

leaves the facts to speak for themselves without suggesting any obvious explanation. One line of future investigation concerns the problem of the "migratory" parents—that is, those who have lived for less than a year in the borough. Certain preliminary figures suggest that the infant mortality rate for such a group is very much higher than for those members of the local population of more than a year's residence.

CORRESPONDENCE

Bronchiectasis

SIR,—In your issue of October 7th (p. 639) Drs. F. C. Roles and G. S. Todd have summarized the results of treatment of 106 cases of bronchiectasis at the Brompton Hospital.

The authors state that "the treatment of bronchiectasis by artificial pneumothorax has now been almost completely abandoned at the Brompton Hospital." As a member of the staff of this hospital I should like to dissociate myself from this opinion. In my experience an artificial pneumothorax, if performed sufficiently early, so that the lung can be adequately collapsed, can cure bronchiectasis, no sputum returning after the lung has been allowed to re-expand. In my experience also, even in long-standing cases, an artificial pneumothorax can completely relieve the patient of his symptoms in certain instances. The difficulty lies in seeing the patients in the early stages. I have further seen a case in which lipiodol injection after collapse by artificial pneumothorax indicated that the bronchiectatic cavity was obliterated, which differs from the opinion expressed by Drs. Roles and Todd that, "with the most complete collapse, the cavities are still invariably present," as shown by lipiodol injection.

Although the authors are enthusiastic about lobectomy as the "goal to be aimed at" in the treatment of bronchiectasis, the figures they quote are arresting: 40 per cent. of the patients treated by lobectomy died, presumably as the result of the operation. If the figures in Table II are analysed to show the mortality rate of the different forms of treatment the results are: lobectomy, 40 per cent.; artificial pneumothorax, 23 per cent.; medical treatment, 47 per cent. Of the 40 per cent. who died after lobectomy it can be assumed that one-half would have survived if they had been treated by medical means alone, in view of the fact that only 47 per cent. of the patients treated medically died.

They draw conclusions as regards the results of treatment by artificial pneumothorax which do not agree with the figures given in their Table II. Thus in Table II they state that of thirteen cases treated by artificial pneumothorax four patients are well and three died. In the text of their article the authors state that three are well and seven died.

It is difficult to understand why the authors consider that the cases which recovered with artificial pneumothorax treatment were "exceptional." The series of cases quoted is, of course, too small to give any real indication of the value of artificial pneumothorax or of lobectomy, but on the evidence given, from which alone the conclusions in the article can fairly be drawn, the results of lobectomy are worse than those of artificial pneumothorax.

While no one with experience of the operation will deny that brilliant results are obtained in certain cases specially selected for lobectomy, and while the technique of the operation is rapidly improving, it should only be advised in those cases in which a satisfactory collapse by artificial pneumothorax is not possible. Far from

lobectomy being the "goal" aimed at in the treatment of bronchiectasis, the ideal should be that no patient should be allowed to reach the stage in which a lobectomy is required. This implies early diagnosis and early treatment by artificial pneumothorax.—I am, etc.,

London, W.1, Oct. 9th.

G. E. BEAUMONT.

SIR,—The paper on bronchiectasis by Drs. F. C. Roles and G. S. Todd in your issue of October 7th gives one something to think about.

Like most clinical tuberculosis officers, I am constantly meeting with cases of bronchiectasis, mainly in children. The types are: (1) the congenital and atelectatic; (2) those following whooping-cough; (3) those following pleuro- and broncho-pneumonias, whether diplococcal or streptococcal; and (4) the putrid, which are usually associated with fuso-spirochaetal infection, often follow mouth operations, and are difficult to distinguish from abscesses. Indeed, the lines dividing septic bronchitis, bronchiolectasis, bronchiectasis, and pulmonary abscess cannot be drawn very sharply, and the most important factor would appear to be the type of organism present, pneumococcal cases doing far better than those in which streptococci, pneumobacilli, moulds, fusiforms, and spirochaetes are present.

My impression has been that, with efficient and persevering postural drainage, the great majority of the mild bronchiectases of children belonging to types (2) and (3) above clear up before adult life is reached. Have I been deceiving myself? Providing no contraindication is present, I put my foot on a chair and invert my patients across my knee over a bowl or basin. The immediate result is usually excellent. I tell my patients or their parents that if this is done morning, noon, and night, before meals, the symptoms will probably disappear by the time adult life is reached. Have I been misleading them, and should I try to get them all admitted to Brompton or Victoria Park for lobectomy?

At the Toronto Children's Hospital we saw in 1930 "bronchiectasis beds," tilted at an angle of 30 or 35 degrees, each with an open panel through which the bronchial discharge drained into a vessel. The patients were slung, head downwards and face downwards, on these beds. Are these conservative methods useless? What of the bronchoscope? What of arsenicals for moulds and fuso— But perhaps I had better stop. There are two things one must not mention in this country to-day—fuso-spirochaetes and B.C.G.—I am, etc.,

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Council.

Buxton, Oct. 7th.

Rupture of Uterus after Version

SIR,—Mr. McCullagh (*British Medical Journal*, October 7th) considers that there is a danger of rupture of the uterus during labour following the correction of a breech with extended legs by external version during the antenatal period, the legs remaining in the extended position. He quotes four cases which I referred to (*British Medical Journal*, July 1st, 1933) in support of his contention. These cases, as explained by the context, were multiparae with previously normal histories, who had transverse presentations and were dealt with by *internal version late in labour*. The rupture of the uterus was produced by the operator.

The point he has raised is a most interesting one, but my cases have no bearing on the matter.—I am, etc.,

E. FARQUHAR MURRAY, M.D.,

Newcastle-on-Tyne, Oct. 9th. F.R.C.S., F.C.O.G.