interval of quiescence leading up to the final and fatal haemorrhage in the substance of the cerebellum containing the haemangioblastoma.

We wish to thank Mr. Melbourne Thomas for permission to publish this case; and we are indebted to Dr. D. C. Taylor and Professor J. Gough for the post-mortem examination and the histological report.

P. T. BRAY, M.B., M.R.C.P., D.C.H., B.Sc.,
Assistant Paediatrician.

W. DAVIES, M.R.C.S., L.R.C.P., D.C.H.,
Resident Medical Officer.
East Glamorgan County Hospital.

Case of Rupture of Left Lower-Lobe Bronchus with Recovery

Traumatic rupture of the bronchus is a rare condition, and is seldom diagnosed. Many of the cases are fatal, as they are associated with severe crushing injuries of the chest. Kinsella and Johnstrud (1947) reported 38 cases. In the following case the rupture occurred without any fracture of the ribs, though presumably the chest must have been compressed, possibly by the motor-cycle falling on it.

CASE HISTORY

A man aged 24 met with a motor-cycle accident in December, 1946, and sustained concussion, multiple abrasions, and a fracture of the right humerus. He was admitted to the City General Hospital, Sheffield, where he recovered fairly quickly; he was discharged towards the end of January. In February, 1947, he became ill, left lower-lobe pulmonary pneumonia being diagnosed, and was re-admitted to hospital. He recovered on sulphonamide therapy, and was discharged. One year later he again became ill, beginning with a rigor and pain in the lower part of the left side of his chest. This lasted a few days, after which he got up and went about but did not feel very well. He had aches in various parts of his body, felt feverish, and had a fairly severe headache most of the time.

He was sent to the Royal Infirmary, Sheffield, as a case of pneumonia. He once more settled down, and his temperature became normal; an x-ray film, however, revealed a collapse of the left lower lobe. I was asked to see him, and after bronchoscopy and bronchography at the City General Hospital I diagnosed a probable

rupture of the left lower-lobe bronchus. The bronchogram showed failure of the left lower lobe to fill, and the bronchoscopy failed to disclose any evidence of entry to the lower lobe. The upper-lobe bronchus was rotated downwards, and the bronchoscope could be introduced into it quite easily. Lobectomy was advised and was carried out at the City General Hospital.

At operation it was found that the left lower-lobe bronchus had been torn partly across, and had only fibrous tissue on one wall, but there was some cartilage still in continuity with the main left bronchus. There was no passage between the lower lobe and the main bronchus, and it was therefore not necessary to suture the bronchus. The man made an uninterrupted recovery and was discharged a fortnight after operation.

The left lower lobe was completely bronchiectatic and the bronchi were filled with an albumin-like substance, apparently inspissated

mucus. It coagulated with formalin. Pus was not found in any of the bronchi, and the infection seemed to have died down.

The accompanying illustration shows the appearance of the specimen.

I am indebted to my chief assistant, Miss Slessor, for performing the bronchoscopy and for the bronchogram.

A. W. FAWCETT, F.R.C.S.

REFERENCE

Kinsella, T. J., and Johnstrud, L. W. (1947) *J. thorac. Surg.*, **16**, 571.

A Case of Spontaneous Rupture of the Uterus

In view of the comparative rarity of this condition the following case seems worthy of record.

CASE REPORT

A married woman was admitted at term at 2.45 a.m. She had been delivered fifteen months previously, with forceps, of a living child of 8 lb. 4 oz. (3.74 kg.). Post-natal examinations made on two occasions by a member of the consultant staff revealed no injury to the cervix or the vagina. Apart from retention of urine and a slight rise of temperature, the puerperium was uneventful.

The present pregnancy had been normal. Labour had begun at 12.45 a.m. with a show and contractions which were one in three minutes on admission. On examination the presentation was L.O.A. with the head in mid-cavity. The membranes ruptured at 3.15 a.m. and the cervix was fully dilated at 3.45 a.m. At 4.50 the head was visible but was progressing very slowly, and the foetal heart became weak and irregular. Five minutes later a particularly strong contraction was felt, after which no further contractions were observed. The patient complained of a dull ache in the abdomen, but her pulse and colour remained normal. On examination the abdomen was slightly tender and a group of limbs were felt very easily at the umbilicus, but the uterus appeared of uniform thickness above and below this point. The foetal heart was inaudible.

The history suggested a ruptured uterus, but in view of the absence of shock or haemorrhage it was decided that the foetus should be delivered. Pitocin was given immediately before. Under anaesthesia, the head was found in an anterior position with little caput or moulding and a foetus was delivered without difficulty, although the sub-pubic angle was rather narrow. It was stillborn and weighed 7 lb. 15 oz. (3.6 kg.). The cord was traced up the vagina into the peritoneal cavity through a tear in the lower segment and cervix. The uterus lay above and was well contracted. There was little haemorrhage and the patient's general condition was satisfactory.

At laparotomy a vertical tear was found in the lower segment, extending through the cervix into the anterior vaginal wall about 4½ in. (11.25 cm.). This was repaired in two layers. The patient became very shocked at the end of the operation, and an intravenous transfusion of 2 pints (1.14 litres) of Group O blood was given. After a prophylactic course of sulphadiazine and penicillin an uninterrupted recovery followed.

On discharge, on the nineteenth day, the vagina and cervix were healing satisfactorily. Two months after delivery the anterior vaginal wall was almost healed and the cervix completely healed.

COMMENT

This case is one of spontaneous rupture of the uterus in the course of a rapid labour with strong contractions. Rupture occurred when the head was still descending, though more slowly than earlier in the second stage. There was no evidence of disproportion, since the head was well flexed in an occipito-anterior position with little caput or moulding, the foetus being also smaller than the first baby. No sign of weakness or injury of the birth canal was found after the first confinement. The lower segment was not unduly thinned at laparotomy. The only apparent explanation would appear to be that the magnitude of the contractions caused the tension in the uterus to rise at such a rate that it ruptured before the tension could be released by downward movement and delivery of the head.

The case is also remarkable for the lack of constitutional disturbance associated with a tear 4½ in. long involving the lower segment, cervix, and anterior vaginal wall, there being no clinical evidence of shock till the close of the laparotomy nearly four hours after the time of rupture. The tear was situated almost in the midline, thereby avoiding the larger vessels, which may offer at least some partial explanation of these facts.

I wish to thank Mr. A. R. Lister for performing the laparotomy, for advice on the conduct of the case, and for criticisms of this report.

G. B. CHAMBERLAIN, M.B., B.S., D.R.C.O.G.,
Resident Medical Officer, York Maternity Hospital.