proved a most valuable addition to the obstetrician's armamentarium.

In many cases the method resulted in speedy dilatation of the cervix to permit earlier delivery of the patient than might have otherwise been expected. Patients showing no response whatever to the treatment were selected for lower segment caesarean section, which was performed on patients who were refreshed by a respite from labour pains. It was deduced from the results obtained that caudal analgesia should be tried when caesarean section might otherwise be seriously regarded as the only satisfactory solution to prolonged and non-progressive labour. By its use many patients will be spared abdominal operation, but, on the other hand, if by failure of response caesarean section is subsequently thought to be necessary, its successful outcome will not have been prejudiced by the previous management.

There were no serious untoward sequelae attributable to caudal analgesia, and this series concludes a pilot study before a more careful statistical investigation is undertaken into the value of the method described in the management of labour exceeding 48 hours.

Summary

The results obtained by employing continuous caudal analgesia as a therapeutic measure in the management of 74 cases of uterine inertia and cervical dystocia, or a combination of these two conditions, are described.

Sixty-four patients were successfully delivered vaginally, with two neonatal deaths, after a period of analgesia lasting from four to fourteen hours.

Ten patients showed no further progress whatever after six hours of caudal analgesia, and were delivered by a lower segment caesarean section.

Continuous caudal analgesia accelerated the progress of labour in a high proportion of cases, and considerably diminished the foetal hazards of this perplexing obstetric problem.

My thanks are due to the nursing staff for preparing the apparatus and managing the patients, and to those obstetricians who have given caudal analgesia a fair chance to see what it can achieve. I am also indebted to Mr. Linton Snaith for his permission to publish the clinical data, and to Professor Harvey Evers and Mr. Hugh Arthur for much helpful criticism and advice in the preparation of this report.

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Medical Memorandum

Supernumerary Pectineus Bursa Causing Femoral Vein Compression

Supernumerary pectineus bursa is a rarity. In the following case recurrent attacks of bursitis had led to femoral vein compression with consequent swelling of the affected leg.

CASE REPORT

A housewife aged 41 was referred to the out-patient department on December 31, 1951, complaining of severe pain in the right thigh which had kept her awake for one night. Her doctor stated that the thigh was greatly swollen and had made a diagnosis of possible venous thrombosis. Two months earlier she had complained only of swelling of the right thigh; there was no pain or tenderness, or any sug-

gestion of a deep vein thrombosis, nor were any inflammatory changes seen in the limb. The doctor thought it was possibly a case of angioneurotic oedema.

On examination her general condition was good. No abnormality was found in the respiratory system, cardiovascular system, or abdomen. The circumference of the right thigh was 2 in. (5 cm.) greater than the left, and the right calf 1 in. (2.5 cm.) greater than the left. There was, however, no evidence of actual oedema. The pulses of the two legs were equal and good. No pelvic abnormality was found on rectal or vaginal examination. There were no varicose veins. X-ray examination of the chest, pelvis, lumbar spine, and femora showed nothing abnormal. No cause could be found for this swelling in the limb and she was asked to report again should she get any further attacks, so that she could be seen during an attack.

She reported back on June 17, 1952, stating that during the previous week a lump the size of a walnut had appeared in the right groin. It had been present for two days and had then disappeared. On examination there was no sign of the lump in the groin, and in view of this she was again asked to attend when the lump reappeared.

Her third attendance, on September 22, 1952, showed a swelling the size of a walnut in the right groin situated below and lateral to the pubic spine. It was cystic and tender; the skin was mobile over it, but the swelling was fixed to the underlying muscle. An irreducible femoral hernia was diagnosed and operation undertaken.

At operation by a Lotheissen approach, dissection below the inguinal ligament revealed a cystic swelling which was found to be lying on the pectineus fascia and intimately adherent to the femoral vein. It was realized that this was not a femoral hernia but a bursa arising from the pectineus fascia. It was excised with the exception of a small portion adherent to the femoral vein.

Pathological Report.—The bursa contained gelatinous fluid and had a smooth lining. On histological examination the material was shown to consist of oedematous and congested fibro-vascular tissue, moderately infiltrated with chronic inflammatory cells, eosinophils predominating. In one edge the material was lined by flattened endothelial cells.

The patient made an uneventful convalescence, and on discharge from hospital on October 7 there was no significant difference in the circumference of the two limbs after exercise. When seen on December 15 she was symptom-free and there was no difference in measurement of the left and right lower limbs.

COMMENT

Supernumerary pectineal bursa is a further lesion to be considered in the differential diagnosis of swellings in the ileo-femoral region. In the case recorded the patient presented with swelling of the thigh, the cause of which remained undiagnosed until the bursa became large enough to appear in Scapa's triangle, when it was diagnosed as a femoral hernia.

Perrigard (1947) recorded this condition under the title of supernumerary bursa of pectineus muscle simulating hernia in the inguinal region. In his patient the bursa was adherent to some of the smaller tributaries of the long saphenous vein, whereas in our patient the bursa was firmly adherent to the femoral vein. In Perrigard's patient there were no symptoms referable to venous obstruction, and the bursa seemed to have been more superficial in its situation. We can find no other reference to this condition in the literature.

A similar condition which may lead to some confusion is the ileo-psoas or ileo-pectineus bursa which lies lateral to the femoral artery and may overlap the arteries and veins to lie anterior to them.

We should like to express our thanks to Dr. K. P. Ball and to Dr. Isobel Finlayson for the detail given in her original letter.

P. WINSTON, F.R.C.S.
 F. A. HENLEY, F.R.C.S.
 Central Middlesex Hospital.

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