The abdomen was opened by a median incision. The incision of the peritoneum also opened the child's sac, and at once rather foul-smelling yellowish fluid escaped and the child's foot presented. The child was lying transversely; it was alive. The placenta was thin and friable and its edges difficult to define. As much as possible was removed. There was surprisingly little haemorrhage. On exploring the abdomen it was found that the uterus, enlarged to the size of a three-months pregnancy, was lying towards the left iliac fossa and that the tube and ovary of the left side were normal. The right tube and ovary could not be found. The child had been lying in a thin-walled sac, apparently of peritoneum, whose attachments were to the right side of the pelvis and right iliac fossa. The placental connexions were entirely within this sac. There were no adhesions at all to bowel, but a few tags of membranous exudate were on the abdominal surface of the sac. There was no connexion between the uterus and the sac, the thinnest part of which was excised and the gap sutured. The abdomen was closed without drainage. At the end of the operation a large dilator was passed through the cervix, and on the day after the operation there was very slight blood-staining of a vulval pad, but no other discharge at any time before or after operation.

The child had no obvious abnormalities; it cried well and took fluids the first day, but died on the second day. No post-mortem examination was possible.

A report (for which I am indebted to the Pathology Department of Witwatersrand University of Johannesburg) states: "The section showed no sign of tubal tissue. There was a large amount of blood clot and chorionic villi pregnancy. From the sections it is difficult to determine whether pregnancy was tubal or intraligamentous." On questioning the woman afterwards I tried to find if there had been any symptoms of tubal pregnancy in the early months, but could get no clear history from her. She made a good recovery and the wound healed well in spite of her being found sitting on a bed-pan on the floor on her first post-operative day and having an epileptic fit on the third day.

The probability in this case is that there had been a tubal pregnancy followed by intraligamentous rupture of the tube with the survival of the membranes, as the sac appeared to consist of broad ligament and there were no placental adhesions to bowel. Unusual features of the case are that the child was alive after three days' "spurious labour" and that there was no "decidual cast" or other discharge from the uterus.—I am, etc.,

Blantyre, Nyasaland.

R. GWEN DABB.

Trilene in Labour

SIR,—Trilene has been recommended as a suitable anaesthetic for women in labour. No one will deny that it can be dangerous, and there is evidence that it delays coagulation time, affects the conduction in the heart, and may damage the nervous system and liver. When it is used as an analgesic in normal labour the risk is probably small, but until a sufficiently large series of cases has been observed and recorded its safety should not be taken for granted.

As an anaesthetic for instrumental delivery it is doubtful if it has any advantages over other available means, and it appears to be definitely dangerous for caesarean section. It was used in 82 cases in a continuous series of 272 caesarean sections during 3 years and 9 months to September, 1946. Five of the mothers who received trilene collapsed and died within 6 days of the operation. Neither the clinical condition of the patient nor post-mortem examination revealed any cause for the death. Only one death occurred among the 190 cases not receiving trilene. In the absence of further evidence trilene should never be employed for caesarean section.—I am, etc.,

Isleworth, Mddx.

D. M. STERN.

Rubella and Pregnancy

SIR,—I venture to send you a personal experience on this subject and apropos of your leading article (p. 778, Nov. 23, 1946). I have a little grand-daughter aged 6 years who is a deaf-mute. Her mother (my daughter-in-law) had German measles in the third month of her pregnancy.

An excellent little school was found at Cuckfield, in Sussex, in which there are 15 deaf-mute children—all the same age and all apparently victims of an epidemic of German measles which occurred in 1940. In 13 out of the 15 children there is a defi-

nite history of the mother having had German measles in the early months of the pregnancy.

This is strong evidence on the question of aetiology. The occurrence of deaf-mutism is such a domestic catastrophe and permanent sorrow that I advocate inducing abortion, as I understand is being done in Australia. But I am in my ninety-second year and unable to take active steps in any cause; I therefore hope that you can.—I am, etc.,

Lancing, Sussex.

ROBERT SANDERSON.

Surgical Aspects of Roundworm Disease

SIR,—The interesting article on "Surgical Aspects of Roundworm Disease" by Capt. F. Barber (Jan. 11, p. 49) prompts me to make a few comments. In West China we have also been impressed by the great variety of symptoms produced by roundworm infestation. I have no clinical records of these cases with me and so can only write from memory.

A Chinese girl of about 16 had attacks of very severe abdominal colic; a tentative diagnosis was made of intestinal volvulus and strangulation—we had seen a case recently that proved to be that at operation. At laparotomy of this girl the small intestine was found to be a mass of knotted worms. The abdomen was closed; the patient was treated with anthelmintics and made an uninterupted recovery.

Another case was a European boy of about 4. He was not well for 1-2 days; ova of the roundworm were found in the faeces, and he was treated with santonin. Next day the condition did not improve but developed into a more typical case of appendicitis with local signs. At operation the appendix was removed; it was definitely inflamed and there was a roundworm occupying the whole length of the lumen. The sequence of events in this second case is very much open to discussion. Was it appendicitis in the first place? Or did the santonin cause the worm to take refuge in the appendix and secondarily set up inflammation in that organ?

I would like to add a few comments on treatment. In the type of case illustrated by the first case above and Capt. Barber's Case 1, I wonder why he recommends removal of the worms surgically. Capt. Barber says: "Medical anthelmintic measures are not advisable for at least two weeks after incision and suture of the gut . . ." This seems to me a contraindication to taking the unnecessary risk of opening the gut. Most of these cases are children who have a general anaesthetic which itself is an anthelmintic, and some worms are subsequently passed and vomited; when the gut has not been opened ordinary anthelmintic measures can be instituted 2-3 days after operation. At laparotomy for other conditions I have not infrequently seen knots of worms in the intestines but have never removed them surgically.

In the type of case illustrated by Capt. Barber's Case 2 I would favour laparotomy if there is serious question of appendicitis; the danger of delay and purgatives, especially in children, is a real one. I can remember three Chinese children whom I lost with perforated appendicitis, one of whom had orthodox Western treatment for worms the day before I saw it, and the other two had had a few days' treatment with Chinese medicine, which was probably herbal anthelmintics and purges. I should add that these three certainly had worms—I found them loose in the abdomen.—I am, etc.,

Alderley Edge, Cheshire.

F. CHRISTOPHER MADDOX.

Osteomyelitis of the Spine

SIR,—Articles have recently appeared in the *Journal* by Mr. Harry Freeman (Oct. 26, 1946, p. 610) and Mr. Peter Martin (Nov. 9, 1946, p. 688) dealing with pyogenic osteomyelitis of the spine. May I be permitted to draw attention to a case which I described in detail in 1935 (*J. Bone Jt. Surg.*, 1935, 17, 468) as having some interest in connexion with this condition?

A female patient aged 20 was admitted to the Royal Sea Bathing Hospital for "surgical" tuberculosis on Aug. 22, 1932, with a chronic osteomyelitis of the lower third of the right femur. While awaiting an operation for saucerization and skin grafting of the diseased area in the femur (after the method devised by Dr. Basil Armstrong, medical superintendent of the hospital), she developed a spastic paraplegia which was complete—with involuntary spastic muscle contractions occurring in flexion, complete loss of sensory perception up to the fifth rib, and loss of control over micturition—by October, 1932. X ray of the spine revealed no abnormality.