It must not be forgotten that Crown work for many flows from the hands of the coroners in England and from the procurators-fiscal in Scotland, that this work is neither pensionable nor the subject of superannuation, and, finally, that such a flow may be interrupted for many reasons. In this connexion the following passage from a recent medical journal, describing the terminal professional phase of an outstanding British medico-legist, is not irrelevant: "It is a sad commentary on the system under which he worked that when, with increasing years, he began to falter and to fumble and when his magnificent memory began to play him false, he still had to cut up bodies at two guineas a time to earn a modest living."

I believe that we must accept much of the responsibility for the present position in which forensic medicine finds itself and which is undoubtedly due to a variety of factors, lack of adequate representation being one of the most important. Even in the British Medical Association many specialized branches of medicine—for example, pathology—are well represented, and their voices can be clearly heard in matters affecting their interests. But once again we are silent, having no proper sponsor. For long enough a tendency to rivalry and competition within our ranks has exercised a rather distintegrating influence on proper co-ordination and unity, and tolerance of unsatisfactory working conditions, of inadequate remuneration, and of other factors which would not have been accepted for a moment by those practising other branches of medicine have each and all exercised a combined effect. Perhaps there is small desire to change the existing position. Some of us who have worked long under the old regime are unlikely to savour the fruits of any changes. But what of those who are to follow? Do we not owe them a duty to ameliorate things? I rather think so, if we pretend to take any interest at all in this matter.

Lines of Approach

If it is thought, as the result of this outline of a somewhat difficult and possibly controversial subject, that the present situation in forensic medicine is unsatisfactory, then obviously some alternative and better method of organizing the subject must be sought. It is not, of course, possible in the limited space at my disposal to discuss this aspect of the subject in any detail, but I would, before concluding, like to submit one or two very general considerations which are to some extent based on my previous remarks. There seems to me to be two feasible and yet very broad lines of approach. The first is to incorporate the subject of forensic medicine as a specialist branch of the National Health Service, with the various university teaching schools as regional headquarters. The second, but to my mind very much less desirable, is to base a complete medico-legal service for the country on the forensic science laboratories, but with many modifications of the existing service as we now know it.

Whichever of these methods might be adopted, and I have no doubt in my mind which is the more desirable, I am certain that it can be adequately staffed for the purposes of practice in the field, and for teaching and research, only if the terms of service are based on similar lines to those of the National Health Service.

I have submitted for consideration some factors which in my estimate suggest a pointer to how things are going in the realm of forensic medicine. For over 30 years I have observed the teaching and the practice of this subject at close range, and I can only say that prospects seem rather disquieting. This, of course, is merely a personal observation, and the answer to the question, Whither forensic medicine? is one that I must leave open to others.

Leprosy is not uncommon in the Iberian Peninsula, according to a recent W.H.O. publication. In Spain there are 1,708 registered cases, and in Portugal 1,416. Figures given for other European countries are Greece 643, France 250 to 300, United Kingdom 100, Norway 16, Sweden 6, and Federal Republic of Germany 4.

Medical Memoranda

Spontaneous Rupture of the Symphysis Pubis in Normal Labour

As spontaneous rupture of the symphysis pubis in normal delivery is an unusual occurrence, a description of the following case may be of interest.

CASE REPORT

A 2-gravida aged 23 was first seen in the antenatal clinic on July 31, 1947. Her first pregnancy, in 1945, was normal and ended with spontaneous delivery of a healthy male child. There was, however, a history of sciatic pain in her right leg, first noticed during the puerperium, which lasted for several weeks and made walking difficult. Her last menstrual period before the second pregnancy was on May 18, 1947; the estimated date of delivery was February 25, 1948. The antenatal period was normal throughout. There were no pelvic abnormalities. Labour began at 8 a.m. on February 9 and the patient was admitted to the maternity ward at 1.50 p.m.

On admission the uterine contractions were of moderate strength, the membranes were intact, the vertex was presenting in the left occipito-anterior position, and the foetal head was engaging. Labour proceeded normally, the contractions becoming fairly strong. The membranes ruptured at 4.45 p.m., by which time the os was fully dilated. The second stage lasted only 15 minutes, and at 5 p.m. a healthy male child was born, weighing 7 lb. 4 oz. (3.3 kg.). The placenta was born after a further 25 minutes. The total duration of labour was 9 hours 25 minutes: first stage, 8 hours 45 minutes; second stage, 15 minutes; third stage, 25 minutes. The patient felt well and did not complain of any pain or discomfort. Three days later, on February 11, she experienced a sudden and sharp pain in her groins after she had tried to turn in bed. From then onwards any attempt to raise either leg, actively or passively, was accompanied by sharp pains in the groins, as was, in fact, any movement of the lower limbs or pelvis; and the most comfortable attitude for her was lying on her back, with her knees slightly bent and both thighs abducted.

On examination it was found that she experienced pain when the symphysis pubis was merely touched, and a groove about as wide as a normal index-finger could be felt between the two pubic rami. No pain was felt on rotating the femur, nor were there any pains in the region of the sacro-iliac joints, though sharp pain was felt on pressure upon the trochanters. There were no signs of oedema or haematoma, but the temperature began to rise to 100° F. (37.8° C.) during the afternoon. A spontaneous separation of the symphysis pubis was suspected. An x-ray film of the pelvis taken on February 13 revealed a separation of the symphysis pubis, the gap measuring 15 mm. (3/5 in.). The pubic bones were slightly out of alignment. Adhesive strappings, enveloping the pelvis tightly, gave noticeable relief and enabled the patient to change her position from time to time without great pain. The temperature subsided to normal on February 14, and the rest of the puerperium was uneventful. The function of the bladder remained unimpaired.

The patient was kept in bed for a fortnight and was then permitted to get up for light exercise. Weight-bearing was still accompanied by pain, especially in the left groin, but both legs could be freely moved in the recumbent position. After another four days of further progress, she was able to walk a short distance. She had a waddling gait and a slight limp. She was discharged from hospital on February 28 wearing a tightly fitting belt round the pelvis. She was given instructions to avoid exertion.

When last seen on April 7, 1948, her condition was much improved, her gait was normal, and her only complaint was

that she became easily tired after walking. An x-ray film taken the same day showed the gap between the two pubic rami to be distinctly smaller—approximately half its former size. Of special interest was the evidence of an opacity at the upper part of the articular border of the right pubic ramus, which was probably caused by callus formation following an avulsion of bony structure at the time of the rupture of the symphysis or the superior pubic ligament.

COMMENT

The outstanding feature of this case is the sudden and unexpected onset of symptoms three days after a normal and easy delivery. No warning symptoms during or after delivery were noticed; on the contrary, the patient gave the usual assistance when being transferred by trolley from the bed in the delivery room to the bed in the ward, a feat which she would have been unable to perform three days later. The comparatively late manifestation of symptoms, though somewhat puzzling, is apparently not so unusual in cases of spontaneous rupture of the symphysis pubis, and was also found by Reis *et al.* (1932). The most plausible explanation seems to be that the physiological softening of ligaments and symphysis had been excessive during pregnancy. Some damage may have been done to the soft structures of the pelvic girdle, including the symphysis pubis, during the patient's first delivery. Finkbeiner (1948) draws attention to the presence of fissures and small cavities in the fibrocartilage of the symphysis, due to the trauma of successive pregnancies, and points out their weakening effect. The wedge effect of the foetal head, enhanced by the latter's quick descent during the short second stage (15 minutes), probably overstretched the ligaments and symphysis to a point short of rupture, the rupture finally occurring three days later, caused perhaps by a somewhat abrupt movement in bed.

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Acquired Sensitivity to Streptomycin and Sodium P.A.S.

The treatment of tuberculosis with combined sodium *para*-aminosalicylate and streptomycin has been in widespread use for about three years, but I believe that the following is the first reported case in which proved simultaneous sensitization to both these drugs has developed.

CASE REPORT

A man aged 29 was a close contact of an open case of tuberculosis in January, 1950, but his x-ray film at that time was normal. In June considerable infiltration of the left upper lobe was shown, and the sputum contained tubercle bacilli. He was asymptomatic, with no abnormal physical signs and an E.S.R. of 2 mm. in one hour. There was no personal or family history of allergy. On July 7 treatment with sodium P.A.S., 18 g. daily, and streptomycin, 0.5 g. twice daily, was begun. He did not complain of either nausea or vomiting during the fifteen days he was taking P.A.S.

The temperature rose on the evening of July 31 (see Chart), and the patient complained of headache, but there were no abnormal physical signs. During the following afternoon a marked erythema of the face with suffused conjunctivae developed, and the cervical glands on the right side were enlarged. "Anthisan," 0.2 g. three times a day, was started. Next day a dark-red morbilliform rash covered the neck, arms, and thorax; the administration of P.A.S. was stopped. On August 3, although his temperature was still raised, the rash had receded, only the abdomen and legs being affected.

By the following day the rash had completely faded, but there were headache, some neck rigidity, and generalized limb pains.

His general condition had improved on August 6, and the temperature had fallen slightly, but it rose again on the 7th, and a generalized erythematous rash developed. His condition was very poor, and he had lost 14 lb. (6.4 kg.) in a week. During the evening he had severe vomiting. Streptomycin was withheld. P.A.S. was not found in the blood. He felt much better on the 8th, but the rash remained and was very irritating. Early desquamation was noticed over the back. The pyrexia continued. The

temperature finally fell to normal on the 12th, and his condition was much improved. The rash had faded, but there were scattered areas of desquamation. On August 15 the serum bilirubin was 0.6 mg. per 100 ml., the cadmium sulphate reaction was 16 units (normal 2-6), and there was slight improvement in the x-ray film compared with one taken on July 13.

On September 1 skin-testing to 20% sodium P.A.S. was positive after 12 hours. Next day, in view of the evident P.A.S. sensitivity, streptomycin was recommenced. On the 3rd the patient developed pyrexia and a generalized erythematous rash, and the streptomycin was stopped. On September 14, because he was clearly sensitized to streptomycin and because no controls had been used in the P.A.S. patch test, it was thought worth while to give a further dose of P.A.S. This resulted in pyrexia and a morbilliform rash within a few hours. On the 16th the serum bilirubin was 1 mg. per 100 ml. and the cadmium sulphate reaction was 8 units. He had regained all the lost weight by September 18, and was generally in good condition.

Several blood counts were done during the course of the illness. No eosinophilia was found, but there was a very high proportion of degenerate neutrophils.

COMMENT

Drug rashes are quite common in cases treated with streptomycin. Pulaski and De Bakey (1946) found them in 5% of their cases. Febrile reactions occur much less often, particularly when the dosage is 1 g. daily or less.

For some time sodium P.A.S. was thought to be relatively free from side-effects, apart from nausea, vomiting, and diarrhoea. However, Hemming and Stewart (1949) reported drug fever, and shortly afterwards Kierland and Carr (1949), in America, described two cases with fever and rashes. The latter found sensitivity occurring in 2-4% of their cases. Other toxic effects include albuminuria, crystalluria, jaundice, enlarged lymph nodes, and anuria. Cayley (1950) has reported cardiac irregularities and paralysis due to potassium deficiency.

The cause of these manifestations is not entirely clear. The drug fever and rash appear to be allergic. This is shown by eosinophilia, positive patch testing, and the effectiveness of desensitization. Climie (1950) has suggested that the sensitizing agent is probably a derivative of meta-aminophenol. Cuthbert (1950) states that it is still impossible to prove whether the liver dysfunction is secondary to allergic thickening of tissues or is due to a toxic side-effect. Madigan