

re-suspended in another large volume of saline and allowed to settle a second time. If the supernatant fluid after the second settlement does not react with a strong antihuman serum, the chances of any serum being left after a third settlement are negligible. The average antihuman serum used for medicolegal purposes in India detects the human serum in a dilution of 1 in 40,000 (Greval and Chowdhury, 1947). A stronger antiserum can be prepared for the purpose. A possible diffusion of the contents of the red cells into the saline will not interfere by giving a false positive reaction. This material does not react with the antiserum prepared against the serum (Greval and Chowdhury, 1945).

Only human serum albumen may be used. This derivative has been reported to be free from the icterogenic agent (Climenko, 1947).

Special selection of donors.—When a real whole blood transfusion is considered absolutely necessary, members of the same family, community and locality (in this order) are likely to provide safer donors than total strangers. The history of the former is better known, and because of a similar environment, the recipient and the donor are likely to have a similar immunological constitution.

No Indian cases.—Post-transfusion homologous serum jaundice has not attracted attention in India yet. The Calcutta Blood Bank provided blood and serum for 6,762 transfusions during 1945, 1946, and a part of 1947, mostly to hospitals, and did not receive a single report of a recipient developing jaundice after a month or so (Chatterji, 1947, personal communication). It is quite possible that the disease, like many other European diseases, does not thrive on Indian soil (Greval, 1946).

A re-estimation of the utility of blood and blood production.—The use of convalescent serum for children cannot be considered safe any longer in Europe at any rate. Measles could not have killed as many children at Oxford as were killed by the serum.

The utility of transfusion, in civil practice, also needs a reconsideration. It should be differentiated from a mere boost. Such a boost in the transfusion of whole blood has been suspected and discouraged (Albrecht, 1946). It should be discouraged in the transfusions of other constituents of blood also.

REFERENCES

- ALBRECHT, F. K. (1946). *Modern Management in Clinical Medicine*. Baillière, Tindall and Cox, London, p. 1156.
- BEATTIE, J. (1946) .. *Proc. Roy. Soc. Med.*, **39**, 658.
- BEATTIE, J., and MARSHALL, J. (1944a). *Nature*, **153**, 525.
- Idem (1944b). *Brit. Med. J.*, *ii*, 651.
- BEESON, P. B., CHESNEY, G., and MCFARLAN, A. M. (1944). *Lancet*, *i*, 814.

- BRADLEY, W. H. (1946) .. *Proc. Roy. Soc. Med.*, **39**, 649.
- CHATTERJI, D. N. (1947). Personal communication.
- CLIMENKO, D. R. (1947). *New York State J. Med.*, **47**, 266.
- COOK, C. D., and HOFFBAUER, F. W. (1946). *Jour. Lab. and Clin. Med.*, **31**, 56.
- GREVAL, S. D. S. (1946). *Indian Med. Gaz.*, **81**, 254.
- GREVAL, S. D. S., and CHOWDHURY, A. B. R. (1945). *Ibid.*, **79**, 81.
- Idem (1947). *Ibid.*, **82**, 125.
- MACCALLUM, F. O. (1946). *Proc. Roy. Soc. Med.*, **39**, 655.
- MAGEE, H. E. (1946) .. *Ibid.*, **39**, 657.
- MEMORANDUM BY MEDICAL OFFICERS OF THE MINISTRY OF HEALTH (ENGLAND) (1945). *Lancet*, *ii*, 116.
- SIMON, D. J., and BROWN, D. (1946). *Ibid.*, *i*, 492.
- SNYDER, H. E. (1947) .. *J. Amer. Med. Assoc.*, **133**, 219.
- WIENER, A. S. (1943) .. *Blood Groups and Transfusion*. Charles C. Thomas, Springfield, Illinois. Baltimore, Maryland, p. 135.

THE DANGERS OF EXCLUDED INTESTINAL SEGMENTS

Loops of intestine, by-passed or excluded for one reason or another, are subject to certain acute accidents which, if not remembered and provided for, may vitiate an otherwise satisfactory operation. The naturally excluded loops—the appendix and Meckel's diverticulum—are no exceptions to this rule. The acute accidents common to these loops, natural or artificial, are intussusception and perforation.

Intussusception of the appendix was first reported in 1859 by McKidd, since when about one hundred cases have been reported in the literature. What proportion of the total number observed this figure represents is unknown, but it must be less than half for by far the greater number of members of the profession are distinctly reluctant to publish their interesting cases. Meckel's diverticulum is mentioned as a cause of intussusception many times between the date of its discovery, at the beginning of the nineteenth century, and 1913, when Wellington collected 326 cases of urgent surgical conditions arising in this remnant. Among these were 144 cases of bowel obstruction, 59 of which were due to intussusception of a Meckel's diverticulum.

Experimentally, Nothnagel (1884) produced intussusception by direct faradic stimulation of the intestine. Propping (1910), using rabbits and large doses of physostigmine, was able to cause small invaginations of the gut. All experimental workers using dogs are familiar with the fact that intussusception will occur following severance and inversion of the ends of the upper small intestine unless the precaution is taken of fixing the distal segment to the anterior or posterior wall of the abdomen.

Perforation of the appendix and of Meckel's diverticulum are well known. But the possibility of perforation of an excluded segment seems to be often forgotten. The dangers of leaving such

excluded segments in the abdomen were pointed out by Grey-Turner (1916), when he cited some of his own cases in illustration.

Experimentally, it is easy to produce perforation by excluding the proximal loop instead of the distal one.

In view of these facts it is well worth while remembering at the operation table what a few more minutes and several anchoring sutures will do towards making a final success of a procedure. It is well to consider any operative plan, made hurriedly to meet unforeseen circumstances, in the light of these facts before embarking on a line of action which may lead to the

exclusion of a distal or proximal segment of intestine.

An article in this connection is appearing on p. 203 of this issue.

A. T. A.

REFERENCES

- GREY-TURNER, C. (1916). *Brit. J. Surg.*, **4**, 227.
 MCKIDD, J. (1859) .. *Edinburgh Med. J.*, **4**, 793.
 NOTHNAGEL, H. (1884) .. *Beitr. Physiol. u. Path. Dames*, p. 2.
 PROPPING (1910) .. *Mitt. Grenzgeb. Med. u. Chir.*, **21**, 536.
 WELLINGTON, J. R. (1913). *Surg. Gyn. and Obstet.*, **16**, 74.

Medical News

FORMATION OF WORLD HEALTH ORGANIZATION

(Abstracted from the *Medical Press*, 28th August, 1946, p. 159)

THE Economic and Social Council of the United Nations, by a resolution of 15th February, 1946, convened an International Health Conference to establish an International Health Organization. The International Health Conference met in the City of New York from 19th June to 22nd July, 1946. More than fifty countries sent representatives, and seventeen States were represented by observers. The Conference drew up and signed the Constitution of the World Health Organization, an arrangement for the establishment of an Interim Commission of the World Health Organization, and a Protocol Concerning the *Office International d'Hygiene Publique*. At the same time, steps were taken to transfer to the new Health Organization such health functions as had been formerly carried out by the League of Nations Health Organization.

THE FOURTH INTERNATIONAL CANCER RESEARCH CONGRESS

THE Fourth International Cancer Research Congress will be held in St. Louis, Missouri, U.S.A., during 2nd to 7th September, 1947. The Union Internationale Contre le Cancer having accepted the invitation of the American Association for Cancer Research, the Congress will be held under the joint auspices of these two organizations, with Dr. E. V. Cowdry, Professor of Anatomy, Washington University School of Medicine and Director of Research of the Barnard Free Skin and Cancer Hospital, serving as President of the Congress.

Of the three Congresses that have been held previously, the first was in Madrid, Spain, in 1933; the second in Brussels, Belgium, in 1936; the third in Atlantic City, New Jersey, U.S.A., in 1939. Due to the recent war, there has been no meeting of the Congress during the past eight years.

The State Department in Washington having approved of the International Cancer Research Congress, official invitations soon will be sent to all foreign governments who are to send delegates.

Initial steps in the organization of the Congress have been completed, in that all officers and committees have been appointed and are enthusiastically at work. In addition to the President, Dr. E. V. Cowdry, Dr. J. Godard, President of the Union Internationale Contre le Cancer, and Dr. W. U. Gardner, President of the American Association of Cancer Research, will serve *ex-officio* as members of the Executive Committee.

The following Committee personnel have accepted Chairmanships:—

- A. N. Arneson, St. Louis, Missouri—Local Arrangements.
 S. Bayne-Jones, New Haven, Connecticut—Finance.
 C. W. Larimore, New York, N.Y.—Exhibits.
 L. A. Scheele, Bethesda, Maryland—Governmental Liaison.

M. G. Seelig, St. Louis, Missouri—Publicity.
 Shields Warren, Boston, Massachusetts—Programme.
 Headquarters will be at the Hotel Jefferson, St. Louis, where some three hundred rooms will be available for guests. In addition to these rooms, other nearby St. Louis hotels have signified a willingness to make reservations on advance notification by those contemplating attendance at the Congress.

THIRTEENTH CLINICAL MEETING OF THE CALCUTTA SCHOOL OF TROPICAL MEDICINE HELD ON MONDAY THE 13TH JANUARY, 1947

DR. DHARMENDRA showed three cases of leprosy of the lepromatous type in whom the disease had remained subsided for two to five years. In the beginning the cases had fairly extensive lesions typical of the lepromatous type; at the time of demonstration, however, there were practically no visible signs of the disease. The lesions had gradually subsided and faded, and the smears once strongly positive for leprosy bacilli became less and less strongly positive, and ultimately negative and had remained negative. The cases were presented to illustrate a little-appreciated feature regarding the course of leprosy; it is not often appreciated that the disease, even in the lepromatous type of cases, may show early subsidence, and may not become progressively worse.

Dr. Chettri described a case of typhus which appeared clinically one of scrub typhus but the agglutination test was not of diagnostic titre.

Major A. L. Som demonstrated a case of posterior extra-articular scapulo-humeral arthrodesis with an arrow graft from tibia (Britton's technique). Recent x-ray showed that the graft was living. It was a case of old fracture dislocation of the upper end of right humerus with axillary palsy. Shoulder joint movements were very limited and painful. Now the patient can raise his right upper limb up to 90° abduction, can take food with right hand, and can perform light duties.

Dr. H. Ray demonstrated a case of chronic advanced gout. The patient was a Mohammedan male, aged about 35 years, and was a cultivator by occupation. No history of any alcoholism or overeating of food rich in nucleoproteins was available. Family history irrelevant. The condition started in the left tarsus