condition also, relying on his vast personal experience of the treatment of stricture.

He bent a solid brass stair-rod into the shape of a urethral bougie and filed it until it was quite smooth. Using his ointment as a lubricant, he inserted this intrument into his urethra and allowed it to slide down as far as it would go. He pushed it past the last inch of resistance into his bladder and thus relieved himself rapidly. He has suffered no ill effects so far, except for the escape of a few drops of urine whenever he coughs. He explained that he knew he was taking his life into his own hands, but he was "fed up with hanging around hospitals." He has promised never to repeat the treatment.—I am, etc.,

London, W.11. DAVID SLOVICK.

Proguanil-resistant Falciparum Malaria

SIR,—I am glad that Drs. J. F. B. Edeson and J. W. Field have opened the subject of proguanil-resistance in falciparum malaria (January 21, p. 147). I hasten to support them from our experience in this part of India. Our clinical observations about the action of proguanil in falciparum malaria may be summarized as follows.

1. Proguanil controls the bouts of fever in 48–72 hours. But low fever without rigors may linger on for days in some cases.

2. The ring forms disappear rapidly from peripheral blood on exhibition of proguanil.

3. When the patient is still under proguanil treatment a large number of crescents appear in peripheral blood.

4. The above condition is associated with a well-marked haemolytic anaemia, rise of temperature daily to about 99° F. (37.2° C.), and a general deterioration in the patient's general condition.

Under these conditions treatment with antimalarial drugs in combination with penicillin, as described in a paper I wrote.[1] has helped to control the infection and leads to rapid recovery without relapses. Our experience during the last two years since the publication of the above observation (in about 100 cases) has confirmed our faith in this line of treatment. Discussion of the treatment on the basis of available knowledge is bound to be fruitless, since the knowledge we boast of is so infinitesimal and also since "facts are stranger than fiction." I therefore ask the workers concerned to try this treatment in resistant and relapsing cases of malaria, benign as well as malignant.—I am, etc.,

Poona, India. P. L. DESHMUKH.

REFERENCE

1 *Ind. med. Gaz.*, 1947, **82**, 511.

Acute Inversion of the Uterus

SIR,—There are several significant points in the case of acute uterine inversion described by Drs. D. Crook, F. Kohn, and T. D. Lambert (March 25, p. 729). From the account given it seems likely that inversion of the uterus recurred almost immediately following reposition, for which the injection of ergometrine may have been partly responsible. The authors say that following replacement "the patient looked pale and ergometrine 0.5 mg. was administered intramuscularly. The pulse rate increased to 90 per minute and a few minutes later blood began to gush from the vulva. The patient collapsed. . . ."

Now the uterine fundus which has just been replaced from the inverted position is for a few moments very atonic; the tendency to sag in its upper part is still present. It is important that a hand be kept within the uterine cavity until the uterus contracts, otherwise a vigorous contraction—especially one induced by an oxytocic drug—will simply drive down the fundus again into the vagina. Failure to appreciate this, and therefore the cause of collapse and continued bleeding, may result in a further injection of ergometrine being given, which would simply aggravate the condition.

The reason for the failure to recognize that the inversion had recurred is almost certainly that "the uterine fundus appeared normal on abdominal examination," although it must have been inverted at that time. This is a most dangerous pitfall in the diagnosis of incomplete uterine inversion. The fundus is felt to be at the normal level on abdominal palpation, though vaginal examination shows that most of the body of the uterus is inverted and may be almost filling the vagina. More careful palpation of the uterus abdominally will probably show the presence of a small dimple; this may not be recognized as such, and nothing more may be made out than an irregularity in shape the significance of which is not recognized, as the height of the fundus above the symphysis pubis may be normal. A further fact pointing to the diagnosis was the persistence of severe abdominal pain.

Recurrence of inversion of the uterus following reposition is always a danger. Prompt measures for resuscitation should be instituted at once, followed by adequate replacement. How much better is this accomplished by an obstetric "flying squad" unit than following removal of the patient, perhaps many miles, to hospital by ambulance.—I am, etc.,

Manchester. C. J. DEWHURST.

Gastro-gastric Intussusception

SIR,—Mr. Alan Thompson (March 4, p. 525) describes a case of gastro-gastric intussusception caused by a malignant polypus. As this condition is an uncommon one, it may be of interest to record a similar case of my own.

A thin and anaemic woman of 66 was admitted to hospital giving a history of vague epigastric discomfort and poor appetite for one year. Four days before operation (which was on December 22, 1940) the epigastric discomfort became more severe and she began to vomit dark thin fluid. Her haemoglobin was 60%. There was a rounded palpable mass in the region of the pylorus, and the diagnosis appeared to be clearly one of carcinoma causing pyloric stenosis. On opening her abdomen, an intussusception was found, the antrum being invaginated into the duodenum, the total length of the intussusception being 4 in. (10 cm.). This was easily reduced. The stomach was opened and a sessile tumour, 1½ in. (3.75 cm.) in diameter, was removed from the posterior wall of the stomach, rather towards the greater curvature. The stomach was repaired. Convalescence was normal. Histologically the tumour was a malignant papilloma.

—I am, etc.,

Farnham, Surrey. S. C. RAW.

Anaesthesia for Fenestration Operation

SIR,—We have read with interest correspondence on the subject of anaesthesia for the fenestration operation. Induced hypotension appears to us to give most consistently the degree of haemostasis necessary. The work of Gillies on total spinal block has led to the development of a technique combining high spinal block with light general anaesthesia for this type of operation. Good results have been obtained during the past eighteen months; in one case, during a Portman's operation, in which this method was used, the dura was opened and there was a loss of cerebrospinal fluid. The patient lived for four days without regaining consciousness. We feel attention should be drawn to the possible danger of this technique when there may be loss of cerebrospinal fluid. A less elaborate routine using pentamethonium bromide is now being tried.—We are, etc.,

Lincoln. A. C. FRASER.
M. SPENCER HARRISON.

Synchronous Double Primary Carcinoma

SIR,—It may interest readers of Dr. T. B. Williamson's medical memorandum (March 18, p. 648) to know that some 23 years ago, while in practice in Lancashire, I was consulted by a single woman aged, to the best of my memory, about 40, who had a fairly early, freely movable carcinoma about the size of a walnut in the right breast, with a palpable axillary gland, while the left nipple was almost obliterated by Paget's disease. I sent her to my old teacher, the late Professor Blair Bell, at Liverpool Royal Infirmary, who did a radical mammectomy on the right side at a first operation, and removed the left breast a fortnight later. The double diagnosis was confirmed by the microscope. The patient appeared to go on well for a few months, but developed intrathoracic metastases from which she died about a year after the operations.