I make the most earnest claim that the family doctor should be the person to deal with this subject, whether with or without consultation with special clinics or consultants. I submit a few reasons for this in summing up some of the points to which I have drawn attention.

1. If the true facts, as shown in the above tables, about the chances of immediate conception and natural rate of child-bearing were explained, many young couples would begin married life naturally, unhampered by artificial contrivances. Such explanation is best given by the family doctor.

2. Most people of education in marriages of true affection would respond to the doctor's advice that it is not for the good of themselves or of their offspring to come together when either does not desire it.

3. The doctor knows the whole circumstances of the case in question, and how pressing or otherwise is the demand for some means of preventing conception, which may vary from avoiding a risk which would be almost certainly fatal, to anxiety as to whether financial resources will adequately maintain and educate another child.

It has been said that the medical practitioner is unable or unwilling to deal with this question, and has no training to equip him for giving wise advice suitable to each case.

I suggest that the remedy for this is that all that is at present known in regard to this subject should be taught to medical students, and their responsibility in regard to it be emphasized. If the family attendant refuses help in this respect it cannot be a matter of complaint if patients seek knowledge and helpful advice from a practitioner who is willing to give it.

One last word as to the medical aspect of the present situation from a wider point of view. The birth rate of the artisan class is falling most rapidly, but closely comparable is the fall in the upper and middle classes. The birth rate is actually rising among miners and unskilled labourers—that is to say, classes in economic comfort are becoming unnaturally sterile, while classes in or approaching destitution are unnaturally prolific.

In physical values, if only through being reared in unfavourable environment, the latter must be lower in vitality than the former, and as the proportion of healthy members of the race is gradually diminished and the proportion of ill-developed members is increased, the physical standard of the national health must deteriorate.

From a medical point of view the position is disastrous, and would not, in my opinion, be cured if all contraceptive practices were swept away. We should thereby add somewhat (though not to the extent imagined) to the stock of those who can afford physical necessities of health, but more drastic measures from a public health point of view are needed to arrest the fertility associated with destitution.

A CASE OF OSTEITIS FIBROSA.

BY

J. LEIGH COX, M.A., B.M., B.Ch. OXON.,
M.R.C.S., L.R.C.P.,
BRIGHAM, SOUTH DEVON.

THE following case presents some points of interest, and may be considered worthy of publication.

A girl, aged 18, cashier in a draper's shop, complained of "cutting pains" in the right knee, which gave out when she was walking. The pains were intermittent, did not incapacitate her from work, and lasted from October to December, 1926.

On Christmas Eve, 1926, she complained of pain in the right tibia, and took to her bed on January 4th, 1927. She then noticed a swelling about the middle of the tibia, and the pain became definitely worse. On examination I found a uniform swelling apparently involving the whole circumference of the bone at the junction of the upper two-thirds and lower third of the right tibia. There was some tenderness on deep pressure, but no other physical signs any-

where. No history of any blow or injury could be elicited. An antero-posterior x-ray photograph was taken of the right tibia and fibula, and showed a small area of rarefaction at the site of the swelling. A provisional diagnosis of chronic osteomyelitis was made, and the patient kept in bed, her temperature and pulse being carefully watched. At the end of a fortnight the pain had subsided and there had been no rise of temperature or pulse. The patient was allowed up and told to report again should there be any recurrence.

In March, 1927, she complained of a gradual onset of pain in the right hip-joint, saying that she got very stiff on sitting down and could not walk on rising. On examination there was a quarter of an inch true shortening of the right leg, marked limitation of movement on abduction, and some tenderness on pressure over the joint. A skiagram showed marked rarefaction of the neck of the right femur, with a spontaneous fracture extending about half-way across it. The upper half of the shaft also appeared to show rarefactive changes. The patient was put to bed for three months and given tab. parathyroid and calcium (P.D. and Co.) thrice daily, and began to walk again in August, 1927. There were no more symptoms, and another skiagram was taken in October. This showed rather more marked rarefaction in the neck of the right femur, but the fracture appeared to be healed.

In April, 1928, the patient again complained of some increase in size of the tibial swelling, with slight intermittent pain in this situation. A lateral view of the tibia revealed an extensive area of rarefaction with marked thinning of the bone. Permission could not be obtained for removal of some blood for the Wassermann reaction and calcium content estimation.

The comparative rarity of this condition and lack of definite knowledge concerning the fundamental metabolic errors responsible seem to make this case worthy of record. The condition is sometimes associated with parathyroid tumours; in this case there were none discovered.

Radiogram of right tibia and fibula, April 4th, 1928.

A CASE OF PARTIAL STAPHYLOMA OF THE CORNEA.

BY

R. Y. STONES, M.C., M.D., M.R.C.P. LOND.,
MENGO HOSPITAL, KAMPALA, UGANDA.

A STAPHYLOMA corneae parziale, the scar of which is giving way, complicated by a staphyloma totale of the other eye, is a somewhat rare condition, so the following case seems to be of sufficient general interest to merit publication.

A young South African farmer, 18 years of age, living at Eldoret, some three hundred miles from Kampala, had a severe infection of both eyes when 3 years old. His parents were on trek miles away from any town, and it was only by the good offices of a regimental surgeon whom they fortunately met that the child's sight was not entirely lost. As it was, the one eye was completely and the other partially blind. The boy first went to school when he was 16, but at his first half-term holiday it was noticed that his sight had deteriorated a little, so on the advice of a doctor he was removed from school and took up farming. The father reported that the sight had again begun to fail during the last two months.

When seen on August 31st, 1927, the left eye was found to be completely blind, the cornea being replaced by a dense leucoma; the tension of the eye was very low. The right eye showed a clear cornea except at the lower and inner quadrant, where an old leucoma was present. This scar had given way in the centre and the iris was protruding. No corneal ulceration was found, and there was no oedema of the conjunctiva. The anterior chamber was shallow and the tension of the eye subnormal; the iris was excentric, showing the presence of anterior synechiae; vision was only 3/60. The fundus could not be seen, a red reflex only being obtained; with a +20 lens striae could be seen in the lens; vitreous opacities were not found.

It was decided that an operation must be performed, and this was conducted according to the method described by Abadie.

Operation.—(1) The corneal tissue over and around the staphyloma was scarified with a sharp scalpel. (2) A "bridge" flap of conjunctiva was got ready and preparatory stitches were inserted. (3) The base of the staphyloma was incised with a Graefe cataract knife. (4) The flap, which covered the staphyloma entirely, was stitched in position. The lens did not escape. The patient did not take the anaesthetic well, and the operation had to be done quickly.

Ten days after this operation the scar again began to give way and the tension was still low, the conjunctival flap having apparently slipped back. Cocaine was instilled and the flap brought over again, after denuding the surface of the cornea. The patient was kept at absolute rest with a firm pad and bandage over the eye for three weeks. Graduated exercises were then begun, but the scar again began to bulge, the anterior chamber was almost gone, and the tension, which had improved after the operation, again fell. A further, more radical, operation was therefore necessary if the eye was to be saved; this was carried out under rectal anaesthesia.

Second Operation.—(1) The conjunctiva was dissected

back all round the limbus and a purse-string suture inserted. (2) The cornea was scarified around the staphyloma. (3) The staphyloma was excised and two fine catgut sutures were used to draw the edges of the wound in the cornea together. (4) The base of the staphyloma was cut through with a Graefe knife. (5) The purse-string suture was tied, drawing the conjunctiva well over the cornea.

A very severe reaction followed this operation, and the eye took ten days to quieten down; the scar which resulted was firm, but in spite of atropine being pressed the iris was drawn over and vision was perception of light only.

Owing to the severe reaction and the irritable condition of his eye the patient was advised to go home for some weeks before an optical iridectomy was done.

He was readmitted on January 2nd, 1928. It was then seen that a firm white scar had formed, the iris was bright and the eye quiet, the anterior chamber was deep and the tension nearly normal. A simple optical iridectomy was done. Two days later a severe reaction set in with an effusion of blood into the anterior chamber. The eye again slowly quietened down, but the vision was only hand movements. No red reflex could be obtained. The lymph and blood clot in the anterior chamber slowly cleared up and the vision improved daily. The patient could soon count fingers at three feet and could distinguish distant objects fairly well.

As the reaction after a simple operation had been so sharp it was considered inadvisable to do anything further for the time being as the boy could find his way about independently, and both he and his parents were satisfied. A month later the mother wrote saying, "The eye is improving. He can see quite well now . . . he is very happy and is out riding almost the whole day."

I wish to record my thanks to Dr. H. B. Owen, D.S.O., medical superintendent, Mulago, who saw the patient in consultation and who shared with me the anxiety of the case.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

TETANY INVOLVING THE RECTUS ABDOMINIS.

THE following case, which came to my notice recently, seems to be worthy of record, both on account of its rarity and of its somewhat abrupt termination.

A married man, aged 53, of rather poor physique, complained of symptoms of ordinary influenza—namely, cough, coryza, malaise, and backache of two days' duration. These symptoms did not inconvenience him so much as that during this time he had experienced agonizing pains in the upper abdomen, which came on at any time during the day and night. He described them as just like a "stitch" or cramp. So severe were they that sleep was impossible. Nothing seemed to relieve them, and they disappeared after five to ten minutes, only to return. He had noticed that the attacks were induced more readily by stooping. His temperature was 99.4° F., pulse 100. The mucous membrane inside the nose was intensely congested and the nares patulous, the result of chronic nasal catarrh. Nothing beyond a few catarrhal signs was present in the chest.

While I was examining his abdomen he was seized suddenly with one of these cramp-like attacks, and I was able to witness the course of events. In the epigastrium there gradually appeared two somewhat sausage-shaped swellings, extending transversely on either side of the mid-abdominal line. They were slightly thicker towards the mid-line, tense, of board-like consistency, and there could be no doubt that they were the upper segments of the rectus abdominis in spasm. He was in great pain during the attack. At the same time the skin over the abdomen was hyperaesthetic and he could not bear me to touch him. I witnessed several attacks that night, each lasting from five to ten minutes. The upper segments alone were affected and went into spasm synchronously; on one occasion, however, the left half only was concerned. Further examination revealed hyperexcitability of the face, and tapping over the pes anserinus elicited fibrillary twitchings of the facial muscles on that side not quite amounting to spasm. I could find no other physical signs in the nervous system and no fibrillation in any voluntary muscles, though his spare musculature seemed at first to suggest progressive muscular atrophy. I ordered 10 grains of compound ipecacuanha powder with 10 grains of aspirin in powders, and a saline expectorant mixture. Two days later I saw the patient again; the cramp had then disappeared entirely and his influenza was much better.

There could be no doubt as to the nature of these tonic spasms. Their gradual and orderly onset excluded

the possibility of localized myoclonus, for here the contractions are almost always shock-like in their intensity and onset, and usually involve the peripheral muscles of the limbs. Moreover, there is frequently a history of mental deterioration or epilepsy; in this case both of these were absent. I am inclined to believe that I was witnessing a case of tetany involving the rectus abdominis, and the presence of Chvostek's signs tend to confirm this.

Though cases of toxic tetany are rare, Frankl-Hockwart mentions its occurrence in acute specific fevers, of which influenza is one. As compared with the number of cases associated with infantile rickets and post-operative thyroidectomy, these toxic cases form a very small percentage.

For the rectus muscle to be involved alone seems altogether unique. I can find no mention of a similar case in the literature.

Bristol.

S. LERNER, M.B., B.S.Lond.

TRIPLE INTUSSUSCEPTION IN AN ELDERLY WOMAN.

THE unusual occurrence of a triple chronic intussusception occurring in an elderly woman seems to be worthy of record, particularly in view of the diagnostic difficulty and the recovery following operation.

A married woman, aged 57, was admitted to my wards in the Glasgow Royal Infirmary suffering from absolute constipation, constant vomiting, and acute pain in the abdomen. She stated that she had not been well for a year or so, with gradually increasing constipation, the passage of slime by the rectum, and pain, particularly on the left side. The pain became very severe, and the constipation almost absolute; vomiting began, and she went to another hospital, where she was x-rayed and the abdomen was examined, but nothing abnormal was found. A week later she returned, and was examined under an anaesthetic, but again nothing was found, and she was sent home; the following day she came to the Royal Infirmary.

On admission the abdomen was found greatly distended, so that palpation was impossible. Peristaltic waves were frequently seen in spite of the distension. The tongue was very dirty, and the breath foul; the temperature was 98° F., the pulse 88, and the respirations 26. Rectal examination was negative, and an enema yielded no result. Carcinoma of the large intestine was considered the probable diagnosis.