ammoniacal napkin rash. Since perusing the literature I have found that Brennemann (1921) has come to the same conclusion as to the origin of the meatal ulcer.

Although this condition seems confined to the circumcised, many children with long redundant prepuces suffer from a similar dermatitis venenata, which may proceed to ulceration on the foreskin itself.

Treatment

As the condition is self-limited many forms of treatment are claimed to be successful. Internally alkalis are recommended by Pritchard (1938), and barley-water is given by most mothers and nurses. Locally tannic acid in alcohol, picric acid, and various antiseptic ointments have been prescribed.

Cooke (1921, 1926) recommends soaking the napkins in 1 in 4,000 perchloride of mercury to discourage the growth of the urea-splitting organisms. Although this treatment is satisfactory if used by the more intelligent mothers, one hesitates to recommend it to the average mother seen in a clinic, not only because of the poisonous nature of the antiseptic but also because of the difficulty in ensuring that the concentration is correct. Some authorities recommend soaking the napkins in boric acid solution, but I have not found this to be very satisfactory. Once the rash has developed it can be treated simply and effectively by dispensing with the night napkin, and using in its place a piece of boric lint, cut to the right size and discarded in the morning. Apparently the boric acid both neutralizes the ammonia and inhibits the growth of the bacteria. A similar procedure will cure the meatal ulcer.

This treatment is obviously too expensive for routine prophylaxis, which, apart from impressing on her the elements of napkin hygiene, must remain an unsolved problem for the poorer-class mother.

Summary

The condition known as scurvy head is shown to consist of two distinct clinical entities, milk crust and pityriasis capitis, although these two conditions are often combined. The treatment is indicated.

The napkin rash due to irritation by ammonia is discussed. The main features in its aetiology, such as age, seasonal, social, and nocturnal incidence, are discussed. Meatal ulcer of the glans penis is considered as a branch of this disease. The treatment is briefly indicated.

The work for this paper was done in the infant welfare centres of Ilford. For this opportunity I wish to make my acknowledgment to Dr. A. H. G. Burton.

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A STITCH FOR USE IN THE HARRIS PROSTATECTOMY

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The stitch here described is one which I use in the Harris prostatectomy for bringing down the posterior edge of the mucosa of the bladder to the urethral mucosa in the reconstructive stage of the operation. It is not an original stitch in itself, but I think its application to this purpose is original. Those who have seen the stitch in

FIG. 1.—Needle entered behind centre of posterior mucosal edge.

FIG. 2.—Stitch tied, giving a loop and two free ends.

operation have been much impressed with the way it fulfils its purpose. The stitch is that used in the operation of amputation of the uterine cervix, and is well illustrated and described in Chapter VII of Berkeley and Bonney's *Textbook of Gynaecological Surgery*; in fact, it was while carrying out that operation that it occurred to me the stitch might prove ideal in prostatectomy.

After the prostate has been shelled out and the self-retaining retractor arranged satisfactorily it is of the greatest help to use a Morson's anterior retractor with speculum, so as to obtain good exposure of the prostatic

cavity. The posterior edge of the mucosa is thus put on the stretch, and now, choosing the centre of this edge, the boomerang needle is entered just behind the edge, not taking a deep bite. The centre of a piece of No. 2 catgut, which should be at least three feet in length, is threaded on to the needle, which is then withdrawn (Fig. 1). This gives a loop posteriorly and two ends in the prostatic cavity anteriorly; the two ends, treated as one thread, are knotted with the loop (Fig. 2). In this

end, which is brought back as the needle is withdrawn. The two free ends are now projecting backwards from behind the interureteric bar, each a little to one side of the midline (Fig. 4).

The next step is to pull on the two free ends. The result is that the posterior mucosal edge *must* travel down to the urethral mucosa and, when the two ends are knotted together, must also be held down there securely (Fig. 5). Finally, the two free ends are taken together

FIG. 3.—Needle entered behind interureteric bar, threaded with one free end.

FIG. 4.—Stitch ready for second tie with two free ends behind interureteric bar.

FIG. 5.—Stitch tied, pulling posterior mucosal edge down to torn urethral edge.

FIG. 6.—Third tie of loop to the two free ends, completing stitch and pressing down mucosal flap.

way a firm hold is obtained of the edge of the mucosa, which has to be drawn down as near as possible to the urethral mucosa. We thus have two free ends and a loop. One end and the loop are each clipped in forceps and laid ready for use; the other end is placed in the forceps for threading the boomerang needle ready for the next step.

The needle is now entered behind the interureteric bar, just to one side of the midline, and is pushed downwards and made to appear through the prostatic capsule as close to the torn urethra as possible. It is threaded with one of the free ends and withdrawn (Fig. 3). The needle is again entered behind the interureteric bar, this time a little to the other side of the midline, and is made to appear through the capsule at the same level as the previous stitch. It is threaded with the remaining free

as one and knotted to the loop: this further presses the flap down and controls bleeding; the spare ends are cut away and the stitch is complete (Fig. 6).

The remainder of the operation is completed in the usual way by passing the rubber catheter and closing the anterior part of the cavity with a figure-of-8 stitch. The catheter is suspended in the bladder by a stitch going through the bladder and abdominal wall, and the bladder is closed with or without drainage according to individual practice. All the cases in which I have used this stitch have done very well, and because of this and the wonderfully good reconstruction that appears to result I hope this short description may suggest a trial by others. The speculum of the Morson retractor and the self-retaining retractor have been omitted from the illustrations for ease of drawing and for clarity.