of the emulsions tried first at the clinic were too painful for the patient. However, the latest formula of ascabiol can safely be used twice daily for three or four days, though I have seldom found it necessary to treat for more than three days. This is a most important matter, as unsuitable emulsifying agents in the benzyl benzoate preparation will soon cause sore scalps and poor results. The action on the nit is a "combined operation," because, used alone, neither benzyl benzoate nor the emulsifying agent gives the desired result; nor does their use as separate solutions applied one after the other on the same or different days.

Method

All the experiments carried out were designed to remove the nits from the hair without the usual tedious work of combing. At first hairs were removed and put into sealed tubes to act as a control for the viability of the nit. This practice was discontinued when it was realized that the object of the experiment was not to determine whether the nit was dead or alive but to discover an easy method of freeing the scalp from nits about whose viability one could never be sure. The results were briefly as follows, after applying the four undermentioned solutions:

Solutions used	Effect on Nits attached to Hairs 24 Hours Later
1. 25% benzyl benzoate dissolved in industrial spirit	Nits still remain adherent to hairs
2. Emulsifying agent (triethanolamine stearate)	No apparent effect on nits
3. Ascabiol (new formula)	Nits loosened; removed by simple wash with soap and water
4. Lethane oil	Nits appear more strongly attached to hairs than before

The effect of ascabiol emulsion is superior to that of lethane oil, as the lice appear to be dissolved in the solution.

The severe cases of infestation with *Pediculus capitis* in which coccal infection had occurred with much crusting of scalp and enlargement of the post-cervical glands were treated daily with the ascabiol. Most of the scalps were clean and healed in less than a week. I do not know of any other form of treatment which gives such quick results, despite the trial in hospital of numerous preparations over a period of many years, with both in-patients and out-patients.

For those wishing to carry out this method of treatment—which is now my routine for all scalps infested with (1) nits only, (2) lice and nits, (3) lice, nits, impetigo, etc.—I have given the technique used at the scabies clinic, where these experiments were carried out by myself and the nursing staff. This method has relieved the staff from the tedium of fine combing: simple washing with soap and water was sufficient to remove all remaining nits.

Routine Treatment now used

First day: Head coated with ascabiol (new formula); application made with painter's brush 1½ in. or 2 in. wide.

Second day: Hair washed with soap and water.

One week later: Head inspected carefully for possible reinfection.

If the infestation is a very heavy one this treatment is given twice in 24 hours. If there is coincident coccal infection of the scalp the treatment is repeated on the second and third successive days; then one of the common forms of healing ointment is given until the inspection of the scalp one week later. Ointments in use are mostly preparations of sulphonamides in Mumford's base, lanette wax, or vaseline. In cases of seborrhoea, sulphur and salicylate in vaseline are sufficient. As already mentioned, treatment with ointments is seldom necessary.

I wish to thank the medical officer of health, Dr. D. Morley Mathieson, for permission to carry out this work at the scabies clinic; also the nursing staff, whose assistance made the work possible. Messrs. May and Baker kindly supplied the benzyl benzoate emulsion "ascabiol" (new formula) used in these experiments.

L. E. McCrea (*J. Urol.*, 1942, 47, 818), who records an illustrative case, states that congenital absence of the penis is one of the rarest anomalies on record, only ten previous cases having been reported. It must not be confused with pseudo-hermaphroditism, hidden penis, or epispadias. The present case was that of an otherwise normal young man who wished to marry. During sexual excitement the presence of erectile tissue in a small eminence on the perineum was manifested by some enlargement, and on manipulation an apparent ejaculation of semen took place.

Medical Memoranda

Recovery from Actinomycosis of the Liver

I can find no other report of recovery from actinomycosis of the liver, and therefore consider that this case should be put on record.

In Oct., 1928, a hitherto healthy young man began to complain of abdominal discomfort and anorexia. He wasted very rapidly, and by the end of the year was extremely ill. His conjunctivae turned yellow, and on examination a large epigastric mass was discovered. In Feb., 1929, he was operated on at Swansea and a portion of the tumour was removed for microscopical examination. After the operation the surgeon informed the patient's wife that there was a tumour of the liver "as big as my two fists"; that he thought it was malignant; and that he was afraid her husband had but a short time to live. Two months later the tumour had completely disappeared and the patient seemed perfectly well. Now, 15 years later, at the age of 46, he has just been passed for insurance purposes as a first-class life.

The report on the section was "actinomycosis of the liver." Because of an article of mine which was published in the *B.M.J.* of Feb. 23, 1939 (p. 347), the patient was treated with 5-minim doses of tr. iodi sine iodidi 3 times a day in milk, and in April of that year he was sent by Dr. Taylor of Swansea to see me for my opinion as to whether the treatment should be continued longer. As a precautionary measure I advised him to take one dose daily for a further 6 weeks.

Bristol.

HUBERT CHITTY, M.S., F.R.C.S.

A Case of Congenital Microcolon

Cases of microcolon in the literature stress the extreme rarity of the condition. Theremin (1877) recorded two cases in 111,451 necropsies in Vienna. Greig (1925) reviewed the literature of the condition and published three cases in which the entire colon was diminutive, and in which there were, in addition, abnormalities in the small gut. The case here recorded is one in which only part of the colon was affected, and is comparable to two cases reported by Klippel and Feil (1912) and Lesné and Baruk (1923).

CASE HISTORY

The patient was a male first-born infant of 5½ months. Both parents were young and healthy. At the age of 6 weeks the child had a mild skin eruption, which was followed by an attack of acute gastro-enteritis; these responded to treatment. A month later the patient developed acute bronchitis and enteritis, and again recovered. The final illness began with a recurrence of the bronchitis, which progressed to bronchopneumonia with a left-sided empyema. During this last illness the abdomen showed gradual and progressive dis-

Photograph showing transverse colon pulled downwards to reveal the transition in size taking place proximal to the splenic flexure. S, Stomach, with omentum removed. C, Transverse colon. M, Microcolon.

tension, which was associated with severe constipation. Repeated enemata produced small results in which the faeces were normal in appearance. Rectal examination disclosed no abnormality. A straight radiograph of the abdomen showed gas distension of the small intestine and the caecum.

POST-MORTEM EXAMINATION

A left-sided empyema was present in association with a small superficial lung abscess; this condition was regarded as the cause of death. The condition of the bowel was of particular interest. The gut was normal in position and fixation. The small intestine was distended, and the distension was more pronounced as the gut was traced distally. The large intestine was distended up to a point

about 1½ inches proximal to the splenic flexure, where the size of the colon became diminutive. The entire descending and pelvic colons were very small. The lumen of the affected segment of gut was quite patent, but was reduced in diameter. There was no evidence of any form of organic obstruction at the junction of the normal colon and microcolon or elsewhere.

It is a feature of particular interest that the segment of colon involved was that deriving its blood supply from the inferior mesenteric artery and corresponding embryologically to the hind-gut.

K. C. McKEOWN, M.Ch., F.R.C.S.ED.

C. A. HOLMAN, M.B., B.S.

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Traumatic Rupture of the Superior Vena Cava

The following case is considered unusual enough to justify description of the post-mortem findings in some detail. It is that of a West African soldier, of limited horsemanship, who was riding his officer's polo-pony at a gallop when the pony swerved to one side and the rider struck his chin against a metal pylon. The force threw him from the pony. The man was seen to give a few gasps, and died within two minutes.

FINDINGS AT NECROPSY

External Appearances.—The body of a well-developed African male about 25 years of age, with the head lolling abnormally. Severe bruising and abrasions were seen on the forehead, chin, and left hip, and a few scratches on the front of the left thigh. The nose was battered in, and the mouth contained much road-grit. There was no haemorrhage from either auditory meatus.

Internal Appearances.—**Skeletal system:**—The cervical spine had fracture-dislocations of C3 and C5, the fractures involving the articular pillars with posterior displacement of the neural arch. The bodies of the vertebrae were intact. **Heart and Mediastinum:**—The pericardium was under tension due to contained blood, and several large bubbles of air were found. About half a pint of liquid blood was present in the pericardial sac. The heart was covered with a slight excess of pericardial fat, and the right ventricle was considerably dilated but empty. There were a few small subendocardial haemorrhages in the left ventricle. All four valves were normal. The coronary arteries were free from atheroma, but small bubbles were visible within their lumina and could be expressed, especially from the anterior descending branch of the left coronary artery. The aorta was normal. The superior vena cava was completely ruptured across just within the pericardial sac, about three-quarters of an inch from its entry into the right auricle. The distal end of the vein was separated from the proximal end by some two inches, the intervening space being filled with blood-clot. The escaped blood had extravasated around the base of the aorta, downwards behind the heart, and upwards as far as the thyroid, to form an irregularly trilobate mass (see Fig.).

Figure showing extent of extravasation. The interrupted shading represents clot behind the haemopericardium.

Lungs:—The right pleural cavity was partially obliterated by old dense fibrous adhesions. The left pleural cavity was normal, but an irregular-shaped haemorrhage, about 1 in. by 2 in., was present under the parietal pleura underlying the fourth and fifth ribs in the mid-axillary line. There was no fracture of the ribs in this region or elsewhere. The visceral pleurae were both intact. At the antero-superior margin of the left lung a large emphysematous bulla was present, filled with blood and air. Many small bubbles were visible under the pleura on both the mediastinal and the costal surfaces. The lungs were bulky, firm, dark, and crepitant. The lower part of the trachea and the main bronchi were filled with frothy blood. On cutting across the lungs they were seen to be turgid with contained blood.

The only other finding of note was that the left ureter was thickened and congested, and there was a cylindrical swelling 1 in. long situated about 3 in. from the kidney pelvis. This was due to schistosomiasis, a condition not uncommon in the West African. The bladder was normal.

COMMENT

From the injuries to the nose, forehead, and chin, the grit in the mouth, and the double fracture-dislocation of the cervical spine, it is thought likely that a severe degree of hyper-extension of the latter occurred. Presumably this caused considerable tension on the superior mediastinal contents, resulting in rupture of the superior vena cava. Death could not have been instantaneous, as evidenced by the subendocardial haemorrhage, the air bubbles in the coronary arteries, and the blood-distended lungs showing interstitial emphysema.

I am indebted to Brig. R. A. Hepple, D.D.M.S., West African Forces, for permission to publish this case.

S. ORAM, M.D., M.R.C.P.,
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Reviews

SKIN GRAFTING OF BURNS

Skin Grafting of Burns. By J. Barrett Brown, M.D., senior consultant in plastic surgery, E.T.O., U.S. Army; associate professor in surgery, Washington University; and Frank McDowell, M.D., assistant in clinical surgery, Washington University. (Pp. 204; illustrated. 30s.) London: J. B. Lippincott Company.

This is an excellent concise statement of the value of skin grafting in the treatment of burns. The authors have drawn from their experience during many years, to which are added observations by one of them (Dr. Barrett Brown) in this country since the war started.

The book is essentially practical, and therefore no attempt is made to sift or discuss the great mass of theoretical and controversial matter that has filled the medical press in recent years. The authors describe the methods they have found most useful and the reasons for their choice. Early treatment comprises adequate cleansing, open surgical drainage (including baths), and pressure dressings. The disadvantages and dangers of coagulants are discussed. Careful histological studies of healing burns, of unhealed ulcers of donor sites, and of healed grafts are included to explain epithelial repair. Split-skin grafts applied early are recommended in all deep burns to obtain primary healing. The exact technique is described, and photographs of grafts as much as 36 in. long are reproduced. The many methods used in late repair are next described. The authors appear to have had most success with split-skin grafts, and many excellent results are illustrated. Flaps and tube pedicles are also used, but these are not described in great detail. There is an interesting chapter on the use and limitations of homografts, and another on the faults of grafts.

This is a book that all should read, if only to learn from the many excellent illustrations the best methods for quick restoration of function in these so often tragic cases.

THE TOO-PROTECTIVE MOTHER

Maternal Overprotection. By David M. Levy, M.D. (Pp. 417. \$4.50 or 30s.) New York: Columbia University Press; London: Oxford University Press. 1943.

This book is the product of collaboration by the staff and students at the Institute of Child Guidance of New York. The importance of mother-child relationship in the study of psychiatry is pointed out, and the "broad front" approach of child guidance team-work is contrasted with the "narrow front" approach of psycho-analysis. Both may be useful. From the large volume of child guidance material a number of cases of "obvious" over-protection were selected, and these could be contrasted with other groups investigated by different groups of workers. Five groups of over-protection could be differentiated, but only the first can be considered as "pure." They are: (i) over-protection of a wanted child; (ii) predominance of but inconsistency of over-protection which is mixed with rejection; (iii) over-protection in infancy followed by rejection on the arrival of a second child; (iv) mild maternal over-protection; (v) non-maternal over-protection.

The criteria of maternal over-protection are taken as: (a) excessive contact; (b) prolongation of infantile care; (c) prevention of independent behaviour; (d) maternal control. This last criterion may be modified when the mother is "conquered" by the child and becomes submissive to it at home while maintaining her protective attitude towards it in face of the outside world. Excessive contact is considered especially in relation to boys sleeping with their mothers, but incestuous fantasies or activities were not found to be prevalent. Prolongation of infantile care is examined statistically in relation to breast-feeding, which is shown to be prolonged in over-protected children. Prevention of independent behaviour is dealt with in relation to school performance. The over-protected child tends to show superior educational achievement, relatively high scores in language, poor scores in arithmetic (because mothers are not good at arithmetic and because the child is not sent on messages which need arithmetical calculations?), and special interest in reading with a general lack of interest in sports. Other effects of this kind of over-protection are discouragement from forming friendships