intertrigo, extensive oedema, and the urine of a haemorrhagic nephritis, typical glomerulo-nephritis being found post mortem. The other twin had oedema, but the urine was normal; there was complete recovery. None of my cases quoted above ever had albuminuria, and in one child (case not recorded) that died the kidneys were microscopically quite normal. Many of the symptoms, such as oedema, which were attributed a few years ago to failure of renal function, are now believed to be extra-renal in origin, the oedema—for example, in the typical case of lipoid nephrosis (= chronic parenchymatous nephritis)—being due to a generalized disturbance of salt and water metabolism, in which the kidney shares equally with every other vascular organ.

It is perfectly possible to have severe oedema without any nephritis, and severe nephritis without any oedema. Pyelitis in the newborn is not accompanied by oedema—at least, not in the half-dozen cases I have seen—so examination of the urine in oedema of the newborn practically never gives much help.

To sum up, then, oedema is a symptom of fairly common occurrence in the newborn, especially in premature and debilitated infants; it is often directly due to the effects of cold in the capillaries and to circulatory weakness. If the condition is recognized early and treated promptly the outlook is quite favourable; whilst in cases that are febrile it is commonly an early manifestation of sepsis. Nephritis is only rarely a cause of oedema in the newborn.

LOCAL ANAESTHESIA FOR TONSILLECTOMY

BY

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The difficulty recently experienced by a colleague in finding someone willing to remove his tonsils under local anaesthesia, prompts this account of a small series of twenty tonsillectomies done wholly under local anaesthesia. The cases were adult private and hospital patients, the initial reason for local anaesthesia being the patients' desire to avoid a general anaesthetic, and a later reason the personal preference of the writer for this method. The patients were selected only in so far as they were agreeable to the method and appeared to have ordinary powers of self-control. In all cases careful examination for other foci of infection was made in order to lessen the risks of troublesome haemorrhage.

The general technique employed will be found fully described in any work on local anaesthesia, and will be briefly dealt with here, particular stress being laid on certain modifications adopted to add to the ease of the patient. It is certain that the disagreeable anticipations naturally associated with the operation can be reduced, in their fulfilment, to something definitely less than the discomforts of many a visit to the dentist. Pain should be completely absent throughout, but the anxiety caused by the sensation of strange happenings and what must feel like a score of lethal weapons being rammed home in the victim's throat—particularly if the jaw is fixed with a gag—may be so great as to place the operation outside the pale of humane therapy. The relief of these feelings, however, depends upon the handling of the case, and the extent to which it may succeed is instanced by one patient in this group who, when about to be returned to the ward, asked anxiously what had gone wrong, and complained that he was being sent back with only the anaesthetic injected. Like most ideals such a state of affairs cannot be expected to obtain in all cases, but it may be closely approximated in a great many cases ordinarily subjected to general anaesthetics.

TECHNIQUE OF ADMINISTRATION

Preliminary morphine was given only to an unduly fearful minority and the patients' co-operation gained by a short explanation of what was to be expected of them. The procedure is as follows:

1. The fauces are liberally sprayed with 10 per cent. cocaine, after cautioning the patient against swallowing any of it.

2. In five minutes the injection of 0.75 per cent. novocain and adrenaline may be commenced. A light syringe and long needle are necessary. Injections are made into the upper and lower poles and just outside the margin of the anterior and posterior pillars, about the centre. Enough should be injected to encircle the tonsil with a band of anaemic tissue and to saturate its bed, from which it will project rather more than usual if not too adherent or fibrosed. The faucial tissues should not be blown into oedematous folds with the solution.

3. By the time the second injection is finished the first tonsil will be ready for dissection. This is done with the finger or dissector and scissors, but requires considerably more gentleness than is at times used in the dissection of tonsils under general anaesthesia. In most cases the work is being done in a field which is nearly dry, and one can proceed deliberately. The smallest adhesions should be snipped instead of torn. It is at this stage that the co-operation of the patient becomes particularly valuable, as by keeping his mouth well open and pharynx relaxed he will give good exposure of the parts with the occasional help of a tongue depressor used only lightly. Any form of gag should be avoided, as being too uncomfortable for the conscious patient. At any stage the partially dissected tonsil may be held with a swab whilst the patient is allowed to relax his jaw and rest; indeed, these spells may be encouraged if the tonsil be looked on as a piece of raw tissue and an efficient haemostat.

4. After the removal of the second tonsil is completed swabs held in the tonsillar fossae for a few minutes suffice to reduce the haemorrhage to a point which just colours the saliva, and the patient is able to walk back to the ward or be driven to his home.

COMMENTARY

In no case was there enough bleeding to require the use of a suction apparatus to maintain a clear view of the field of operation throughout. Some of the cases were practically bloodless. The only complaint made in the first hour or so after the operation was the difficulty in swallowing. As the effects of the anaesthetic passed off the patient seemed to complain of rather more first-day pain than is found in the case of those receiving a general anaesthetic. This, however, would be explained by the lack of the dulling effect of a general anaesthetic and a certain sense of disappointment following their early cheerfulness. In no case was there any troublesome reactionary haemorrhage, the total blood lost seeming only a fraction of that usually experienced. There was no appreciable difference in the convalescence. Perhaps the use of some other solution giving a more prolonged partial anaesthesia, or the dusting of the tonsil bed with some such substance as anaesthesin powder, would considerably lessen the after-pain and leave the patient with only pleasant memories of his tonsillectomy.

Without entering into any controversy as to the surgical virtues of avoiding a general when a local anaesthetic serves as well from both patient's and surgeon's point of view, it is suggested that the local is a perfectly practical and satisfactory method for tonsillectomy in adults. As with any local anaesthetic properly used, rather more time must be allowed: the average time in these cases

was about thirty minutes. Other requirements are a large measure of sympathy and confidence between patient and operator, and what may not unfairly be described as a certain daintiness of touch on the part of the surgeon. An anaesthetic method which demands these last two qualities seems to be no bad training for a surgeon, whether junior or senior, and the wider development of them might do much to improve the current standards of local anaesthetic administration, which seem too often to justify the unfavourable opinions held of them.

Memoranda

MEDICAL, SURGICAL, OBSTETRICAL

AN UNUSUAL CASE OF SUBPERITONEAL UTERINE FIBROID

(With Special Plate)

In view of the large size of the tumour and the very slight inconvenience which it caused, the following case is, I think, worthy of record.

The patient, Miss P., first consulted me on January 16th, complaining of some slight abdominal pain and discomfort. On examination she was found to have a large abdominal tumour of pelvic origin, more marked on the left side than on the right, and reaching to above the umbilicus. The tumour was of firm consistence, solid and smooth in outline. It was freely movable from side to side, and occupied the whole of the lower abdomen. It was not painful or tender on palpation. Vaginal examination, made without anaesthesia, was indefinite owing to the absence of relaxation of the patient. The os uteri was not softened; the breasts showed no pregnancy signs; menstrual history indicated a regular and normal flow and duration; x-ray examination was negative.

Operation, performed on January 20th, revealed an enormous subperitoneal fibroid arising from the fundus of the uterus and attached by a short pedicle. The uterus itself contained several other small fibroids—mural and subperitoneal. The pedicle was clamped, the tumour removed, and hysterectomy performed. The patient made an uneventful recovery. The weight of the tumour was 8 lb.; the circumference 30 in., the length 9 in., and the breadth 6½ in. Fig. 1 (on Plate) illustrates the size of the growth by comparison with the scale measure by its side.

I wish to express my thanks to my partner, Dr. P. Kinmont, for his assistance with the case.

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FOREIGN BODY IN THE COMMON BILE DUCT

Few cases have been reported of a foreign body being found in the common bile duct. Oppel¹ reported a case in which a patient had the operation of cholecystectomy, and some four months later developed a fatal peritonitis. A swab was found in the common bile duct; this had apparently migrated from the peritoneum, as the bile duct had not been opened at the previous operation. Lemierre and Pollet² reported a case in which a liver abscess occurred in an insane patient. This was due to a swallowed spoon-handle, which had entered the common bile duct via the ampulla of Vater. Fedoroff³ reported a case in which, following an operation for gall-stones, the wound was drained by a T-shaped drainage tube. On the seventeenth day, when the tube was going to be removed, the vertical portion had already been extruded from the wound, while the short horizontal part had remained in the duct (which was opened at operation). For two and a half years there were no symptoms, but then the patient developed attacks of colic with occasional jaundice. After a further two years the patient was operated on again. The tube was found in the retro-duodenal portion of the common bile duct, and had under-

gone no changes whatsoever during its five years' stay. Recovery was uneventful. In view of the few such cases reported the following may be of interest.

REPORT OF CASE

The patient, a man aged 65, was admitted to the Derby City Hospital in June, 1931, complaining of indigestion, vomiting, and pain which he located under the right costal margin. He also described a lump which he said he could feel there. The history extended back for an indefinite period, but his symptoms had been more marked for some two or three weeks. There was no history of jaundice or colic. On examination the patient was well nourished and on the whole in moderately good health. On palpation, a rounded, tender swelling below the liver, suggestive of an enlarged gall-bladder, was clearly felt. There was no general enlargement of the liver, and the patient was not jaundiced. The temperature was normal. His symptoms improved, but the swelling continued to be palpable. Cholecystography showed no shadow in the area of the gall-bladder after fourteen or eighteen hours.

At operation the gall-bladder was found to be distended, and contained a mulberry stone of medium size in the cystic duct, some smaller stones being present in the gall-bladder. Palpation of the common bile duct revealed no further stones, but a piece of wire was felt to be projecting through the lateral wall of the duct just below the termination of the cystic duct. Cholecystectomy was performed, the piece of wire removed, and the operation completed in the usual way.

During his convalescence the patient was questioned about the origin of the wire, but was unable to shed any light on the matter. At no time could he remember the possibility of having swallowed it accidentally. No previous operation had been performed on the patient, and presumably the article in question must have been swallowed at some time and have migrated up the common bile duct.

The wire was just under one inch in length, and was bent in the shape of an L, the shorter arm having perforated the wall of the duct; it was steel wire approximately 0.001 inch thick, and had not been corroded to any great extent.

I am indebted to Dr. R. Ström-Olsen for assistance with the translation of the references.

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Hospital.

REFERENCES

- ¹ Oppel: *Zentralbl. f. Chir.*, 1926.
- ² Lemierre and Pollet: *Bull. et Mém. Soc. Méd. de Paris*, 1927.
- ³ Fedoroff: *Zentralbl. f. Chir.*, 1920.

GANGRENE AND PERFORATION DUE TO EMBOLISM OF THE INFERIOR MESENTERIC ARTERY

An account of this condition, appearing in the *British Medical Journal* of January 30th, 1932, prompts me to record a somewhat similar case that came under my notice a few years ago, at a time when I was acting as resident clinical assistant in one of the city mental hospitals.

Clinical History

The patient, a stout man of about 64 years of age, enjoyed perfect health until the onset of this fatal illness. His first complaint was that his bowels had not moved for some days, and Epsom salts had been taken with no result. Castor oil was then given by the attendant in charge, and the following day, though he complained of abdominal discomfort, he still passed nothing per rectum. Throughout the day the attendant reported nothing further, but on doing the evening round of the institution I examined his abdomen and discovered that it was distended and markedly rigid. Slight tenderness was experienced on palpation, more marked in the right iliac fossa. Pain, fairly severe and now constant, was complained of all over the abdomen, especially in the right iliac fossa. Temperature, 103°; pulse rate, about 100. The patient was removed to hospital, where a further examination was made on the arrival of the surgeon. The abdomen was now board-like, and severe pain was complained of on palpation. There was also collapse, and a rapid and feeble pulse. On opening the abdomen it was evident that peritonitis had been present. The intestines, especially the colon, were adherent to omentum.