This report was compiled primarily for the general practitioners of Great Britain, and for them alone, but I contend it is not reaching them. It caused a slight sensation in the lay press when published, and the daily papers all published verbatim the more "dramatic" parts of it; but this is already a month ago, and the report looks like being forgotten and neglected unless steps are taken to bring it to the notice and consideration of the general practitioners.

But for the size of the report I would suggest that a copy of it be sent gratis to every practitioner on the *Register*, but I do not think this is a very practical suggestion, as, with the best will in the world, few men in practice have the time to read so lengthy a report. I would suggest, however, that the parts of the report which are concerned with the suggestions for the care of the woman in pregnancy and labour be condensed into a pamphlet and sent round to every doctor on the *Register*, with a letter requesting him to read it and to carry out these suggestions in so far as lies in his power. This would obviate the necessity of his having to pick out the essential parts of the report for himself; and if it were presented to him in this manner there is a big possibility that it would be widely read and its suggestions put into practice, otherwise the valuable work of those who compiled it is likely to be lost, with its message having reached only a mere fraction of the doctors for whom it was intended.—I am, etc.,

Balham, S.W.12, Aug. 27th. JULIUS HORWICH, M.D.

PUERPERAL SEPTICAEMIA AND THE MIDWIFE

SIR,—I recently read in a daily newspaper that a medical officer of health had stated that while formerly the death rate from puerperal septicaemia was 6 per 1,000, it was now 4 per 1,000, and that the cause of puerperal septicaemia, according to his researches, was due to streptococcal infection in the noses and throats of the nurses and medical men in attendance.

During forty years of practice I have never lost a case from puerperal septicaemia, and may be considered lucky, though probably it may be a coincidence that the majority of my nurses were over middle age. Professor A. R. Simpson and Dr. Milne Murray both stressed a point in their lectures which I have rarely seen mentioned in treatises on the subject, and I presume that neither of these famous obstetricians would have laid such emphasis upon it unless he had had practical reasons. The former said: "No nurse during her menses ought to attend a parturient woman." The latter was even more dogmatic in his warning: "A nurse, during her menstrual period, constitutes herself a grave and potential danger to the lying-in woman." Here is a fine field for investigation among medical officers of health and bacteriologists!—I am, etc.,

Dumfries, Aug. 30th. J. D. ROBSON.

ANAESTHESIA IN LABOUR

SIR,—I read with consternation the various official dicta which appear from time to time about anaesthesia in labour. In 1847 Sir J. Y. Simpson made his momentous discovery of the anaesthetic properties of chloroform, but I fear that the story has been forgotten. What prompted him to search for an anaesthetic? He was not a surgeon, but an obstetrician, and as such was much moved by the desire to alleviate the sufferings of women in labour. He not only made his discovery, but overcame severe opposition to it and established it in the face of much obloquy.

Since that time the practical results of his work have not progressed one foot, and indeed the recent report of the Departmental Committee on Maternal Morbidity and Mortality that it "would regret a general demand for anaesthesia" is not only disgraceful to a body of professional men whose palpable duty is to relieve pain, but is a complete apostasy of the life and work of Simpson. Fortunately the general practitioner is not yet overcome by Departmental Committees, and he continues to do his best for his cases; but it is time to promulgate some official counterblast to this heresy.

I recently attended a public meeting in Glasgow where the question of a national maternity service was discussed, and it was sufficiently clear that it is the object of the present medical governors of this country to do all in their power to replace doctors by midwives. What does this mean? To me it means as clearly as possible that the working-class women of this country will be condemned to suffer labour without any kind of relief whatever. It does not mean that the better classes will be deprived of this benefit, and, although distinguished professors of obstetrics condemn anaesthesia as an unnecessary addition to the hazards of childbirth, I have yet to meet that hardy obstetrician who could withstand the entreaties of his patient for relief when the fee was fifty guineas.

What is the reason for this official atavism? Puerperal sepsis is the secret. For some reason or other the public health authorities entertain the idea that this condition is preventable and can be eradicated. To this end nothing is spared, and the most fantastic suggestions and extravagances are freely entertained.

In 1842 a Mr. Ward amputated a thigh painlessly under mesmeric trance. He read a paper thereon to the Royal Medical and Chirurgical Society. One member thereupon proposed that no account of such a paper having been read be entered in the minutes of the society, and he further asserted "that if the history of the man experiencing no agony during the operation were true, the fact was unworthy of their consideration, because pain was a wise provision of Nature, and patients ought to suffer pain while their surgeons were operating; they were all the better for it and recovered better." History, it is said, repeats itself.

As for myself, I shall continue to use whatever anaesthetic presents itself. At the moment I use morphine and hyoscine, followed by chloroform, in a dosage and manner a considerable experience has shown to be useful. I have done some 350 cases by this method, and have had nothing but excellent results. Most of my patients remember nothing about their labour for the last four hours or thereabouts, and are pleasantly surprised that their children are born. I see no reason why some such method could not be taught to midwives.

The present regrettable viewpoint is the result of an overweening confidence in the powers of the rational mind. The question of the relief of pain is not a matter of thought, but of feeling, and it is to the compassion of the profession that women—our own sisters and mothers—should appeal.—I am, etc.,

Glasgow, Aug. 29th. THOMAS ROBERTSON.

PERSISTENT PRIAPISM

SIR,—The case described by Messrs. Forrest and Graetz in the *Journal* of August 13th (p. 295) seems to be an example of long-protracted priapism due to an organic lesion of some kind. An apparently healthy man aged 49 years suddenly developed priapism, which persisted unaltered for forty-nine days and nights; then it gradually commenced to subside. The causative lesion doubtless varies in different cases, but what has specially interested me is the occasional connexion with myelosis (leukaemic or aleukaemic myelosis), as that association may possibly

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be compared to the relation of myelosis with apoplectiform Ménière's symptoms (Weber, F. P., *Medico-Chir. Trans.*, 1900, lxxxiii, 185) and spontaneous massive haematoma (Weber, F. P., *Proc. Roy. Soc. Med.*, Clinical Section, 1920–1, xiv, 16).

The first case of persistent priapism that I saw was in a man aged 42 years, when I was house-physician at St. Bartholomew's Hospital for Sir Dyce Duckworth, who described it in the *Transactions of the Clinical Society of London* (1892, xxv, 97). In that case the priapism lasted fully three weeks, and was definitely associated with gout. The second case was at the German Hospital in a man aged 46 years (Weber, F. P., *Edin. Med. Journ.*, 1898, New Series, iv, 267). The priapism began to subside after twenty-three days. In that case there was a probable history of syphilis twelve years previously.

In 1909, with my surgical colleague E. Michels, I saw a man aged 33 years with obvious myeloid leukaemia. The presence of the leukaemia had first been recognized during the previous year, *after* an attack of prolonged priapism, which left loss of erectile power when it subsided. In some of the other published cases leukaemia was not diagnosed until after an attack of prolonged priapism. In the case of a man aged 23 years (Vorster's first case, quoted by C. Goebel, *Mitteil. a. d. Grenzgeb. d. Med. u. Chir.*, 1904, xiii, 581) the blood examination at the time of the priapism was said to be negative, though leukaemia showed itself afterwards. In a case reported by H. Liniger (*Monatschr. f. Unfallheilk.*, 1912, xix, 51) the blood examination was also said to have showed nothing definite at the period of the priapism (November, 1910), though afterwards (March, 1911) it showed typical myeloid leukaemia.

In spite of the relative rarity of persistent priapism the literature on the subject is very extensive, and the following are only a few references regarding its association with leukaemia: G. L. Peabody (1880), A. H. Ward (1897), C. Goebel (1904, with references to previous literature), W. M. Stevens (1905), V. Blum (1906), W. Kunst (1907), Della Favera (1908), A. v. Winiwarter (1910), Warthin (1910), H. Liniger (1912), Völsch (1914), G. W. Theobald (1922), P. Williams (1924), Moure and Leibovici (1925), Brown and Doig (1927).

I was interested to read in the *Journal* of August 20th (p. 385) that Dr. C. Davies-Jones suspected that Messrs. Forrest and Graetz's case of priapism might have a "Freudian" aspect and should be referred for psychological treatment, for I do not think that any condition could be more obviously due to organic disease of some kind, though in this case, as in many others, the nature and position of the lesion may be uncertain. There can, however, be little doubt that exhaustive psycho-analytical investigation would reveal something of psychological interest that might be mistaken for "evidence." The thumb press used to coax out a confession of some kind almost whenever it was employed, and the giant in the children's tale of "Jack the Giant-killer" had no difficulty in squeezing moisture out of stones. Needless to say, in all cases of the kind psychological treatment would ultimately be followed by the subsidence of the priapism and would probably not render the leukaemia, gout, or local trauma (for example, some slight traumatism connected with the last erection), or any other causative condition any worse.—I am, etc.,

London, W., Aug. 23rd. F. PARKES WEBER.

SIR,—We were interested in the suggestion of Dr. Davies-Jones (August 20th) that our case of priapism might have a psychological cause. While admitting, however, that our knowledge of the workings of the mind is sadly lacking, we think the fact that the priapism lasted fifty days and was unaffected by deep anaesthesia tends to rule out a psychological cause and to support a theory mentioned by Riches (*Journ. Urol.*, 1930, ii) that the cause is a thrombosis of the veins draining the corpora cavernosa. Our patient was, moreover, quite a sane, placid, and contented individual, in no way suggesting other than an organic basis for the condition.—We are, etc.,

F. P. FORREST.
Exeter, Aug. 21st. G. H. A. GRAETZ.

COMPLICATIONS OF HOOKWORM DISEASE

SIR,—Two conditions, apparently resulting from hookworm infection, have occurred in my practice with sufficient frequency to merit attention, though they are not usually recorded in the textbooks. The one condition is a polyarthritis with high fever and a general resemblance to acute rheumatism. The other is a tendency to haemorrhage from the smaller arteries and capillaries.

Of the first condition a typical case was that of a half-caste girl, 19 years of age, whose sudden onset of fever, pains, and polyarthritis suggested rheumatic fever or gonorrhoeal rheumatism. Sweating was not pronounced, the condition did not improve with salicylates, and there was no evidence of gonorrhoea. Resolution of all symptoms suggestive of rheumatic fever promptly followed the expulsion of the hookworms with which she was heavily infected.

During the last eight years I have met the condition perhaps twice a year. In Fiji acute rheumatism is not uncommon. Chorea is, I think, rare. The only three cases of chorea seen by me in the last two years have been severely infected with hookworm, although hookworm infection is not heavy in this district. I surmise, therefore, that marked hookworm infection is a potent predisposing cause of chorea. It appears also that heavy hookworm infection can cause a condition closely resembling rheumatic fever.

The second condition, the tendency to undue haemorrhage from small arteries and capillaries, has seemed to me of great importance in some surgical, gynaecological, and obstetric cases. In at least one case of slight but obstinate menorrhagia much gynaecological treatment was unavailing, but complete relief ensued on expulsion of hookworms, which had been insufficient to cause a clinically noticeable anaemia.—I am, etc.,

Fiji, July 2nd. P. HARPER, M.D.

COLLES'S FRACTURE

SIR,—With reference to the paper on Colles's fractures by Mr. Harry Platt, in the *Journal* of August 13th, we beg to make the following observations.

1. *The Reduction of Colles's Fractures under Local Anaesthesia*:—In an article published by us in the *Lancet* of July 25th we drew attention to the advantages of local anaesthesia, and also mentioned the fact that its advantages are not made use of in the large teaching hospitals. It is especially useful to practitioners who can reduce fractures single-handed. We agree with Mr. Platt that it is wiser and easier to use this method in cases where the fracture is seen within a day or so after the injury.

2. *Reduction under Nitrous Oxide*.—On this point we disagree with Mr. Platt, as we are of the opinion that Colles's fractures should never be reduced under NO_2, because in the majority of cases it is impossible to obtain the necessary muscular relaxation so essential for correct reduction of the fracture.

3. *Fixation and Splinting*.—The author states that he prefers to use a plaster splint with the hand in slight flexion and adduction, as in this position the displacement is less likely to recur either immediately or about the third week, when it may be detected by the diligent masseuse. This tendency in some of these fractures to displace

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