of Morgagni, and is preserved in the Pathological Museum of the University of Oxford. The patient made an uninterrupted recovery.

This case has seemed worthy of record rather on account of the rarity of the condition than of its clinical significance. I have failed to find any allusion to this lesion in the literature of the subject, nor do any cases appear to have been published recently, at least in this country, America, or on the Continent. It would be interesting to know whether previous cases have been observed but not published.

The description of the original colicky pain was suggestive of a uterine origin, and was attributed to the incipient abortion, but the severe right-sided pain which induced vomiting did not begin until the abortion was almost complete—that is, three weeks later—when the uterus contained nothing but a few necrotic fragments. It seems not improbable that this pain was due to the stretching of the covering peritoneum produced by the engorgement of the strangulated hydatid. No cause was found for the torsion. The ovarian cysts were both simple follicular cysts following an old perioöphoritis, which had produced on the right side a few inconsiderable adhesions; the appendix presumably could have had nothing to do with the condition.

TORSION OF THE APPENDIX OF THE TESTIS (HYDATID OF MORGAGNI).

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THIS condition appears to be one of rare occurrence, in view of the fact that we can find no reference to it in standard textbooks or recent English literature. It is therefore of interest that during the year 1928 we have each operated on two such cases at the Queen's Hospital for Children. All four cases we were able to diagnose before operation.

In each case the patient was a boy aged 12 years, and had not attained puberty. The cases demonstrated a marked similarity of onset and subsequent history, and the following case may be taken as typical.

The patient, five days before admission, complained of sudden pain in the right testis, without history of trauma. There was no vomiting or constitutional disturbance. Pain continued in spite of rest in bed, and on attendance at hospital the following condition was observed. There was swelling and tenderness of the whole testis, the skin of the scrotum was reddened and oedematous, and the spermatic cord was thickened throughout its length. On palpation a small body, about the size of a pea, was felt lying between the upper pole of the testis and the globus major. This small swelling was exquisitely tender, and not freely movable.

At operation the tumour was found to be of a deep plum colour, and obviously full of blood clot. There was marked oedema of the spermatic cord. The tumour was in the position of the hydatid of Morgagni, and had a pedicle, which had obviously undergone torsion. The pedicle was ligatured and the hydatid removed. On microscopic examination the following report was obtained: Section shows organizing blood clot undergoing degeneration; here and there are cystic spaces lined with flat unciliated epithelium.

The patient was immediately relieved after operation, and made an uninterrupted recovery.

In one case of five days' duration the hydatid showed signs of commencing sloughing. Another case was brought to the hospital six hours after onset, and already demonstrated oedema and reddening of the scrotal skin. Two cases occurred on the right side, and two on the left.

In conclusion, we wonder if this condition is really of rare occurrence, or whether these cases are frequently treated as orchitis of unknown origin, and left until the twisted hydatid sloughs, and resolution eventually occurs; presumably a painful and protracted process.

VARICOSE VEINS: THEIR MODERN TREATMENT BY SCLEROSING INJECTIONS.

METHODS AND TECHNIQUE OF "SICARD AND GAUGIER"
AS PRACTISED AT THE HÔPITAL NECKER, PARIS.

BY

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SCLEROSING injections for the treatment of varicose conditions have emerged successfully from the trial stage and are now almost universally regarded as being safe, effective, and the treatment of choice for varix.

The object of treatment is to obliterate the whole or part of the veins concerned in the superficial circulation of the limb—namely, the internal and external saphenous veins and their branches. These veins run in the subcutaneous tissue and have no support except their own walls; when the superficial circulation is occluded the blood returns by the deep veins, which are well supported by the muscles of the leg.

The principal points of interest to the doctor who intends taking up this work are: (1) methods of selecting cases suitable for treatment; (2) technique of injection; (3) choice of sclerosing fluid and strength of dosage; (4) number of injections necessary and interval between each; (5) the pathological effects of injection on the vein; (6) after-effects and possible complications. The advantages of this method are that when properly administered injections are safe and certain in their results, cause little pain or discomfort, and the patient need not lie up.

A bewilderingly large literature on injection treatment is being added to daily; most of it is interesting and helpful, but a lack of agreement on the essential points just mentioned is unfortunately a frequent and salient feature. In the confusion thus caused many who wish to take up this work find it difficult to decide what procedure to follow. Ill results of a serious character following treatment are being reported with increasing frequency, and are mainly due to defective technique and lack of authoritative knowledge on the subject. As it is universally conceded that it is to Professor Sicard of Paris we are indebted for establishing, in 1916, the treatment of varicose veins of the limbs by injection as a safe and effective procedure (the idea had been experimented with unsatisfactorily for seventy years), those who are about to adopt this method of treatment for the first time will be wise to follow the methods of this, the greatest authority, or at least adopt those methods as a sound basis on which to found their own experience. (The principle of employing sclerosing fluids for treatment of varix was, however, first successfully put into practice by British doctors, but only for the treatment of haemorrhoids. Morgan and Colles of Dublin were the pioneers seventy years ago, and Mr. Swinford Edwards, whose house-surgeon at St. Mark's Hospital it was my privilege to be, first introduced the method to this country, his article in the *British Medical Journal* of October 13th, 1888, being still one of the most instructive.)

Sicard's opinions and advice on this subject are as authoritative as Ehrlich's on the treatment of syphilis by arsenical injections. His special clinic at the Hôpital Necker, Paris, is of world-wide reputation, and here he and his colleagues, Gaugier, Paraf, Forestier, Haguénau, and Lermoyez, have treated many thousands of cases, necessitating hundreds of thousands of injections, with excellent results and without a single serious mishap.

Sodium salicylate is the sclerosing injection they recommend, and since the publication of their results many other workers, acknowledging their indebtedness to Sicard's work, have endeavoured to find, if possible, an even more effective chemical for injection; quinine (Génévrier), mercury biniodide (Montpellier and Lacroix of Algiers), glucose (Nobl), the citrate (Troisier), chloride (Linsler), and carbonate of sodium, and other solutions, all have now their own advocates. Every new sclerosing fluid recommended by any authoritative worker is given an

extensive trial in a series of cases at the Hôpital Necker, and compared with a series of cases treated by sodium salicylate, and many thousands of injections of the solutions just mentioned have been given in this fashion. From this unique experience Sicard and his colleagues are of opinion, whilst appraising the work of the distinguished men just mentioned, that sodium salicylate is the most effective, safest, and gentlest in its after-effects, of all injections.

Thanks to the courtesy of Professor Sicard and Dr. Gaugier it was my privilege to assist on many occasions at the injection of a large number of cases at the Hôpital Necker, and I am deeply indebted and grateful to Dr. Gaugier for his kindness in explaining to me their methods and technique, which I have since followed with most gratifying results. I had for many years previously had much experience of sclerosing injections in the treatment of haemorrhoids, both at St. Mark's Hospital and in private practice, and had given many thousands of intravenous arsenical injections, mainly at the London Lock Hospital, so that the acquisition of the technique presented few difficulties. These methods and technique, which I will state as briefly as possible, are as follows.

1. Selection of Cases.

Every patient should first undergo a complete general examination—heart, kidneys, etc.

Contraindications to Injection.—(a) Obstruction in the veins of the deep circulation is the most important. To ascertain if the deep circulation is obstructed, fasten a tourniquet below the knee and make the patient walk round the room. If no obstruction is present the swollen veins empty themselves into the deep circulation, and then appear almost flat, but should occlusion exist the superficial veins of the leg become more swollen and the leg painful. Should this test be neglected and injection given when the deep circulation is occluded a most painful and oedematous condition of the limb, coming on rapidly, due to stirring up of the phlebitis, and lasting many weeks, may result. Phlebitis of the deep veins, of old or recent origin, is the commonest cause of obstruction, and phlegmasia alba dolens is the commonest cause of deep phlebitis. Marked dilatation in the veins of the pubic area when present is usually a relic of this condition, and should put one on guard. (b) Arteritis (intermittent claudication) and any condition in which embarrassment of the circulation already exists. The clinical history is the best guide in the diagnosis of intermittent claudication; in this condition the patient suffers whilst walking and is relieved on standing, whilst the varicose patient suffers while standing and is relieved on walking. (c) Cardiac insufficiency of any degree and advanced kidney disease are the next most important contraindications. When other cardiac lesions exist, and when albumin or sugar is present even in small amounts, injections should be administered with great caution. (d) Excessively high blood pressure. (e) Extreme old age. (f) Pregnancy is a contraindication, because varicose veins associated with this condition either undergo spontaneous cure or get considerably better soon after delivery, but especially because it has been demonstrated by Bar that the blood of pregnant women is hyperfibrinous, and therefore predisposed to phlebitis. Marked vulvar varicosities can, however, be injected, as they may be a serious complication at the time of delivery. (g) Multiple uterine fibromata may also be a contraindication.

2. Technique of Injection.

The patient stands on a chair beside a table, the latter being provided with a handrail on which the patient leans (it is now possible for special tables to be obtained). The upright position renders the veins tense, a tourniquet being useless. The most prominent point of the most prominent vein of the leg below the knee is selected; midway between ankle and knee is, as a rule, the best part to choose. The injection must be completely intravenous, and made with the usual aseptic precautions of sterilizing skin, needle, etc. The syringe should be of light weight; a small all-glass 5 c.cm. syringe is best. The injection, as a rule, is best made in two stages, especially when the veins are not very large. It is well to have two of the small

glass syringes, one empty with needle attached, the other without needle and filled with solution. The size of the needle should be that of the ordinary small hypodermic syringe, and the point should be very short. The vein is entered with the needle attached to the empty syringe, the patient standing. To ascertain if the needle is in the vein the piston is slightly withdrawn, when blood should enter the syringe. When blood enters the syringe (and not before) the syringe is detached from the needle, and whilst the needle is still in the vein the patient is made to lie down. When the patient is lying down (not before) the syringe filled with solution is attached to the needle in the vein; injection should be done slowly, especially as regards the smaller veins, otherwise painful spasm or rupture, leading to escape of fluid and subsequent ulceration, may occur. The standing position makes it easy to enter the vein. The recumbent position causes the vein to empty itself, and if the solution is injected then it gets into immediate and intimate contact with the endothelium. The needle is allowed to remain in the vein for one minute at the end of injection, and is then briskly withdrawn, a tampon of cotton-wool being rapidly pressed over the point of exit. This is important, a common cause of pain, local discoloration, and ulceration after injection being the slow withdrawal of the needle, which allows some of the injected solution to escape into the surrounding tissues. Should the veins be large the injection can be made in one stage, with the patient lying down.

There are two causes of pain at injection; the first is injecting the fluid outside the vein. The patient complains immediately of pain and burning at the site of injection. The needle should be withdrawn at once and another part of the vein selected. The second kind of pain is cramp-like or stinging, and may extend the whole length of the limb. It usually comes on towards the end of, or immediately after, injection, and is due to vasomotor disturbance caused by the solution irritating the endothelial lining of the vein and thus exciting the sympathetic. It lasts about a minute or two, is quite bearable, and does not recur. This pain does not always happen, but does so frequently. The patient should be warned to expect it, and assured that it will only last a minute or two and will not return. It is best to keep the patient lying down for about ten minutes after injection, as muscular action is liable to aspirate the fluid from the superficial circulation into the deep. In the region of the malleolus and over bone the injections should be small in amount and of weak strength, otherwise pain and oedema lasting some weeks may result. As only large varicose veins are easy to inject, considerable practice in intravenous technique is advisable before consistently successful results can be attained.

3. The Sclerosing Fluid and Strength of Dosage.

Sodium salicylate is the injection of choice. It should be a chemically pure and colourless solution. Solutions which have turned violet should be rejected. The salicylate should be made up in specially hard glass which cannot be acted on by the solution. The first injection should consist of 2 c.cm. of a 20 per cent. solution, and this amount and strength should not be exceeded at a first visit. Two days later the second injection is given, the amount and strength of which depends on the effect produced by the first. The injections are gradually increased in strength and quantity, 3 c.cm. of 30 per cent. being given on the second and 4 c.cm. of 40 per cent. on the third occasion. One should never exceed 6 c.cm. in amount and 40 per cent. strength at one visit. The action produced by the preceding injection is the true guide to the strength and amount of each succeeding injection, and a little practical experience will soon teach the surgeon much on these points. The strength and amount of dosage should, however, be increased as rapidly as possible when no contraindications exist, in order to hasten the irritation of the endothelial lining of the veins; small and weak doses frequently repeated only harden the walls of the vein without causing obliteration, and the veins thus hardened will offer a great resistance to subsequent injections even though those injections be numerous and strong; this is the commonest cause of failure to procure obliteration. It is inadvisable to add novocain or any other

analgesic to the salicylate with the object of diminishing the cramp-like pain. The novocain renders the fluid anaesthetic, and in the event of the solution being injected by mistake into the perivenous tissues, the absence of pain may cause the doctor to be unaware of his error and subsequent ulceration will be the result.

4. Number of Injections Necessary and Interval between each.

This depends on the number, extent, tortuosity, and calibre of the veins, and on whether one or both limbs are varicose, five or six injections as a rule being sufficient for each limb. Three to five inches of vein on an average are usually occluded with 4 c.cm. of a 40 per cent. solution, but much more is not infrequently obliterated; two injections of 5 c.cm. of 40 per cent. solution are sometimes sufficient to obliterate completely the internal saphenous vein.

There is no fixed rule as to interval between injections. If both limbs are affected the patient may attend daily, each limb being injected on alternate days, a different segment of vein being selected each time, depending upon the amount of reaction of the previous injection. With experience the necessary knowledge on these points will soon be acquired.

5. Effects of Injection on the Vein.

The manner in which chemical injections cause obliteration of veins is different from that in which infective phlebitis is produced. The immediate effects of injection are vasomotor, especially vaso-constriction (through stimulation of the sympathetic which supplies the smooth muscle regulating the calibre of veins), pallor of the part, and a "goose flesh" appearance of the skin. A chemical endovenitis with thrombosis occurs during the first hour, and some hours later the inflammation spreads to all the coats of the vein and even outside the vein (periphlebitis). This has been proved (Jentzer and Askanazy) by adding collargol to the salicylate solution and then injecting the mixture. Part of the vein was then removed, the collargol being found in all tunics of the vein and seen in the tissues outside the vein. This type of inflammation is called "venitis"; it is localized, limited, and chemical in origin; as distinguished from infective "phlebitis," which is diffuse, of infectious origin, and attacks the deep veins. Embolism does not occur in "venitis," as the clot is aseptic and firmly adherent to the vessel wall, whereas in "phlebitis" the clot may be soft or brittle, and embolism is frequent. The termination of the "venitis" is as follows. The sclerosing fluid irritates the endothelium, which becomes congested and hypertrophied. The fibrin of the blood becomes deposited on the whole length of the irritated and injured endothelium, to which it adheres firmly. The clot becomes organized, sclerosis follows, and the venous cicatricial tissue becomes gradually absorbed in the following weeks. In venitis there is no fever as in phlebitis, because there is no infection; no oedema, because the superficial veins, and not the deep ones, are alone obliterated; and there are no continuous severe pains as in phlebitis, because the vessels of the nerves (the vasa nervorum) are not affected by the salicylate solution. It happens very occasionally that, owing to ulceration, an infective venitis—that is, of a superficial vein—is found; but even in this condition embolism is extremely rare, practically never occurring unless the deep veins are infected. Sicard and Gally proved radiographically (by means of lipiodol in the vein) that the blood flow in varicose veins is reversed, therefore even if embolism does occur it is not dangerous, as the embolus would be carried towards the periphery and not centrally. No case of embolism has occurred at the Hôpital Necker in over three hundred thousand injections, and in my own experience, including the treatment of haemorrhoids with sclerosing injections in many hundreds of cases, I have never had a single case of embolism. Dr. Bensaude of the Hôpital St. Antoine, Paris, the best known French authority on the use of sclerosing injections for the treatment of haemorrhoids, assured me that in the thousands of cases he has treated embolism had never occurred.

Painful Effects of Injection and their Causes.—When the injection has been properly given there are only two

possible painful effects, the one immediate—that is, the cramp previously mentioned, a vasomotor phenomenon always temporary, quite bearable, and without danger—the other, more remote and not common, "perivenitis," which is never serious, and indeed when it occurs causes a more rapid and certain cure. Whilst perivenitis persists the part looks red and is tender and warm to touch, but there is no temperature and the patient need not lie up unless symptoms are excessively painful, which is rare. When ulceration occurs following injection it is due to the solution entering the perivenous tissues through faulty technique as follows: (a) Injecting fluid outside the vein; (b) rupture of the vein from employment of a too strong solution and especially an excessive quantity of a strong solution, and (c) injecting small veins too rapidly, causing rupture; (d) lack of asepsis. In several hundred cases in whose treatment I assisted at the Hôpital Necker and in my own practice I have not seen one instance of ulcer due to injection of sodium salicylate. As success depends mainly on skilful technique, sclerosing injections, either for haemorrhoids or varicose veins of the limb, should only be given when experience in rectal and intravenous work has been acquired.

6. After-effects and Possible Complications.

(a) Perivenitis, just mentioned, is the only important after-effect; it usually lasts a few days, rarely longer than a week, and no special treatment or bandage is necessary. In the rare cases where reaction is excessive, rest, local applications, and a supporting bandage are advisable. It must be understood that I am only speaking of the effects of sodium salicylate. With some other solutions marked and very painful perivenitis is not uncommon, and in these cases the treatment ceases to be ambulatory. All varices are not equally affected by injection. The single sinuous vein will frequently yield to even a weak sclerosing solution, and disappears rapidly with no after-effects such as pain or discomfort. In these days of short dresses this type of vein, by protruding through the thin stocking, causes much disfigurement. For this reason more women than men, from "mobiles de coquetterie," as Sicard says, present themselves for treatment, men as a rule only seeking advice when they suffer from voluminous varices which cause much discomfort and hinder them working. The after-effects are naturally more marked in the latter type of case. (b) A pigmented brownish line which marks accurately the course of the obliterated vein may persist for a long time; it is due to the destruction of the sympathetic in the sclerosed vein.

Complications of varicose veins such as eczema, ulcer, and haemorrhage, are not contraindications, but are themselves benefited by injections; in the case of ulceration local treatment should be employed in addition to the injections, which latter should be given in the healthy area away from the ulcer. The veins diminish in calibre from the day of injection, and the patient rapidly loses the feeling of heaviness in the limbs of which he previously complained, and all that can be felt (not seen, because the vein does not protrude under the skin after the first injection) is a hard cylindrical zone slightly painful to touch. The patient need not lie up after injection, but can carry on his work and social duties as usual.

Recurrence does not take place in veins which have been completely sclerosed, but occasionally sclerosis is incomplete (especially if the injection has been made perivenously as for haemorrhoids) and the central lumen persists. Fresh injections into the thickened vein will be necessary. New varices sometimes appear a few months after treatment. These readily yield to further injections.

When the sclerosing treatment is finished, general treatment should be instituted in most cases to maintain and prolong the effects of the local treatment. This general treatment should be directed towards the cause of the varices. Sicard and Gaugier are of opinion that varix (excluding that due to pressure and infection) is endocrine in origin—a special hormone circulating in the blood and acting on the sympathetic which regulates the calibre of the vein. When the internal secretion of the endocrine glands is defective or vitiated, varicosity results; in their opinion the genital glands (testicles and ovaries) and hypophysis

cerebri are those chiefly concerned, and a course of treatment with extracts of these glands is suggested. Violent exercise, excessive standing, and constipation should be avoided and attention to general hygiene counselled.

The technical details in the foregoing paragraphs are written with the approval of Professor Sicard and Dr. Gaugier, to whom I again express my thanks and indebtedness for enabling me to place them before their British confères.

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A NEW METHOD OF TREATMENT OF LEPROTIC INFECTION OF THE NASAL MUCOSA.

BY

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THOUGH in leprosy the nasal mucous membrane is no longer held to be a common site of the primary lesion, it nevertheless remains true that, particularly in cases of the so-called systemic type, the nose, either internally or externally, is a region of very great importance with regard both to frequency of involvement and persistence of infection. In pure nerve leprosy, however, nasal lesions are not common, and indeed probably all supposed nerve cases which show infection of the nasal mucous membrane should be considered to belong to the systemic type.

External lesions of the nose show features no different from those of lesions of the skin covering other parts of the face. Internally the nasal mucous membrane may be the seat of a generalized infiltration of the whole mucosa or localized infiltrations of the septal mucosa, which, when they ulcerate, as sometimes happens, are very difficult to treat. The lesion may spread to the cartilage of the septum, leading to perforation or to complete destruction, or it may extend to the skin at the margins of the alae nasi, forming a creeping ulceration, which gradually erodes the skin and underlying tissues. Probably in some cases the accessory sinuses become involved, and in many, generally advanced, cases it spreads backwards with infiltration and ulceration of the nasopharyngeal and laryngeal mucous membrane. A few early cases of the systemic type have been seen in which the first visible lesion was in the skin of the nose. In these the nasal mucous membrane, at first uninfected, later became involved, apparently by direct extension from the skin.

The affected mucous membrane is never insensitive, sometimes it is highly sensitive, and the ulcers which occasionally form tend to become encrusted and to remain so for long periods. The removal of these crusts causes haemorrhage, which may be severe, and one never fails to find numbers of bacilli beneath. If, when taking a swab, the crust is not removed, the smear may be negative. Wade and Solis¹ have stressed the importance of examining the nasal mucous membrane of the "negative" leper. In this country great emphasis has been laid on such examination, probably too great, for cases bacteriologically negative are not segregated and are *ipso facto* deprived of treatment, which is carried out only at the Leper Hospital. These cases at length swell the ranks of the mutilated victims, who still form a large proportion of our segregated lepers. Our experience here is that some 70 per cent. of cases of the systemic type and some 20 per cent. of cases of the nerve type show infection of the nasal mucous membrane before treatment.

Of late years we have been fortunate in obtaining a number of early cases where nodular infiltration has barely commenced, or at any rate is by no means widespread.

In these cases, where nasal infection exists, it tends to persist after the nodules have disappeared. Moreover, in many cases, particularly of the nerve type, this persistence may postpone for some time the conditional discharge of the patient. From these considerations the importance is obvious of a line of treatment which will sterilize the nasal mucous membrane in a few months.

Technique of Treatment.

Ionization appears to bring about the required result. At first we used a 1 per cent. solution of sodium salts prepared in this laboratory by saponification from "hydnoceol," which is pure creosoted hydnoceol oil supplied under this trade name by Messrs. Smith, Stanistreet and Co., Calcutta. Afterwards we used alepol, potassium iodide, and sodium chloride in 1 per cent. solution. The ionization current was obtained either from a galvanic battery or from the main through one of the galvanosets manufactured by the Medical Supply Association, London. Nasal electrodes were improvised from the ordinary small "button" electrodes, wrapped in absorbent wool which had been immersed for a short time in the solution to be used. One electrode was placed in each nostril, pushed well up and kept in position by means of bandages or rubber bands. The patient was told to breathe through the mouth, and a current, whose amperage (usually 20 to 30 ma.) was limited by his capacity of endurance, passed for twenty to thirty minutes.

Type of Cases Treated.

The patients treated may be divided into three groups. (1) Thirteen cases of both systemic and nerve types who had received the usual general and specific treatment for periods varying from nine months to two years, with disappearance of all signs save infection of the nasal mucous membrane. (2) Ten cases, all of the systemic type, under treatment for similar periods, but still showing other signs of activity besides intranasal infection. (3) Two cases of the systemic type before commencing treatment. All these patients were examined once weekly, the whole surface of the nasal mucous membrane being swabbed on both sides to the point of abrasion. The whole slide was examined before being returned as negative or as showing very few bacilli. Five controls, including representatives of the first two groups, were similarly examined week by week.

Results of Treatment.

No lessening of the number of bacilli is apparent until about ten to fourteen days after treatment. Bacilli may disappear after one or two sessions, but frequently there is a relapse, and at least three sessions, generally more, at fortnightly intervals, appear to be necessary for permanent cure. The treatment is somewhat unpleasant, but is readily borne, even by small children, and patients say that nasal breathing is much freer after the treatment. About two weeks after the last of three or more sessions, often after only one or two, the bacilli either disappear or become fewer in number and hard to find on the slide. Later there comes a stage when negative results alternate with positive, a stage which, as the Cullion workers have pointed out, often precedes the permanent stage in cases improving under general treatment.

Thirteen of the twenty-five cases treated have been returned at least once as negative, some eight times in succession, though only six had at any time since their admission given a negative result, and then in each case on a single occasion.

Nineteen of the twenty-five have either become negative or show such a reduction in the numbers of bacilli that they have become very hard to find. In the other six cases, all of long standing, it is possible that the sinuses had become involved. The controls showed no such reduction or extreme variability in the results of nasal examination.

It is impossible at present to say whether the cure is permanent, for only two months have elapsed since the conclusion of treatment in many of the cases, but owing to the impending absence of the writer on long leave it was thought desirable to publish these results at once, with a view to confirmation by others who may wish to try the method.