for 48 hours, and then 0.5 g. four-hourly for 24 hours—a total of 17 g. in 3 days. His temperature fell to normal on the second day, and on Nov. 3 he was discharged apparently cured.

The man improved for about a fortnight; then his cough returned with added severity and he brought up much foul-smelling greenish-yellow sputum. Cough was his main symptom at this time. Vomiting occurred on several occasions, and his cough became almost incessant. A noticeable feature was that the cough was made worse by movement: he was more free from the paroxysms of coughing when supine than when in an upright position. His temperature varied from 99° to 101°, and clinical examination on Dec. 8 showed that there was an effusion at the right apex. X-ray examination on Dec. 10 confirmed this. Aspiration of the right chest in the sixth interspace in the mid-axillary line produced pus which on culture gave a profuse nearly pure growth of *B. friedländeri*. The patient was admitted as a case of post-pneumonic empyema on Dec. 14: temperature 99.6°, pulse 84, and respirations 26.

Operation Notes.—Premedication consisted of morphine gr. 1/4, atropine gr. 1/100, and scopolamine gr. 1/150. The skin and sub-cutaneous tissue in the right upper chest were infiltrated with 0.5% planocaine, and aspiration of the chest in the sixth interspace in the mid-axillary line produced pus. A portion of the sixth rib was removed and the parietal pleura was opened. A large apical cavity was entered and 45 oz. of thick green pus was withdrawn. During a violent fit of coughing a slough of the whole of the right upper lobe was expelled from the wound, being followed by a gush of foul-smelling pus. A large drainage-tube was inserted into the cavity, and the skin lightly sutured and a light dressing applied. The lung slough measured 20 by 8 by 6 cm. It had a grey ragged appearance and was pitted with small holes.

Post-operative Progress.—On return from the theatre the patient's general condition was good: temperature 99.6°, pulse 96, and respirations 32. Cough, which was spasmodic, was relieved with linctus heroin 2 dr. t.d.s. Drainage was profuse, and his temperature, pulse, and respirations reached normal levels on the third post-operative day. X-ray examination at this time showed that the tube was in good position and that there was no fluid level in the cavity. Satisfactory progress was maintained, and on Dec. 22 a thoracoscope was passed into the cavity. Clean pink pleura could be seen all round except on the lower and posterior part, where the dappled surface of the lower and middle lobes could be made out. The root structures were plainly visible, and at least three large bronchial openings could be seen. There was a polypoidal projection from what seemed to be the pulmonary artery, which was presumably organizing blood-clot.

Convalescence continued to be satisfactory and drainage gradually decreased. Apart from a slight morning cough the patient was now entirely free. On Jan. 23, 1943, he was allowed to get up, and on Feb. 19 was discharged from the hospital with a self-retaining catheter in position in the cavity. The tube was changed frequently, and x-ray examinations were made at intervals of about three weeks. The tube was finally removed on June 2, and the sinus rapidly closed. X-ray examination showed that there was then still a cavity at the right apex, with at least one patent bronchus at its lower end. The patient is now (June 20) quite well, free from cough and dyspnoea, is gaining weight, and has started work.

Comment

The illness began with an attack of lobar pneumonia, which was followed by a period of recovery. This was interrupted by the appearance of excessive cough, which was productive of thick greenish-yellow sputum, with attendant symptoms of malaise and pyrexia. Clinical examination some two months later suggested an empyema, and drainage was indicated. At this time the cough was noted to be positional: the patient coughed more when he was upright than when flat in bed. The presence of *B. friedländeri* in the pus from the cavity was a rare and unexpected finding. Removal of the tube six months after drainage was started still left a cavity in the right upper zone. This cavity is draining into a patent bronchus on its lower and medial aspect. Up to now the presence of a cavity has not given rise to any symptoms. The question of an apical thoracoplasty must, however, be kept in mind, so that the cavity may be closed completely if it should again give rise to any symptoms.

Summary

One case of spontaneous lobectomy is described. The finding of a nearly pure culture of *B. friedländeri* in the pus from an empyema is noted as a rare event.

For permission to describe this case I have to thank Mr. P. R. Allison, under whose supervision it was while in hospital.

Medical Memoranda

"Spinning the Occipito-posterior"

In a fairly concentrated experience of obstetric practice (hospital, consulting, and private) spread over 25 years, at least 500 cases of occipito-posterior presentation, at a very moderate estimate, must have been treated (probably many more). During this period a method of treatment, feasible in a limited number of cases only, has been thrust upon me by Nature's own ordinance rather than by any skill or genius on my own part. I have termed this method, perhaps rather fancifully, "spinning the occipito-posterior."

The method depends upon the combination of several favourable circumstances, some of which are partly under medical control. These are as follows:

1. The membranes must be intact.
2. The head must not be absolutely jammed in the lower strait.
3. There must be at least two to three fingers dilatation.
4. There must be no disproportion between the head and the pelvis.
5. The attempt should be made within 24 hours (probably) of the onset of "painful contractions of poor quality" so characteristic of occipito-posterior presentations.

In such cases the usual approved method of treatment is by analgesics and psychological control of the patient.

There is an alternative. In the course of examination, to determine position and progress, a two-finger vaginal examination should, if possible, be made. With a knowledge of "intact membranes," the head may be pushed upwards, between pains, possibly half an inch or more into the cavity of the pelvis. The result is that liquor amnii can pass down on all sides of the head, so that, for practical purposes, it again floats in the lower part of the amniotic sac. Should the pressure upwards be timed to coincide with the onset of a contraction, the head will sometimes spin completely round to occipito-anterior practically instantaneously. Retaining this position by fundal pressure and promptly rupturing the membranes and letting off liquor will lead to a reasonably rapid and normal delivery.

It is obvious that this method has a limited application, but might possibly be used much more often if the necessary conditions were looked for and the attempt made.

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Fracture of the Neck of the Femur after Amputation

Fracture through the neck of the femur due to hyperaemic decalcification—the fatigue type of fracture—is allied architecturally to the lesion described below. A search of the literature being fruitless, it was thought worth while to record the following case both as a matter of interest and as a warning.

CASE RECORD

A shunter aged 43 was admitted to the orthopaedic department of Peterborough Memorial Hospital on July 24, 1943, an express train having run over his right foot, amputating it close to the ankle-joint. After resuscitation, as he was profoundly shocked, an amputation was performed 5½ in. from the inner side of his knee-joint. Three weeks later he was discharged from hospital, but attended for a considerable time for stump and hip exercises. In due course he was measured for his artificial limb by one of the best makers. On Dec. 8 this arrived, and on the following day he walked over to the hospital to show me his prowess. On Dec. 11, when some miles outside Peterborough, he felt something give in his hip-joint while stepping from a high pavement to the road. As he could not move he was brought to hospital again by ambulance. Radiographs showed a typical transcervical fracture and also the typical appearance of a disuse atrophy. A few days later a vitallium nail was driven across the fracture. After three months, as there was sound bony union, weight-bearing was started—this time very gradually. Now he is doing everything a modern artificial limb permits.

COMMENT

This case, in my opinion, is a mixture between the fatigue type of fracture and that due to disuse atrophy, the precipitating factor no doubt being the latter, the hyperaemia caused by the unaccustomed activity helping to decalcify still further the weakened bony structure. This case serves as a warning—to me, at any rate—that weight-bearing should be given in graduated doses after an amputation, and no such warning or similar cases to this has been recorded.

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