spurious form of shortened leg, with the compensatory curve in the dorsal instead of the lumbar region. The cure is obvious—exercises and a proper stance.

As I have not seen the condition mentioned much in the literature, and there is no reason to suppose that the girls are not average specimens, it seems worth while to record these cases in order to draw attention to a condition which can be easily overlooked and may lead to troublesome backache in later life if not corrected while the spine is young and pliable.—I am, etc.,

Manchester

NESTA H. WELLS.

Penicillin and Gonorrhoea

SIR.—May I congratulate Dr. C. C. R. Downing for his excellent paper (March 27, p. 599) on the treatment of gonorrhoea by penicillin? As Dr. Downing states, the cure of gonorrhoea is indeed too efficient nowadays, and the patient often goes away with the idea that the disease is not so serious as he has been led to believe and that therefore he or she can afford to risk reinfection.

Secondly, there is no doubt that penicillin does mask the appearance of primary syphilis. Recently in the Middle East I began treating all cases of gonorrhoea with sulphonamides, as two of my cases later developed typical primary chancres. No spirochaetes, however, were demonstrated and the Wassermann reaction has continued to remain negative. Several weeks later I had two other similar cases, but here again no spirochaetes were demonstrated and both cases have been serologically negative. These must therefore be considered to be cases of chancroid.

Thirdly, as Dr. Downing points out, it is extremely difficult to persuade patients to return for blood tests many months after they consider themselves cured. Luckily in the Royal Navy this problem does not arise, as cases are kept under surveillance during this period no matter where they go.—I am, etc.,

H.M.S. Challenger.

F. S. PRESTON,
Surg.-Lieut. R.N.V.R.

Refractory Iron-deficiency Anaemia

SIR.—With reference to the article entitled "Refractory Iron-deficiency Anaemia Treated with Intravenous Saccharated Oxide of Iron," by Prof. L. S. P. Davidson and Dr. R. H. Girdwood (April 17, p. 733), your annotation on refractory iron-deficiency anaemia (p. 739), and the letter on iron in anaemia, by Drs. H. G. B. Slack and John F. Wilkinson (p. 753)—my method of the treatment of anaemia with intravenous injections of iron arsanilate might be of interest. The preparation and administration of this insoluble salt are described in a paper entitled "Interim notes on the therapeutics of bismuth, antimony, zinc, iron and copper arsanilate, in the treatment of malignant disease, syphilis, yaws, leprosy, tuberculosis, whooping-cough, and some minor complaints in the African," published in the *East African Medical Journal* (August, 1946).

A considerable number of cases have now been treated as out-patients with good results; and in only one, out of several hundreds of injections in which the several arsanilates have been used during the last six years, has there been a slight rigor. The maximum quantity of iron arsanilate used intravenously in any one case during recent months was 15 grains, in 1½ grain doses suspended in 2 ml. of water and given on alternate days.—I am, etc.,

Fort Johnston, Nyasaland.

J. O. SHIRCORE.

Chronic Recurrent Iridocyclitis

SIR.—The following is an account of a case of chronic recurrent iridocyclitis, treated with an "anti-allergic" drug, both locally and by mouth.

The patient, a woman aged 62, had presented from time to time over a period of 15 years with a severe iridocyclitis. The first time she was seen was in 1931, when she came to hospital complaining of a painful red right eye. On examination the right eye was intensely red with ciliary congestion, and K.P. were present. This was accompanied by lacrimation and photophobia. She was treated with hot steamings and atropine ointment. After some months there was a little improvement, but she had several relapses between this time and 1934. Meanwhile the left eye became involved also.

She was taken into hospital and treated on several occasions during the next ten years or so, during which time she was treated with atropine, heat, short-wave therapy, etc. Each time after being discharged from hospital she would have a relapse.

In February of this year she presented with both eyes intensely red and painful. There was a great deal of ciliary congestion, and K.P. were present in large numbers; both corneae showed staining areas.

We commenced treatment with guttae "antistin privine" t.d.s., together with ung. atropinae 1% to both eyes; tab. antistin 100 mg. b.d. by mouth were also given. In three days both eyes were white and the patient free from pain. To quote the patient's own words, "I've never known my eyes to be so free from pain before." This treatment was continued for two weeks and discontinued about a month ago. Since this time both eyes have remained quiet.

The above is not claimed as a cure for all forms of iridocyclitis, but merely put forward as a suggestion that an "anti-allergic" drug, such as the one used, when applied locally and given by mouth, offers a form of therapy, with sometimes dramatic results, in a number of cases of "idiopathic" disease of the uveal tract which fail to respond to the more orthodox and acknowledged forms of treatment.—I am, etc.,

London, W.9.

LAURENCE CARTLEDGE.

Pregnancies after Caesarean Operation

SIR.—The following case illustrates the importance of advising every pregnant woman who has undergone a caesarean operation for one reason or another to enter hospital for all subsequent confinements, where surgical help is readily available should any further abnormality present itself.

Owing to a contracted pelvis this particular woman, aged 24, was delivered by caesarean section 18 months previously. She was again admitted for a similar purpose, and after labour had begun was brought into the theatre. Nothing unusual had taken place and labour was proceeding normally, but previous catheterization of an apparently full bladder yielded no result, the suprapubic swelling remaining until she was under full general anaesthetic, when it appeared to vanish.

The abdomen was opened, and it became immediately obvious the uterus had ruptured along the line and length of the old incision. The protruding and distended membranes had been mistaken for a full bladder. The operation was carried out in the usual manner, the child and placenta being delivered through the ready-made opening. Intraoperative haemorrhage was negligible. Mother and child were none the worse for this experience, and although recovery was uneventful a serious occurrence of this nature happening in less fortunate circumstances might well have ended in disaster.

A colleague, Dr. Carson, who performed the operation tells me that of the 200 or more cases he can personally call to mind in which this surgical procedure was adopted for overcoming obstetric difficulties, it is the first time he has met with this particular complication, and in view of its unusual manifestation its recording in the *Journal* may serve a useful purpose.—I am, etc.,

Blakeney, Glos.

J. M. ASHTON.

Risks of Dicoumarol Therapy

SIR.—It was a relief to read your annotation on the risks of dicoumarol therapy (May 22, p. 988). In spite of all that has been written as regards the advantages of dicoumarol the dangers persist even if not always obvious.

The policy of giving 200 mg. daily for more than two or three days is wrong and dangerous. 300 mg. daily for two days only, or 300 mg. on the first day followed by 200 mg. on the second day, is usually safe. After the first two days no more dicoumarol should be given for 10 to 14 days, and then very small doses (25 mg. or 50 mg.) should be tried. If the response is favourable 100 mg. may be given every other day for a period to be determined by the result of the daily estimation of prothrombin time. Prothrombin time should be estimated, as I have indicated (*British Medical Journal*, Nov. 8, 1947, p. 748), before the course of dicoumarol is started and every day after the first two days.

In the beginning the reaction to dicoumarol takes place slowly, perhaps 48 hours, but after the 10–14 days' intermission a small dose of dicoumarol (25 mg. to 50 mg.) may result in a profound alteration of prothrombin time, accelerated (24 hours) as compared with 48 hours for the initial doses; and the prothrombin time returns more rapidly to normal (24 or 48 hours