game of bridge while talking or thinking about something quite foreign to cards. The above ability or the lack of it has a great bearing on the making of a good or a bad driver.

Driving is so easy in a well-found car that it is no longer, in most circumstances, a whole-time job. One must perforce think of more than the driving, and it is here that the trouble arises. If one can only do one thing at a time, then when one's mind wanders, which it inevitably will sooner or later, then the driving suffers, and one becomes a potential danger. Many drivers will most of the time unconsciously react correctly to road stimuli, but this unconscious or subconscious reaction is not to be trusted, it is too vulnerable to variations of physical health, alcohol, and other factors.

When one considers such slogans as "Keep your eye on the ball" and "Don't speak to the man at the wheel," it may sound heretical to suggest that in order to be a tolerably safe driver it is necessary to keep only part of one's conscious mind on the business of driving, and to expect more from all drivers at all times is being unreasonable. But I myself would certainly feel safer being driven by a garrulous, agile-minded driver than by one who religiously kept his mind glued to the road, for in the latter case there would be the thought of what might happen when he became unstuck.

It would be both unpractical and undesirable to submit every applicant for a driving licence to a psychological examination; matters are quite complicated enough as it is; but this much could be done without any additional irritation. The car in which the victim is to have his test should be fitted with a wireless set, which the examiner should switch on when the test was under way. Then if subsequently there was any doubt in assessing the driver's capability—that is, if he were a borderline case—he should be asked what he had heard over the wireless while driving, and his ability to answer would sway the decision either for or against. A just-good-enough driver who answered that he was sure he hadn't a notion, he'd kept his mind on his driving, would fail, whereas a similar driver who could give some account of the programme would pass.—I am, etc.,

Thame, Oxon.

E. GRANGER.

Heparin for Coronary Thrombosis

SIR,—Prof. Lambert Rogers in an article entitled "Advances in Surgery" (*Practitioner*, 1947, 159, 247) cites a remarkable case of pulmonary thrombosis in *extremis* cured or relieved by an injection of 600 mg. of heparin. I suggest that here we have a drug that will prove of inestimable value for promptly treating cases of coronary thrombosis, and that it will save the life of many valuable patients, especially among doctors. It will prevent those most serious ravages to the heart muscle, and give time to treat the underlying arteriosclerosis with a suitable regimen and the use of iodides, etc., for many months. I suggest it should be given after the shock of the attack is treated with morphine, etc.—I am, etc.,

Glasgow.

JOHN T. MACLACHLAN.

* * The use of dicoumarol in coronary thrombosis was discussed in an annotation on Oct. 25 (p. 662).—ED., *B.M.J.*

Treatment of Neurosyphilis

SIR,—I was surprised to find no mention of the well-known pentavalent arsenical called "stovarsol" in either of the two articles on the treatment of neurosyphilis in the *Journal* of Oct. 11. The drug is less toxic to the optic nerve than tryparsamide and has a spirochaeticidal action when given by mouth. On the other hand it may cause rashes and gastro-intestinal disturbances. The alimentary symptoms can be avoided by using bismuth-stovarsol ("bistovol"), which has an additional advantage because some of the bismuth is absorbed.

I have used bistovol by mouth in about 170 unselected cases of G.P.I. prior to malarial treatment and have observed clinical and serological improvement very similar to that noted in the same hospital with penicillin. Moreover, the recovery rate for this series of consecutive admissions was 26% compared with only 10% recovery rate for 200 consecutive admissions treated with tryparsamide and malaria. The details of these results have already been published in the *British Journal of Venereal Diseases*, 1945, 21, 174.—I am, etc.,

Lancaster.

R. PAKENHAM-WALSH.

Pulmonary Haemosiderosis in Mitral Stenosis

SIR,—Dr. Muriel O'Doherty's letter (Oct. 11, p. 587) flatly and frankly disagrees with the pathological interpretations given by Dr. T. E. Gumpert in his interesting article (Sept. 27, p. 488). The correlation of the skiagraphic picture with the morbid anatomy is, as we have already shown (Scott, L. D. W. Scott Park, S. D., and Lendrum, A. C., *Brit. J. Radiol.*, 1947, 20, 100), a difficult enough matter, depending as it does on a correct reading of the morbid anatomy. The detailed histological study of our material (to be reported) does not support Dr. O'Doherty's view that the haemosiderin-laden phagocytes transfer the iron out of the alveoli and lead to hyalinized fibrous nodules in the intralobular stroma.

The striking fact about these cases is the persistence in the alveoli of the siderophores. In the immediately adjoining stromal tissues there is frequently seen iron incrustation of the elastica and the capillary walls, but no obvious haemosiderin, free or in cells, and it would appear as if a high local concentration of soluble iron must occur around the siderophore-filled alveoli. I presume that the fibrous change thereafter occurring in these parts comes to obstruct the lymphatic pathways and so actually prevents escape of the siderophores from the crammed alveoli.

The facts remain that a mitral stenotic showing the obvious skiagraphic picture of haemosiderosis may have an unchanged skiagraph over many months; that microscopically the fibrosis is seen only in the tissues immediately adjacent to the group of filled alveoli; and that despite the presence of many such groups of haemosiderin-containing alveoli there may be scarcely any recognizable iron in the lymphatics or lymph nodes.—I am, etc.,

Dundee.

A. C. LENDRUM.

Retained Placenta

SIR,—It may interest Dr. Walter Calvert (Oct. 11, p. 589) to know that the method he calls "continuous light cord traction" was used by no less ancient a practitioner than the Father of Medicine himself. A description of the method is given in Smellie's *Midwifery*, the introduction to which, Dr. Smellie says, "contains a summary account of the practice of midwifery, both among the ancients and moderns . . . for the information of those who have not had time or opportunity to peruse the books from which it is collected. . . ." Of Hippocrates he says that he "no doubt availed himself of the observations of those who went before him in the exercise of the same profession." On page 13 of my own copy (edition unknown) comes the following paragraph:

"In the book *de superfoetatione*, after having described the methods of delivering a dead child, he [Hippocrates] says, if the secundines come not away easily, the child must be left hanging to them, and the woman seated on an high stool, that the *foetus* by its weight may pull them along; and lest this should be too suddenly effected, the child may be laid on wool newly plucked, or on two bladders filled with water, and covered with wool, which being pricked, as the water evacuates, they will subside, and the child sinking gradually, will gently draw the secundines away: but should the navel-string happen to be broke, proper weights must be tied to it, in order to answer the same purpose; these being the easiest and least hurtful methods of extracting the *Placenta*."

What a wealth of ancient knowledge and eighteenth-century scholarship is revealed in the introduction to this delightful book!—I am, etc.,

Peaslake, Surrey.

G. I. WATSON.

Bilateral Abdominal Testes with Teratomatous Change and Torsion

SIR,—I was interested to read the reports of Drs. A. H. Bennett and W. G. Shaw (Feb. 15, p. 256) and Dr. E. C. Chitty (March 15, p. 356), who respectively report cases of seminoma and sarcoma in intra-abdominal testes associated with torsion. It seems to me perhaps that it might be of interest to report a case of bilateral intra-abdominal testes with teratomatous change and torsion of the right testicle.

CASE REPORT

At 2 a.m. on Feb. 14, 1947, a Mohammedan missionary aged 34 was admitted to the West London Hospital with a diagnosis of renal colic. He was seen by the house-surgeon, who did not consider his condition warranted a second opinion. On the 15th his