Retrodisplaced Gravid Uterus

SIR,—Through your columns I should be grateful for the opportunity of making some observations on the letters referring to my paper (Feb. 1, p. 169) written by my two friends, Dr. M. Hamilton (March 15, p. 350) and Dr. J. A. Chalmers (March 22, p. 392).

Polak's figures quoted by me and those obtained at U.C.H. show that sterility and retrodisplacement of the uterus are associated. This point was made in my opening paragraph and has been kindly enlarged upon by Dr. Hamilton in his letter. What is not certain, however, is that the displacement in itself is the cause of the sterility. It is possible that there are other factors associated with the retrodisplacement which are responsible for the sterility and which are at present imperfectly understood. It is because of this that I have suggested that correction of the displacement in such cases should be left as the last method of treatment after all other treatments have failed.

I stated "that the incidence of abortion in patients with retrodisplaced gravid uteri is at least no higher than that for all pregnancies." The importance of the displacement as a cause of abortion has been overemphasized and is only likely to be a factor when it causes incarceration. These deductions were made on the figures obtained at U.C.H. and on those of Danforth and Galloway quoted by me. Dr. Hamilton, in his more logical manner, prefers to state that my figures "do not disprove the hypothesis that retrodisplacement (without incarceration) does not significantly predispose towards abortion." If the incidence of abortion (without incarceration) is not influenced by the position of the uterus then correction of the displacement is necessary only to avoid incarceration. I believe this applies to the primigravida and to the multipara, who may have had a previous abortion from a displaced uterus. Dr. Chalmers disagrees with me on this last point and attempts to show that two of the three cases quoted by me prove his point.

From the history of patient No. 39, Dr. Chalmers makes the deduction that the ventrosuspension operation was unsuccessful and that the first two unsuccessful pregnancies occurred in a retrodisplaced uterus. Is this not putting the cart before the horse? The ventrosuspension operation was carried out at a reputable London teaching hospital (not U.C.H.), and I am sure they would be as indignant at Dr. Chalmers's "reasonable" deduction as he would be in similar circumstances. In any event, supposing the operation was unsuccessful, does not the case show that conservative treatment is possible and that continuity of the abdominal wall can be maintained? I would prefer to regard this patient as an habitual aborter, with the uterus accommodating the pregnancy for a longer period on each successive occasion.

In case 42 abortion occurred 11 weeks after anteversion had been attained (not 9 weeks as stated by Dr. Chalmers). If circulatory factors dependent on the position of the uterus were the cause of the abortion as suggested, would the latent period be so long and would not abortion be much commoner than it is with incarceration when such factors are more likely to be active? Dr. Chalmers has misread me when he says that I point out that circulatory abnormalities may interfere with the imbedding of the ovum in a retrodisplaced uterus. I only quoted Barnett's observation on the subject. Indeed, Barnett says that abortion due to such factors usually occurs at 2½ months, not 23 weeks. Personally I prefer to regard and treat such patients as cases of habitual abortion, and I admit that I do not know the cause of the abortion in the majority of such cases.—I am, etc.,

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H. H. FOURACRE BARNS.

Marrow Biopsy

SIR,—Prof. D. F. Cappell, Dr. H. E. Hutchison, and Dr. G. Harvey Smith (March 29, p. 403) call attention to the value of examination of specimens obtained from marrow by paraffin sections in addition to the usual smears. But their advocacy of a rather complicated and inevitably messy method of fixing the "mush" from the sternal puncture needle is surely out of date.

The Turkel trephine is little larger than the Salah needle, and it permits of the obtaining of a "sausage" of marrow as well as of the usual juice for making films. Essentially, it consists of an outer needle (with stylet), and a narrower inner one with a serrated end. The outer needle (with stylet in place) is pushed in until its tip sticks in the anterior lamella of the sternum. The stylet is then withdrawn and replaced by the inner (trephine-ended) needle (also with stylet in place). When the end of the inner needle is in contact with the bone, the stylet is withdrawn, and the inner needle is turned to and fro while slight pressure is exerted, until a sudden cessation of resistance indicates that the medullary cavity has been entered; then a few more half-turns will fill the end of the inner needle with marrow. Next, leaving the inner (trephine) needle in position, the outer needle is pushed onwards in the marrow cavity. The inner needle is withdrawn and its contents expelled into fixative. A syringe is attached to the outer needle and marrow juice obtained by suction.

In this way marrow tissue is obtained while films are not diluted by aspiration of as much marrow as Cappell, Hutchison, and Smith find necessary. In fact there is "at last the answer to the haematologist's prayer for a means of combining the advantages of sternal trephining with those of sternal puncture" (annotation, p. 419).—I am, etc.,

London, W.1.

A. PINEY.

Intrathecal Penicillin in Cerebrospinal Fever

SIR,—In his article on "Medical Aspects of Penicillin Treatment" (March 8, p. 290) Dr. B. A. Young expresses a doubt as to the necessity for intrathecal penicillin in meningococcal meningitis and also a desire to know the practice of fever hospitals.

Speaking for the Park Hospital, I can say that the results obtained for many years with sulphonamides alone, especially sulphathiazole and sulphadiazine, have been so good that we consider intrathecal penicillin as an unnecessary complication in the routine treatment of these cases. Those who have had experience in the treatment of cerebrospinal fever in the past with meningococcal antitoxin have not forgotten the condition of patients receiving daily intrathecal injections of antitoxic serum, neither have they forgotten that often better results were obtained with intravenous administration alone. When they see the ease with which sulphonamide-treated patients now recover, they cannot help but view all return to unessential intrathecal medication as a retrograde step.

Moreover it is not sufficiently realized that the majority of the deaths from cerebrospinal fever at the present time occur in fulminant septicaemic cases, with or without adrenal haemorrhage and often with little or no evidence of suppurative meningitis. Intrathecal penicillin cannot help these patients. Intensive sulphathiazole treatment, combined with systemic penicillin for 24 hours, can save them. It is indeed a curious fact that since penicillin has become generally available the case mortality for cerebrospinal fever should have gone up. One can read in the introduction to the *Medical Annual* for 1946: "The limitations of penicillin are being recognized, but it is surprising to find that sulphonamides may be superior to penicillin in the treatment of meningococcal meningitis."

It has become the practice apparently in many hospitals to administer penicillin intrathecally at the first lumbar puncture to all patients suffering from a purulent meningitis, whether primary or secondary, and before a bacteriological examination. As at least 80% of all cases of primary suppurative meningitis are due to the meningococcus, this means that a large number of cases of cerebrospinal fever are receiving unnecessary intrathecal penicillin. This would not matter much if the injection was without danger. But even the purest penicillin, given with all precautions intrathecally, is often followed in infants and children by various reactions—twitchings, convulsions, apnoea, vomiting, and collapse. In very ill cases with concomitant septicaemia it is easy to understand that the reaction may turn the scales against the patient.

During the years 1944, 1945, and 1946 136 cases of cerebrospinal fever have been treated at the Park Hospital, and the case mortality for all ages, all degrees of severity, late and moribund cases included, has been 8.8%.

The value of intrathecal penicillin in suppurative meningitis, secondary to otitis media, infected sinuses, cranial injuries, etc.,