of the latter cases the patient was a severely dwarfed hunchback, and in the other the patient herself had been born with a spina bifida from which she had survived but which had left a severe pelvic deformity. In both of the latter cases pelvic measurements taken by x-ray pelvimetry were extremely small.

In the case of the shoulder presentations I encountered exactly the same difficulty as Mr. Malpas describes—namely, that it was nearly impossible to bring the babies' legs down the lower-segment incision without tremendous strain on both the foetal trunk and the uterine muscle. In the other two cases I found that the pelvic deformity was such that it was extremely difficult both to elevate the foetal head and at the same time draw it anteriorly into the uterine incision.

In each one of these five cases I found that the solution was to convert the transverse incision in the lower uterine segment into a T-shaped incision. This was carried out simply by incising the lowest part of the upper segment vertically from the middle of the transverse lower-uterine-segment incision. The length of this second incision was in each case about 3 in. (7.5 cm.), but I found that on completing the operation, and with full retraction of the uterus, this 3-in. incision now measured only about 1 in. (2.5 cm.). All that was then required was the insertion of one or two stitches into the vertical incision, followed by closure of the transverse lower-segment incision in the usual manner. It was quite simple to overlap both incisions with the reflection of peritoneum which is raised as a routine in performing lower-segment caesarean section. The resulting convalescence was excellent in all of these patients.—I am, etc.,

London, W.1.

D. G. WILSON CLYNE.

Anaesthesia in Ludwig's Angina

SIR,—Dr. V. Torry Baxter, referring to my letter (Jan. 1, p. 31), has written (Jan. 22, p. 153) an able account of the considerations involved in anaesthetizing cases of this disease in which there is severe obstruction to breathing, but he goes on to state that to induce unconsciousness as a preliminary to surgical intervention in cases of Ludwig's angina is to court disaster. Whilst agreeing with this statement when it is applied to cases with severe respiratory obstruction, I am convinced it is not true of all cases.

By no means all cases of Ludwig's angina are complicated by respiratory obstruction; indeed, most of the cases that come to operation are breathing normally, while some are only obstructed to a minor degree. If Dr. Baxter's statement is true, disaster has for many years been courted with the aid of chloroform and, more recently, cyclopropane, with what can only be described as a very indifferent response. If, however, there is anyone who would wish to see this courtship fairly crowned with success, let him try induction with "pentothal" on a few of these cases. He will not have to wait long before his wish is abundantly fulfilled.

Mr. Eric K. Gardner (Jan. 22, p. 153) raises a point which will be generally agreed. Junior residents should not be expected to undertake this responsibility. If they were aware of the dangers involved they would doubtless more often enlist the help of their seniors. But as long as intravenous anaesthesia continues to be recommended for this operation in the latest surgical textbooks one can hardly blame them for administering it, and can only sympathize with them and the relatives when the results are disastrous.—I am, etc.,

Sutton, Surrey.

JOHN H. WILLIS.

Bronchography without Surface Anaesthesia

SIR,—Anaesthesia for bronchoscopy and gastroscopy is undoubtedly necessary, and it may therefore be essential to use one of the more potent but toxic surface anaesthetics in cases requiring these procedures. However, Mr. C. A. Jackson in his article on amethocaine hydrochloride (Jan. 15, p. 99) and, more especially, Dr. C. Elaine Field in her letter (Feb. 5, p. 236) advocate the use of amethocaine hydrochloride in bronchography.

When bronchography is done by the cricothyroid-membrane route it has been common practice to inject some potentially dangerous surface anaesthetic through the needle into the trachea before the contrast oil is instilled. In an attempt to avoid the use of any member of this group of drugs, I and

others have done many successful bronchographies in adults without the use of any intratracheal surface anaesthesia. Coughing and discomfort are no more than with anaesthesia, which must always be very limited in view of the small bulk of fluid used. Procaine is, of course, used to infiltrate the skin and subcutaneous tissues over the membrane before the introduction of the needle.

I would therefore urge the abandonment of the use of any of the surface anaesthetics in bronchography. Let it be remembered that over a thousand years ago, in the *Guide to Physicians* by Isaac Judaeus, appeared the aphorism, "Treating the sick is like boring holes in pearls, and the physician must act with caution lest he destroy the pearl committed to his charge."—I am, etc.,

Liverpool.

EWAN F. B. CADMAN.

Proguanil and Blackwater Fever

SIR,—In view of the recent letters on proguanil ("paludrine") I thought the following case might be of interest.

A young European was brought to hospital who had been comatose for 18 hours; blackwater fever was diagnosed, but despite treatment he died within 12 hours. This patient had been in the country some 15 months, living most of that time in the bush in a highly malarious district. For the whole period he took one tablet of proguanil every alternate day regularly. He had also been in Egypt for a short period before coming to Uganda. He had never suffered from malaria nor from fever of unknown origin, and he had never taken quinine at any time until this illness.

Before coming to hospital he had received treatment for clinical malaria in his bungalow—quinine bihydrochloride 30 gr. (2 g.) on three successive days. He was admitted to hospital on the fourth day of the disease.

From experience we have found that anything less than one tablet of proguanil a day will not suppress malaria. There have been several cases where the person was taking one tablet on alternate days regularly, yet they developed a typical attack of malaria with a positive blood slide (subtertian). It is presumed that the case reported above was in fact blackwater fever from the onset; if so, was it precipitated perhaps by the fact that proguanil was acting as an insufficient suppressive on the malarial parasites?

I am indebted to the D.M.S., Uganda, for permission to publish this report.

—I am, etc.,

Mbale, Uganda.

A. M. BEST.

Strong Corsets and Pelvic Congestion

SIR,—During the past two years I have observed a group of 32 cases of women who have reported either at my consulting-rooms or the out-patient department with the symptoms of pelvic congestion. These took the form of backache, bouts of urinary frequency, fullness in the rectum, iliac-fossa aching, and general pelvic dragging. All these symptoms might appear together or singly, or in one or other combination.

The ages of these patients ranged from 22 to 42 years. A feature common to them all was that they had obese abdominal walls with very firm fat. Cystoscopy revealed on several occasions that the vessels, especially the veins of the trigone, were obviously more congested than normal (this was during the period of urinary frequency). When iliac-fossa aching appeared to be confined to one side it was more frequently noticeable on the right than the left side.

The second noticeable feature was that the patients' symptoms in this group dated from the acquisition of good, strong surgical corsets. Previous to the use of these strong, well-fitting corsets, which no doubt did mould the patient's figure in an approved fashion, this group had used what they considered loose utility supports. It was noticeable that this firm fat, presumably due to a high carbohydrate diet, had been deposited freely in the abdomen because there was no real pressure on this area to induce it to be deposited elsewhere (shoulders, breasts, thighs). I assumed that these strong corsets were compressing this firm fat against the inferior vena cava and impeding the venous return from the lower limbs, with stagnation in the pelvic veins or right ovarian veins. I asked these patients to either dispense with corsets for a month or wear them loosely. The improvement in the patients' symptoms