Dr. Rees remarked that it is principally owing to the very surprising effects which he has observed from the use of lemon-juice—he could not know that 100 g. of lemon contains 50 mg. of ascorbic acid—in the treatment of rheumatic gout that he has been induced to notice this case. He has been in the habit of prescribing this remedy, with marked and rapid benefit. The early relief from pain was such that had anyone unacquainted with the remedy in use watched the progress of the case he would almost inevitably have concluded that sedatives had been employed. Among the out-patients at Guy's Hospital he has met with "several prominent examples of cure" by this method.

In his *Manual of the Practice of Medicine*, London, 1856, Dr. G. H. Barlow, physician to Guy's Hospital, mentions "one of the most ingenious methods" of treating rheumatic inflammation, and says: "Dr. Rees recommended lemon-juice to be given in doses, which he ultimately increased to two or three ounces, three or four times a day; and in a considerable number of cases the patient has become convalescent in five or six days."

The history of medicine is often a tale of discoveries that were soon forgotten, only to be rediscovered years or even centuries later and hailed as new observations.—I am, etc.,

London, E.17. B. JUHN.

A Twice-ruptured Uterus

SIR,—This case is reported because it is not often, even in Malaya, that one is called upon to treat the same patient on two occasions for rupture of the uterus.

The patient was a Chinese Hokkien, aged 28 years, of very small stature—height 4 ft. 9 in. (144 cm.), usual weight 5 st. 4 lb. (33 kg.). Her pelvis was of the justo minor type, the interspinous diameter being 8½ in. (21.6 cm.), the intercristal 9½ in. (24 cm.), and the external conjugate 6½ in. (16.5 cm.).

I first saw her on May 29, 1947, when she was carried in from a taxi in a desperate condition, with a barely perceptible pulse, groaning with continuous pain. The uterus was in a state of spasm, and there was considerable bleeding from an extensive laceration of the vagina, from which a foetal foot, a hand, and a loop of bruised cord were protruding. No foetal heart could be heard.

The story was that this was the third pregnancy, the two earlier ones having ended seven years and four years ago respectively in destructive operations after some days in labour. On each occasion she had been told that vaginal delivery was not possible for her, and that her next labour must be conducted in hospital by caesarean section. The present labour had begun two days before with rupture of the membranes and slight and irregular pains. For the past 18 hours, however, she had had strong and frequent pains, and the old lady who lived next door had examined her repeatedly, and had made many attempts to deliver her. Finally the old lady had given it up, and so the husband had summoned a taxi and driven five miles along the main road to the hospital.

Intravenous morphine and saline, followed by pentothal to relieve the pain, effected some improvement in her condition, and she was then examined under open ether anaesthesia. There was an extensive tear of the perineum, extending through the left vaginal wall to the vault and through the left side of the cervix. The laceration involved the left broad ligament. The foetus was delivered by evisceration and perforation of the head, and was followed by the already separated placenta. Investigation then showed that the tear of the broad ligament was incomplete and did not involve the peritoneal cavity. It was plugged with flavine gauze.

The convalescence was extremely hectic and complicated by considerable abdominal distension for the first week, but thanks to chemotherapy the patient survived, and her temperature gradually settled over a period of three weeks. She refused to be sterilized and left hospital against advice as soon as she was able to walk a few steps. She was warned that another pregnancy would involve considerable risk and that her only hope of surviving it would be a caesarean section in hospital before term.

I next saw her on September 9, 1949, when she walked into the labour ward, saying she had lost her card but had been in hospital before. She was luckily recognized, and her record was found at once. She had been in labour for eight hours and had had strong pains and some bleeding per vaginam for the last two to three hours. The fundus was at term. The foetal head was not engaged, but riding high above the inlet, and a foetal heart could be heard. She was rushed to the theatre, but the membranes ruptured *en route* and the head failed to engage.

The abdomen was opened under gas-oxygen-ether anaesthesia, and free blood and liquor were encountered. A living male child weighing 6 lb. (2.7 kg.) was delivered by classical caesarean section. Haemostatic sutures were inserted into the uterus and the pelvis inspected. There was a complete tear of the left lower uterine segment through the left broad ligament, which was ploughed up and greatly distorted by blood clot. On the right there was a smaller, incomplete tear involving the broad ligament. Subtotal hysterectomy was performed; haemostasis was secured with considerable difficulty owing to the distortions of the structure from old adhesions and fresh bleeding. The cervix and vagina were involved in the recent tear. She was given a transfusion a few hours later, when compatible relatives were found. Her convalescence was surprisingly smooth, probably owing to the exclusion this time of the unwashed hands of the old lady who lived next door.

She left hospital on October 2 in good condition with a healthy son. When asked why she had so persistently disregarded all medical advice she replied that she was willing and anxious to do what we had advised, but that the final decision rested, of course, with her mother-in-law, who said that babies should be born at home.

I am indebted to the Principal Medical Officer, Johore, for permission to publish this report.

—I am, etc.,

Johore Bahru, Malaya. MARJORIE J. LYON.

Brachial Neuralgia

SIR,—Dr. M. G. Good (May 27, p. 1272) states:

"For years I have been emphasizing that the majority of cases of sciatica are muscular in origin—'muscular sciatica'—caused by a polymyalgia of hip muscles (quadratus lumborum, glutei, tensor fasciae latae), and can be cured by procaine injection of the appropriate myalgic spots without ever resorting to the ordeal of a laminectomy."

I suggest that Dr. Good watches some operations for prolapsed intervertebral disk carried out by reputable neurosurgeons or orthopaedic surgeons. When he sees how the "root" of the matter is dealt with he may desist from attempting to score "outers" with his needle.—I am, etc.,

Norwich. H. A. BRITTAIN.

A Simple Method of Bronchography

SIR,—Drs. D. E. Vaughan Jones and M. R. William Spacek have recently described a technique for the instillation of iodized oil into the trachea (May 13, p. 1140). Professor R. R. Macintosh and Dr. William W. Mushin (June 3, p. 1319) subsequently pointed out that the Magill tube is unnecessary and in the case of small children may cause difficulty. We have developed a technique for rapid bronchography in the chest clinic which is essentially similar to that recommended by Professor Macintosh and Dr. Mushin in that a fine rubber catheter is employed. No originality is claimed for our method, but the details may be of interest to others seeking a safe and easy means of carrying out bronchography in adults and older children in the out-patient department.

Strong sedation has been found quite unnecessary, and indeed is best avoided so that the patient's full co-operation may not be impaired. His assistance is further ensured by a preliminary explanation of the purpose and technique of the procedure. A subcutaneous injection of atropine sulph. gr. 1/100 (0.65 mg.) and codein phosph. gr. 1/8 (8 mg.), or proportionately less in children, is given half-an-hour beforehand, together with a dose of linctus codein and a tablet of "decicain" (amethocaine) to suck. With the patient sitting comfortably facing the operator and holding his own tongue forward, the larynx is sprayed with 2% "butyn." A Jacques rubber catheter (size 9 English gauge for adults, 5 or 6 for children) is lubricated with a jelly containing 2% "butyn" and passed through the nostril so that the tip comes to lie just behind the epiglottis. If necessary its position can be checked with a laryngeal mirror. At the end of expiration "butyn," ½ to 1½ ml., according to the size of the patient, is squirted rapidly through the catheter, and when coughing has subsided the tip of the catheter is pushed on down between the vocal cords to lie in the trachea, and the upper end is secured to the forehead.

Respiration is in no wise hindered by the narrow tube, which remains in position throughout bronchography without causing discomfort. The patient can move freely and oil can be instilled through the catheter with the patient in any desired position. Satisfactory coating of all or any of the bronchi should be obtained without difficulty, and there is very little tendency for the patient to cough