work of the late Dr. W. Gordon, of Exeter, who at that time was secretary of the South-Western Branch of the Association. Such was the strong line he took within the Parliamentary Bills Committee on the subject of reform of the Army Medical Service that a special subcommittee was formed; and a letter from him as chairman of this subcommittee was addressed to the Secretary of State for War (Lord Lansdowne), afterwards published.[1] Later in 1896 "the elaborate and able memorandum" on the subject by the subcommittee's chairman is referred to in the proceedings of the Parliamentary Bills Committee.[2] and the report itself was published.[3] Eventually, early in 1898, a highly authoritative deputation was well received by Lord Lansdowne.[4]

It is of course not recorded in the minutes, but it is within my knowledge privately from Dr. Gordon, that Lord Lansdowne, before coming to his final and favourable conclusion, sought a further interview (which was a prolonged one) with Dr. Gordon as chairman of the subcommittee. Such ability and energy had he exhibited in the conduct of this matter that at the succeeding Annual Meeting he was awarded the thanks of the whole Association on the success of his efforts. It is appropriate that at this moment these facts be again put on record, but a full account will be found in the B.M.A.'s *Annual Handbook* of 1921–2, which contains a special historical section, and in E. Muirhead Little's *History of the B.M.A.*, p. 153, *et seq.*—I am, etc.,

Newquay, Cornwall. F. A. ROPER.

REFERENCES

1 *British Medical Journal*, 1896, **2**, 208.
2 Ibid., 1896, **2**, 1331.
3 Ibid., 1897, **1**, 732.
4 Ibid., 1898, **1**, 329.

Lower-segment Caesarean Section

SIR,—As the author, in 1933, of the use of Willett's forceps in lower-segment caesarean section I must strongly demur to Professor F. J. Browne's condemnation of them (July 10, p. 105). I have so employed them for the last 16 years and have never occasioned injury to the child's scalp beyond, in about one case in three, a small swelling underneath it, which is almost certainly mostly serum, for there is rarely any bruising, and which disappears in a week or two. They were not advocated for violent traction on the head, but only a pulling sufficient to keep it against the uterine incision and prevent bleeding from its edges. Forceful clumsiness no doubt makes them a barbarous instrument, but the barbarity is in the operator's hands and not in the forceps. I generally have two and sometimes three on at the same time, and this diminishes the force brought to bear because it is distributed over a larger area. Meanwhile the uterine incision is enlarged until it is big enough to let the head slip out. The advantage of the forceps is that they permit of traction on the head while the uterine incision is still small, and this much reduces the amount of bleeding. Sepsis, such as Professor Browne describes, argues a failure of aseptic technique by someone during or after the operation.—I am, etc.,

London, W.1. VICTOR BONNEY.

Whooping-cough and Measles

SIR,—There has recently been an outbreak of whooping-cough and of measles at an orphanage to which I have the honour to be medical officer. The children were isolated in two wards for the separate diseases, but five whooping-cough cases (aged 4–8, with duration of from 7–14 days' actual whooping and vomiting) subsequently developed measles in addition.

The first child so infected became acutely ill with bronchopneumonia, and to relieve the overworked staff I got him admitted to the local isolation hospital. The remaining four, after the usual few days' discomfort of measles, made uninterrupted recoveries, with this interesting difference. From the second or third days from the appearance of the rash they entirely lost their spasms, nor have they had further attacks although now up and about. The bronchopneumonia child had no spasms when in hospital, although he had been whooping and vomiting strongly before going. The whoops may have been missed in the general chest condition, but the matron was inclined to think he had "not been suffering from whooping-cough at all" until I told her about the others.

Are these five cases merely coincidences, or is there any known medical reason why an added measles should have apparently "cured" these distressing spasms so quickly? Mixed cases of this type must be rare and I do not remember one before in twenty-three years.—I am, etc.,

Malmesbury, Wilts. B. L. HODGE.

Acute Intussusception in Childhood

SIR,—Drs. Brenda Morrison and Donald Court are to be congratulated on their very interesting and instructive paper on this subject (April 24, p. 776). They have given a very full, accurate, and detailed description of the common signs and symptoms of this disease.

They found that fever was more commonly associated with intussusception than was usually believed to be the case. I believe, however, that the temperature is of no diagnostic significance. Also they found that the passage of blood per rectum was absent in 24% of their cases, and that 30% passed some blood within the first twelve hours. In my experience the passage of blood per rectum has been absent in some cases where the intussusception commenced in the terminal ileum within six to ten inches of the ileo-caecal valve, and these are the cases which soon become irreducible. With regard to the early diagnosis they stress the importance of a personal interview with the mother of the infant. Few cases would be missed if the doctor would listen carefully to the history of the child's illness as given by the mother, who is such an accurate and close observer where her infant's health is concerned. She notices the sudden onset of the illness, the pallor and sweating due to shock, the recurring spasms due to pain, and lastly, when it occurs, the passage of blood. With regard to the presence of a palpable abdominal tumour, this may be difficult to palpate, but there must be few if any cases where such a tumour cannot be palpated either with or without an anaesthetic.

With regard to treatment, the problem of reducing an intussusception is very similar to that where the reduction of a hernia is concerned, in that some reduce very readily and others soon become strangulated, and the duration of the trouble is not always the principal factor determining the possibility of reduction. Some will reduce easily after several days and others become irreducible within a few hours. It has been my experience after systematically attempting reduction of intussusceptions by hydrostatic pressure, using a column of saline or water from a height of three feet six inches, that over 60% of all cases presenting themselves for treatment become reduced if the pressure is maintained for eight minutes. After using this method over the last 35 years in several hundred cases I am convinced that it should always be given a trial.

Mr. Ralph H. Gardiner (May 22, p. 999) states that he regards the method of what he calls the "use of pressure enemata" as an extremely dangerous procedure, one of his reasons being the impossibility of telling whether the intussusception has been completely reduced. I know that this is also the opinion of many other surgeons. I feel sure, however, that both Mr. Gardiner and these many others have never given this method a proper trial. The method is simple, safe, and effective in most cases, and in over 40% of all cases presenting themselves for treatment one can be quite sure that reduction has been effected, although in 18% of those reduced an operation to confirm this fact should be done. If all cases are operated upon then at least 40% will be operated upon unnecessarily.

The principal sign indicating complete reduction is distension of the abdomen when no such distension of the abdomen was present before the injection was used. The distension is due to some of the saline passing through the ileo-caecal sphincter into the small bowel. It was after using thin barium enemata many years ago to bring about reduction, and then taking an *x* ray when I observed that in many cases the opaque solution had passed into the small bowel. As this brought about an even distension of the abdomen where before the injection was given the abdomen was soft and flaccid, I came to the conclusion that it was better to use hydrostatic pressure in a room adjoining the operating theatre and with the child prepared for an operation, so that no time would be wasted if one decided that an operation was necessary. I may state that in no case since using this method over the last 35 years have I made the mistake of sending the child back to the ward as having had the intussusception reduced when such was not the case.—I am, etc.,

Sydney, Australia. P. L. HIPSLEY.