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. Torrey 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

was definitely established; by wearing their corsets more loosely applied thereafter these patients very definitely improved or were free of symptoms without further therapy.

There are two other groups of cases which fit into a similar picture but of which I have not had sufficient cases with such definite reference in order to link them with the above. The first group consists of young women with long lower limbs beginning to wear a high-type girdle. These develop backache or right iliac-fossa aching, presumably due to abdominal constriction at the umbilical level. It would seem that by the time the blood from the lower limbs reaches the pelvis the *vis a tergo* is sufficiently low to permit stagnation in the pelvic or ovarian vessels (10 cases). The second group were elderly women who began to develop a progressively worse prolapse, also suggestively dated from the acquisition of strong corsets and abdominal compression (9 cases).

I would advise that corset manufacturers should warn their fitters that where the patient has not been accustomed to strong abdominal support corset fittings should be so applied that the abdominal compression can be increased gradually over a period of months, so as to obviate this syndrome developing.—I am, etc.,

Derby.

LINDSAY O. WATT.

Prescription of Barbiturates

SIR,—I was greatly interested in Dr. Nathan Finn's letter (Jan. 29, p. 195) regarding the prescription of barbiturates, as this problem has occupied my mind for some time. The idea of combining phenobarbitone with an effective emetic in the same tablet presents itself quite obviously, but the solution is not as simple as it appears to be.

From theoretical and practical considerations we have to include the optimum emetic dose (e.g., pulv. ipecac., which is the only drug suitable for the purpose) into the minimum lethal dose of phenobarbitone. The M.L.D. of phenobarbitone is 5–6 gr. (0.32–0.4 g.),¹ and the emetic dose of pulv. ipecac. is 15–20 gr. (1–1.3 g.). This means that every $\frac{1}{2}$ -gr. (32 mg.) tablet of phenobarbitone will contain nearly the maximum expectorant dose of pulv. ipecac. with all its irritant properties—a quite undesirable feature.

Secondly, it is most important to remember that phenobarbitone, being absorbed simultaneously with pulv. ipecac. (probably at an even faster rate), will neutralize the vomiting effect of the latter by virtue of its own sedative properties. In practice the patient will be dead before he is "due" to vomit.

I see the solution of this important problem not in the combination of barbiturates with emetics but in avoiding prescribing these drugs to a phenobarbitone-conscious public and in the choice of other sedatives wherever possible. The open-chain ureides, like carbromal, etc., are fairly safe and generally not much less effective alternatives.—I am, etc.,

London, N.W.2.

H. H. MARGULIES.

REFERENCE

- ¹ Mutch, N., *British Medical Journal*, 1934, 1, 319.

Cogs in a Machine

SIR,—With reference to the "health records" for this country in 1948, I should like to point out that it is absurd for us to congratulate ourselves upon the better health of the nation when arguing only from those figures which relate to physical well-being. There are no statistics available to give an adequate picture of the nation's health over the whole field—in, that is to say, its physical, mental, and psychological condition. Yet the human being is a threefold entity (body, mind, and spirit), each part of whose nature is intimately related to the other.

Most medical practitioners are becoming uncomfortably aware of the increasingly high incidence of psychological and psychosomatic conditions. Not only are positive personality disorders on the increase; very many people are exhibiting symptoms whose ultimate origin is psychological. Even where this is not the case, increasing numbers of people are becoming subject to irritability, disproportionate anxiety, and apparently unreasonable feelings of insecurity, which, while realizing their insufficient foundation, they find they cannot control.

To no small degree the reason is to be found in our machine civilization, which turns the individual into a cog in the industrial or military machine. This procrustean bed, to which each one of us in our proud individuality has to be

lopped, is proving very uneasy. The natural revenge is an increasing number of cases of derangement of the nervous system.

In this country, even to-day, there is a tendency to confuse the treatment of the disordered psyche with the treatment of the disordered brain. For the sake of the millions to whom the pressures of modern life have brought abnormal stress this attitude should be modified. The effects of machine civilization should be investigated and the conditions of life and work adjusted to human needs. This is all the more necessary because in the field of physical health our average of attainment is rising. Personality disorders and psychic conflicts are handed down from one generation to the next, not according to laws of heredity as in the physical sense, but according to laws of stress and reaction—maladjusted parents producing maladjusted children.

There is in English public life an extraordinary tendency to close the eyes to the fact that human health and human happiness cannot be attained by concentrating only upon one aspect of the human being. Although more sensible diet and more advanced discoveries in the realm of therapeutics have helped to improve our general level of physical health, that still gives us only one part of the picture. Moreover, if the mental and psychological well-being of the people is overlooked, it cannot be long before their physical health suffers too.—I am, etc.,

London, W.1.

EUSTACE CRESSER.

Malignant Tumour of the Small Intestine

SIR,—While awaiting a proof of the report on jejunal carcinoma (Feb. 12, p. 283) I wanted to add a few rather vital words to one sentence. Where it says in the penultimate paragraph "ulcer of finger-tip size in the lower curve of the stomach," please add, "No abnormality was noted in the jejunum."—I am, etc.,

Bristol.

A. WILFRID ADAMS.

POINTS FROM LETTERS

Dental Caries

Dr. WILLIAM WALLACE (Glasgow) writes: A novel but neglected solution of the dental caries problem may be referred to in the *Transactions of the Royal Medico-chirurgical Society of Glasgow* (1933, 27, 217). I might now allude to the study of the comparative rate of the incidence of dental caries in the teeth of three groups of five-year-old children by Lady Mellanby and her colleagues (May 31, 1947, p. 751); they admit that they have failed to discover the direct or immediate excitant of this disease and also that there is "an anomalous" freedom from caries in teeth of defective structure in institutional children. They now wish to know why and how this is so, and state: "If there are secrets yet to be discovered which can explain these results, as there almost certainly are, every effort should be made to reveal them." This disease is virtually pandemic. It is what may be called a primitive one—i.e., one due to the absence of something the teeth cannot do without (namely, daily use) lest they contract a microbic rust—when from nausea or loss of appetite mastication becomes interrupted for a day or more, during which time the ameloclast seizes the opportunity of affixing itself in an interstice between two teeth or a fissure in a premolar or molar. Anticipation of decay in the second molars is the key to the prevention of dental caries.

The Crisis in Lobar Pneumonia

Dr. L. R. HOLT (Stamford, Lincs) writes: The history of the following case of lobar pneumonia, which had no treatment with the "sulpha" drugs, seems to be worthy of record. I was recently called out to an ex-R.A.F. camp near here, which is now occupied by "squatters," to see a girl aged 6½ years about whom the mother gave the following story. Eight days prior to my visit the little girl had been seized with sudden pain in the left chest, accompanied by high fever, dry cough, and vomiting. As it was a Sunday and the parents did not wish to disturb the doctor on the Sabbath (how rare in these days of the new N.H.S.) they deferred until the next day. But she seemed a little better on the Monday, and so they hung on, day after day, until on the evening of the seventh day the child became delirious, sweated profusely, and was apparently exhausted. I was summoned for the first time on the following morning, and on examining the child found signs of consolidation of the lower lobe of the left lung consistent with lobar pneumonia: the temperature was 98.6° F. (37° C.), respiratory rate 40, and the pulse rate 120. Employing conservative measures, she made an uninterrupted recovery. How many of the younger generation of doctors have witnessed the "crisis" of lobar pneumonia, which this girl undoubtedly exhibited on the evening prior to my first visit? It must be a rare clinical experience in these days of penicillin and the "sulpha" drugs.