vomiting due to pregnancy, gastro-enteritis, post-operative states, carcinomatosis, radiation therapy, drug-induced vomiting, and nausea or vomiting of psychogenic origin.

Dosage. A range of anti-emetic effect is 8-16 mg. daily in divided doses. Children between the ages of 1 and 6 years can be started on 2 mg. 2-3 times daily. Children between the ages of 6 and 12 years can be started on 2 mg. 3-4 times daily; a total daily dose of more than 12 mg is seldom required to elicit a favourable response.


SYRUP CHLOR-TRIMETON COMPOUND, SCHERING CORPORATION, USA
Scherag (Pty.) Ltd. supply the following information:

Syrup Chlor-trimeton Compound contains in each teaspoonful (5 c.c.) 1·25 mg. of the antihistamine Chlor-trimeton and 2·5 mg. of the vasoconstrictor phenylephrine hydrochloride.

Syrup Chlor-trimeton compound offers effective relief in nasal congestion due to common colds, vasomotor rhinitis, allergic rhinitis, coughs due to allergic bronchitis, bronchial asthma. Its complementary anti-allergic and decongestive action produces a decongestive effect greater than with either of its components acting alone. Nasal congestion is relieved and thus the patient can breathe freely once again. Nasal discharge is dried up to end the annoyance and discomfort of a 'runny' nose. Relief is prolonged to ensure a good night's sleep.

Syrup Chlor-trimeton compound is so safe that it can be prescribed even for very young children. Its delicious oral medication flavour overcomes all objections from young patients. For older patients who dislike nasal medication or for those who cannot take tablets this syrup is a convenient dosage form.

Dosage. Children under 1 year: ½-1 teaspoonful every 3 or 4 hours. 1-3 years: ½-1 teaspoonful every 3 or 4 hours. 3-6 years: 1-2 teaspoonfuls every 3 or 4 hours. Adults: 2 teaspoonfuls every 3 or 4 hours.


ARCOFAC
Petersen Ltd., sole distributors in the Union of South Africa for The Armour Laboratories, wish to apologise to the members of the medical profession and their patients for the inconvenience caused by the recent non-availability of Arcofac (Armour cholesterol-lowering factor). Fresh shipments have arrived and continuity of supplies is now assured.

REVIEWS OF BOOKS : BOEKRESENSIES

INTRODUCTION TO BIOSTATISTICS

Contents: Preface. 1. Introduction. 2. Classification and Tabulation. 3. Tabular teasponsful every 3 or 4 hours. Adults: 2 teaspoonfuls

DIAGNOSIS

GLAUCOMA


When one estimates that there are approximately 980,000 individuals suffering from glaucoma in the United States, and that 800,000 of these are not aware of its presence, it is obvious that early diagnosis is extremely important.

This statement which opens Chapter 13 is in itself sufficient reason for the publication of the second edition of this informative and important book.

The book deals in detail with the physiology and anatomy of the eye especially in regard to their relationship to glaucoma and gives the latest view on the etiology of the glaucomas. Special attention is paid to differentiating between the diagnosis and treatment of closed angle and open angle glaucoma with pratical stress on the part played by gonioscopy.

An estimation of the efficiency of the various provocative tests in the hands of the author as compared with those obtained by other ophthalmologists is made.
The latest methods of conservative treatment, particularly with dioxam, are given and then the whole range of operative procedures outlined. This last deals particularly with surgical approach for the different types of glaucoma.

An outstanding feature of this book is the very valuable and comprehensive bibliography which is appended to each chapter. Obviously an immense amount of work has been done in compiling this and it will make the task of any surgeon who is interested in the subject and who requires references, very easy.

The last chapter deals with the establishment of glaucoma clinics. This is a very stimulating idea and may well prove the forerunner for the establishment of similar clinics throughout the world.

The book is well printed and liberally illustrated and will be a distinct acquisition to all ophthalmologists.

M.F.

YEAR BOOK OF GENERAL SURGERY


The familiar face of this well-known year book has, alas, required some alteration. The editor, Dr. Evarts A. Graham, whose death took place in 1957, and who has been mourned by all men of medicine, has been succeeded by Dr. Michael De Bakey. The mantle of the master has fallen on worthy shoulders, and the spirit of its first editor is easily seen throughout the whole book in the choice of articles and more particularly in the editor's annotations. Graham's annotations were a joy to read; pithy, pointed and humorous. Dr. De Bakey carries on in the same tradition, perhaps not with the same humour—he is a 'new boy'—but the signs are there that he will be a worthy successor to a great man.

The book contains summaries of many of the major and important articles on surgical advances that have appeared in world literature in the year under review. As usual, the growing points of surgical effort occupy large sections. The vermiform appendix, one time surgical stamping ground of all and sundry, now occupies two pages! O quae mutatio rerum!

As always, this book will have to be read by all senior students of surgery and all practising surgeons. The chapters on anaesthesia appear to contain rather more articles than in previous editions, but the number of articles of physiological interest is something that can never be overdone.

S.T.T.

CORRESPONDENCE : BRIEWERUBRIEK

TRICHLOROETHYLENE

To the Editor: With reference to the most informative and interesting article by H. J. Schmidt1 on 'A History of Anaesthesia in South Africa' in the Journal of 1 March 1958 the author mentions that 'in 1946 another new inhalational anaesthetic, trichloroethylene (Trilene), made its appearance in South Africa'.

For the sake of the record and accuracy I desire to point out that I was already using it for anaesthesia in neurosurgery in 1943. Its use was suggested to me by its reported usefulness in trigeminal neuralgia, for which purpose Scherag Ltd. marketed its product under the trade name of Chlorylen, packed in 1 oz. bottles. In 1945 at the first post-war medical congress in Durban I read a paper on its use in neurosurgery based on several hundred cases. It must be confessed that its extreme usefulness in this branch of anaesthesia persuaded me at its inception here to monopolize all available supplies.

Actually it was first described in 1864.

Department of Surgery General Hospital Johannesburg 2 May 1958

I. Siff Senior Assistant Anaesthetist


TRAUMATIC INTUSSUPTION

To the Editor: I was extremely interested in the article on the above subject by Rakoff and Honigberger in the Journal of 5 April 1958. It brings to mind two cases of a similar nature which passed through my hands while District Surgeon in Kokstad during 1955 or 1956. They may be of interest to readers.

Case No. 1. A healthy young adult Native male admitted to the Kokstad Hospital with a history of having been assaulted with a long, very thin, sharpened stick. In fact, the wounds were 2 inches long immediately below the right nipple, attracted particular attention because it was associated with marked peritonitic pain and tenderness in the right upper quadrant of the abdomen. Laparotomy revealed an entrance wound on the diaphragmatic surface of the liver, no exit wound on the inferior surface, but a small area of fibrinous exudate related to the first part of the duodenum. No perforation was found in stomach, duodenum or colon. While exploring the small gut for the site of the perforation (none was found, and the mystery of the little patch of exudate remains unsolved), I came across an intussusception in the ileum. It was obviously of recent origin, and it reduced easily. No polyph or abnormalities of any sort could be felt through the wall of the gut. The patient made an uneventful recovery.

Case No. 2. Again a healthy young adult active male, who had undergone a laparotomy 4 weeks previously on the Reef for a bullet wound in the abdomen. He was admitted with partial small-bowel obstruction which soon became complete, and laparotomy revealed a thick band lying across the lower ileum, the proximal bowel being very distended. On releasing the bowel from this obvious obstruction, I found an intussusception about 2 inches long immediately distal to it in the collapsed bowel. This was a well-established intussusception, too oedematous to reduce. It was therefore resected, together with the segment that had been compressed. On examination of the specimen no polyph or other abnormality was found. The post-operative course was uneventful.

In case No. 2, one can perhaps visualize the bowel, frantically trying to extricate itself from the remorseless grip of the obstructing band, finally intussuscepting in its peristaltic efforts—presumably a local reflex phenomenon mediated by its myenteric plexus. Incidentally, this case received saline pre-operatively to replace fluids lost by vomiting and suction. In the light of contemporary teaching this was wrong, as it tends to lead to waterlogging of the tissues, especially in the affected portion of the gut. If I had merely reconstituted his blood volume by means of plasma or Dextran, I might have found the local oedema less, and the intussusception reducible.

Case 1 is a little harder to explain as there is no evidence that the small gut received any direct injury except perhaps a small self-sealing prick high up in the duodenum—an injury that should have led to atony rather than to the peristaltic efforts which we imagine to be necessary for the production of intussusception. We know that a high percentage of monkeys subjected to leucotomy die of multiple small-gut intussusceptions due to the effect of the higher nervous centres on bowel motility. Any theories based on this fact would be too fanciful for acceptance, and the probable explanation in this case is, again, that it was a local reflex phenomenon.

A. W. B. Heywood

To Royal College of Surgeons
Nicholson Street
Edinburgh, 8
Scotland
28 April 1958