in appearance, as were the aorta and coronary arteries. The liver was enlarged, and was the seat of many tubercles. These varied in size from 1/4 in. to 1/2 in., and showed a surprising lack of caseation. They were in several cases surrounded by necrotic liver tissue and there was little or no fibrosis around the tubercles. The spleen was enlarged to about four times the normal size and was congested. Here again were seen many tubercles similar in size and appearance to those in the liver. There was a fibrinous perisplenitis. The kidneys showed several small tubercles scattered through the organs. The pancreas appeared normal, though there was an enlarged semicaseous lymph gland near the head. The suprarenals were normal. The oesophagus, stomach, and intestines were also normal in appearance. There was little free fluid in the abdominal cavity, and only an occasional small tubercle was present in the peritoneum.

Microscopical Examination.—Smears taken from the peribronchial lymph gland and from a tubercle in the liver showed acid alcohol-fast bacilli. Sections of the tubercle in the myocardium revealed a central area of early caseation, surrounded by endothelioid cells, histiocytes, and small round cells. Scanty giant cells of the Langhans type were present. Acid alcohol-fast bacilli were also found.

Comments

The heart and pericardium are seldom involved in military tuberculosis, and although solitary tubercles in the myocardium have been described, they are quite exceptional. Tuberculosis of the pericardium is not uncommon, and is due in most cases to a backward infection by the lymphatics from a tuberculous gland. To quote *Muir's Pathology* (4th edition, 1940): "At an early stage tubercles are formed, but these soon lead to inflammatory reaction and become covered with fibrin. The disease may thus appear like an ordinary fibrinous pericarditis, and its real nature may be discovered only on microscopical examination." In this case, however, there were, as already described, many large and very obvious tubercles. The lesion in the myocardium (1/2 in. in diameter) was discrete and presumably blood-borne, as no connexion between it and the pericardium could be traced either macroscopically or microscopically. The condition in the liver, too, is very rare. To quote the above author again: "The presence of large almost tumour-like tuberculous masses in the liver has been recorded in a few cases, but the occurrence is very rare."

The disease in this case would appear to have been a blood-stream infection with a ? primary focus in the peribronchial lymph gland. The size of the tubercles and the absence of macroscopic caseation in the tubercles in the various affected organs argue a comparatively high resistance on the part of the patient, and in some way account for the lack of clinical signs which, until within a few weeks of his death, consisted merely of a persistent pyrexia and the early erythema nodosum.

We wish to thank Col. W. D. Arthur, M.B.E., and Lieut.-Col. W. L. Ackerman for their help and permission to forward this paper.

of incomplete anaesthesia and the consequent suffering very quickly spread round a ward. Patients then arrive at the theatre in the worst possible state of anxiety for a local. Therefore as soon as any pain is felt it is essential for something to be done, and the best is a very light inhalation, open ether being satisfactory. One case in this series was so treated, and the confidence of the wards was not upset.

The patients were sent to the theatre at the same time, and were anaesthetized in a batch if the number on the list did not exceed four. One patient was circumcised after a lapse of an hour, and there was no falling off in the standard of analgesia. The question of premedication is simple in these cases. From this series it was decided that, whether morphine was given or not, the results were the same as regards the analgesia, but a greater tranquillity of mind was present in the premedicated. But we were dealing with trained soldiers, and it is suggested that in the case of a civil clinic all cases be premedicated. In order to cut down the number of stretcher-bearers which would be required—since the ward which provided these cases was a long distance from the theatre—the patients walked to the anaesthetic room. At the beginning of the series all cases were given morphine gr. 1/3 intravenously on arrival. Then the local analgesic was injected, novotox being the agent, and the dose within the limits of 6 to 8 c.cm. A 10-c.cm. syringe fitted with a hypodermic needle was used. The first injection was made into the base of the penis on the dorsal surface in the midline, and the area on each side of this puncture was infiltrated as far as the lateral border of the organ. Approximately 4 c.cm. of agent would be used over this area. A second puncture was then made into the ventral surface in the midline, and this area was similarly infiltrated to meet the lateral boundaries of the first injection. Less solution would be required here, since the previous infiltration had included the lateral borders. But before the needle was removed at least 1.5 c.cm. was inserted into the midline of the ventral surface. This was most important, as in any case of imperfect anaesthesia the frenum is the sensitive structure. After the infiltration was completed a period of at least ten minutes was allowed to elapse before the operation was started. When premedication was abandoned, about half-way through the series, the patients were allowed to walk back to the ward, accompanied by an orderly, and every one arrived there none the worse for the experience.

It has been suggested that the efficient haemostasis provided by the local block might lead to post-operative haemorrhage; this did not happen. No doubt the haemostasis is produced by the mechanical compression of the vessels by the ring of swelling resulting from the infiltration. There were no ill effects.

I am indebted to Major J. D. Wilson, R.A.M.C., surgical specialist to the hospital where these cases were treated, for his interest and co-operation in the anaesthesia.

H. L. ROGERSON, M.R.C.S., L.R.C.P.,
Major, R.A.M.C.

A Case of Sensitiveness to Strychnine

The following record seems worthy of publication not only for its rarity but for the moral lesson it affords.

CASE REPORT

A married woman aged 42 came under my care in a busy panel practice recently, already certified as unfit for work on account of rheumatism, of which there was no objective evidence. Thinking that aperient treatment might be of value, I prescribed a bottle of mist. casc. co. Next day I was summoned urgently, to find that after one dose of the new medicine the patient had collapsed, and was pale and pulseless. No definite diagnosis occurred to me, although I toyed with the idea of belladonna poisoning in an aberrant form, since, as some may know, the mist. casc. co. of the 1943 *Formulary* contains the astonishing amount of 12½ minims of the tincture to the dose, whereas the 1939 mist. casc. co. contains only 3 minims, as I found on looking it up.

After some weeks of treatment with iron the patient asked for a tonic, intending to return to work. I prescribed the mist. phosph. c. strych., of which the patient warily took only a teaspoonful, and within a few minutes suffered a similar though not so severe attack. On my arrival in haste I had to defend myself against accusations of poisoning. Since the only item common to the two mixtures is strychnine, I was forced to the conclusion that this must be the cause of the attacks, and at the request of the patient obtained another opinion. My colleague rather sceptically injected intradermally 0.05 c.cm. of liq. strych., which caused an immediate wheal followed in a minute or two by a typical anaphylactic attack, which required the injection of adrenaline.

I have now equipped the patient with a written note to be shown to any future doctor. Inquiry among friends and chemists of wide experience has not brought to light a similar case.

D. R. C. SHEPHERD, M.R.C.P.

Medical Memoranda

Local Analgesia for Adult Circumcision

No claims for originality are made when a technique of local block for adult circumcision is described; but at the same time the textbooks do not stress this method as being a technique of choice for this operation. Under certain conditions it is definitely the most satisfactory anaesthesia. If a general anaesthetic is employed circumcision in the adult demands a much deeper level of anaesthesia than is often realized. For instance, a "shot of pentothal" will not do; a large dose of this barbiturate is not sufficient in most cases. The advantages claimed for local block are speed for the surgeon in the organization of a clinic, a high degree of haemostasis, and the use of a very small quantity of an inexpensive fluid. And the patient is not subjected to the risks of a general anaesthetic, small though these are.

Recently, local block for adult circumcision was carried out in 41 cases at a military hospital in India, on British and Indian troops. The cases were largely drawn from the venereal disease department, but there were cases of non-venereal balanitis and phimosis also. During this series, admittedly small, no other technique was used, although there were slight variations in the method. Sepsis was not considered to be a contra-indication, and a few of the cases were in such a condition that the operation was confined to a "dorsal slit."

Of course the soldier is the ideal subject for all forms of block analgesia, provided that they are successful. Reports