occurred in early cases. Howard *et al.*, (1953) considered that it was of some value as an adjunct to surgery in the treatment of Dupuytren's contracture.

Badner *et al.*, (1953) have injected hydrocortisone into the fibrous plaques in the penis in Peyronie's disease and noted improvement in 16 out of 17 patients so treated.

Conclusion

Hydrocortisone injected locally often relieves symptoms in a variety of painful soft tissue lesions. The drug is particularly valuable in the management of tennis elbow, periarthritis of the shoulder and tenosynovitis including De Quervain's disease.

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split only part of the circumference of the aorta and have skirted vital branches, such as the renal arteries.

A low blood pressure on admission to hospital is a bad sign. Except in young patients the blood pressure is extremely likely to have been raised before dissection and a fall to normal levels or below usually means a severe dissection with rupture. Of the 18 patients at the Radcliffe Infirmary, five had low or normal blood pressures and all died. Of the remaining 13, five survived.

If the patient does not die from external rupture of the aneurysm, he is in danger from renal failure. This occurs much more often than dissection of the renal arteries. Mainly because of relative hypotension, renal insufficiency develops and the patient succumbs from uraemia five to ten days after admission. Nearly all patients show some rise of blood urea concentration and proteinuria.

If a patient escapes death from external rupture or renal failure, pain is likely to trouble him severely for the first few days and mildly for longer. His survival will probably be due to the haematoma re-entering the aorta and forming a double vessel but recovery is possible without this by arrest and healing of the dissection. Fever is to be expected and may last one or even two weeks. The temperature may reach 102°F. Nerve or peripheral vascular signs which last for more than a few hours are likely to persist indefinitely but gangrene of an occluded limb does not develop. Of the patients who survive their illness about one-third die from another dissection, one-third from heart failure and the rest from other causes.

Treatment

Absolute rest is essential. Pain must be relieved and this needs morphine in adequate doses, repeated if necessary. Later other drugs may be adequate. The patient will need to stay in bed for six to eight weeks.

If the blood pressure remains high it is reasonable to use hypotensive drugs since the risk of rupture is related to the blood pressure. The patient is usually too ill to take drugs by mouth and the need is urgent so ' ansolysen ' (pentapyrrolidinium bitartrate) should be given subcutaneously, starting with a dose of 2.5 mg. and repeating and increasing the dose as dictated by hourly recordings of the blood pressure. It is important not to precipitate renal failure by over-treatment. If serious renal failure does develop, it is treated by a high calorie, low protein diet and control of fluid and electrolyte balance, but the outlook is very bad.

Anticoagulants, which might be appropriate treatment for cardiac infarction or arterial occlusion, are to be avoided, although they have been given in error without apparent ill-effect.

Surgeons have not been daunted even by a condition as unpromising as dissecting aneurysm. There are two reports of operations in which an opening was made in the media at the tip of the dissection to allow the blood to re-enter the lumen of the aorta (Gurin *et al.*, 1935; Shaw, 1955). Both patients survived the operation and vascular occlusion of the legs was relieved, but they died about a week later from uraemia.

It is too soon to say whether surgery will have any part to play in the management of dissecting aneurysm. One is tempted to say that it will not, but a few years ago one would have said the same about coarctation of the aorta, aortic stenosis or septal defect. The possibility that it may do should sharpen our appetite for precise diagnosis.

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forgotten. Many thousands of animals and birds are kept in unsatisfactory and unhygienic conditions. The usual practice of accommodating pets in the house leaves much to be desired.

During the preparation of this paper the Paediatric Clinics of North America[5a] published a more extensive review of 'Unusual Infections in Childhood' to which practitioners are referred for more detailed accounts of the above diseases and of others common in the United States. There is also a more comprehensive list of references in each section though mainly concerning American literature.

I would like to record my appreciation of the work done by Health Visitors of the City of Salford and their Superintendent, Miss B. Langton, in the short survey of domestic pets described above.

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parts of the colon at widely separated intervals. In both cases a diagnosis of carcinoma was made.

Group 4

True Ileo Colitis

This condition is well described by Brooke but I have never met with one to my knowledge. The disease is said to start as a steatorrhea and then to proceed to the symptoms of an ileo colitis. A follow through meal shows infection of the ileum but this does not follow a regular pattern and the lesions may involve a considerable amount of the small intestine.

Surgical treatment is difficult since it is rarely possible to identify with certainty the upper limit of the infection, even at operation. These patients are very liable to be diagnosed as ulcerative colitis and the end results are likely to be disastrous should an ileostomy be carried out.

Conclusions

1. There are at least four different kinds of chronic infection of the right colon:

(a) Right-sided colitis with a normal ileum.
(b) Right-sided colitis with an infected ileum.
(c) Segmental colitis.
(d) Diffuse ileo colitis.

2. Ileostomy should never be carried out on any of these types of infection.

3. Types (a) and (b) should be treated by a two-stage excision with implantation of the normal ileum into the pelvic colon.

4. Type (c) should be treated by right hemicolectomy.

5. Type (d), if recognized, should be treated by general medical measures.

6. The diagnostic criterion in all these cases is that the pelvic colon and rectum are free from disease when examined by a sigmoidoscope.

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Full particulars from the Clerk to the Trustees, Society of Apothecaries, Black Friars Lane, Queen Victoria Street, London, E.C.4.

Experimental Research into Problems of Ageing. Candidates are invited to submit papers descriptive of work in this field for awards for 1955-56. Five awards of an average value of £300 each are available for the period 1955-56; the announcement of awards will be made in July, 1956. Entries must be received not later than February 10, 1956, and the work submitted should not have been published before July 31, 1955. Papers should not be more than 7,000 words in length and may be in the candidate's own language.

Full particulars are obtainable from the Director, Ciba Foundation, 41 Portland Place, London, W.1.

Health Congress. The Royal Society for the Promotion of Health Congress will take place in Blackpool from April 24 to 27, 1956.

For further information application should be made to the Secretary, The Royal Society of Health, 90 Buckingham Palace Road, London, S.W.1.

British Association of Urological Surgeons, Home and Overseas. The Annual Meeting will be held in Liverpool on June 28, 29 and 30, 1956.

Full particulars from the Honorary Secretary, British Association of Urological Surgeons, Home and Overseas, 46 Lincoln's Inn Fields, London, W.C.2.

Anglo-French Exchange Bursaries. Applications are now invited for the bursaries which will be awarded in 1956 to young British doctors under the exchange scheme arranged by the French Embassy in London between the Institut d'Hygiene in Paris and the Ciba Foundation in London. The value of the French grants is 60,000 fr. a month, tax free, and they will be awarded for periods of two to four months to medical men who wish to obtain clinical experience or carry out research in France. Since the aim of the exchange is to spread in each country knowledge of achievements, outlook and methods on the other side of the Channel, preference will normally go to candidates who are in teaching or in posts where they can pass on the experience they have acquired. The British selection board is composed as follows: Prof. Alexander Haddow, Prof. John McMichael and representatives of the British Council (Dr. Margaret Suttill), the British Postgraduate Medical Federation (Dr. C. F. Hamilton Turner), the Medical Research Council (Dr. F. J. C. Herrald) and Dr. G. E. W. Wolstenholme (Ciba Foundation).

Application forms may be obtained from Dr. Wolstenholme, Ciba Foundation, 41 Portland Place, London, W.1. The closing date for applications is February 4, 1956.