



superior technique compared to the established practise of employing glass capillary tubes.¹

Among immediate advantages we see are the ready availability of disposable Mantoux syringes and their needles, their acceptably low cost, and their sterility. Used with care, puncturing vesicles causes no discomfort and less fluid oozes out around the fine shaft of the needle than around the thicker, blunter capillary tube. Furthermore, reasonably delicate and controllable suction is afforded by this fine bore syringe which permits more complete evacuation of fluid from the vesicle—a factor of some importance when vesicles are scanty and poorly filled.

Once evacuation of the vesicles is complete certain potential difficulties arise in transporting the filled syringe to the laboratory. Firstly, the needle, which should not be removed as it usually contains useful additional fluid, has the potential to cause accidental trauma. This can be overcome by replacing the original plastic sheath over the needle and affixing it to the nozzle end of the syringe by binding with adhesive tape—an action which also prevents leakage. Secondly, the withdrawn piston can be inadvertently pushed back into the syringe barrel; here again, adhesive tape can bind the piston to the barrel thereby preventing this possibility. A useful tip is to leave a free inch or so of the adhesive tape at both sites of application as this aids removal of the tape and affords a site for labelling the specimen. Finally, a suitable container for transportation is desirable. This initially proved difficult but we fortuitously found a box with sliding lid (rather like an old-fashioned pencil box in miniature) which proved ideal.

In the virology laboratory our technicians have found the Mantoux syringe/needle assembly easy to handle and prefer it to capillary tubes both for routine and electron-microscopic examinations. We also have a strong suspicion that a higher yield of virus particles is obtained by the syringe, and our best electron-microscopy results have occurred when this technique has been employed.

We feel this method can be recommended to others involved in similar work. It can, at least, provide a practical method of collecting vesicle fluid if a traditional collection kit is unavailable. Furthermore, anyone inexperienced in using capillary tubes for this purpose will probably obtain a greater amount of vesicle fluid using the disposable Mantoux syringe.

Finally, the method described does not do away with the desirability of collecting smears on glass slides or scabs from patients with suspected variola and, should the Mantoux syringe/needle assembly require to be sent by post, the packing would of course

have to meet the statutory regulations.—We are, etc.,

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¹ Department of Health and Social Security,
Scottish Home and Health Department.
Diagnosis of Smallpox: Medical Memorandum,
London, H.M.S.O., 1969.

Ortho-Novin

SIR,—The article by Dr. L. Poller and others (11 December 1971, p. 648), entitled "Oestrogen/Progesterone Oral Contraception and Blood Clotting: A Long-term Follow-up," refers to Ortho-Novin. I would like to draw your attention to the fact that this was Ortho-Novin 2 mg and not the currently available Ortho-Novin 1/50. Ortho-Novin 2 mg contains 2 mg norethisterone and 100 µg of mestranol.—I am, etc.,

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Knee Presentation

SIR,—Knee is a rare variety of breech presentation¹ associated with pelvic malformation² and extension of the other thigh.³ In view of pelvic malformation it is not always possible to pull a foot down and allow a spontaneous breech delivery as advised by Baird.¹ I wish to report a case so that the management may help others who encounter this condition.

The patient was a 22-year-old primigravida, 5 ft (1.5 m) in height. She had been booked for confinement in a general practitioner maternity unit. The pregnancy was uneventful and the patient went into labour spontaneously 14 days past her expected date of confinement. At this time it was thought that the fetal head was engaged in the pelvis and vaginal examination was not performed until the patient had been in labour 14 hours.

This examination found the cervix to be fully dilated and a buttock almost at the introitus. As the unit was not equipped for this type of case, the help of the obstetric flying squad was sought. The patient had been in the second stage of labour for two hours when the squad arrived and she was reassessed. The left knee was found to be

the presenting part at the introitus, the left foot was also in the pelvis, but the buttocks were held up above the pelvic brim. The pelvis was obviously contracted and once the left foot had been brought down, so that the thigh filled the pelvic brim, the patient was sedated by intravenous cyclo-morphine, and transferred by ambulance the 12 miles to the main unit where a live male infant weighing 2915 grammes was delivered by lower segment caesarean section. The second stage of labour had been three hours by this time. Postoperatively the patient was pyrexial, though a high vaginal swab was sterile, and the pyrexia responded to a course of ampicillin. Subsequent lateral radiographic pelvimetry showed the antero-posterior diameter of the pelvic inlet to be nine centimetres.—I am, etc.,

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- ¹ Baird, D., ed., *Combined Textbook of Obstetrics and Gynaecology*, 8th edn., pp. 435 and 466. London, Livingstone, 1969.
- ² Chassar Moir, J., ed., *Munro Kerr's Operative Obstetrics*, 6th edn., p. 169, London, Bailliere, Tindall and Cox, 1956.
- ³ Clyne, D. G. W., *A Textbook of Gynaecology and Obstetrics*, p. 660, London, Longmans, 1963.

Irritable Hip in the Adult

SIR,—Transient arthritis in the hip is an established clinical entity in the child. Otherwise known as observation hip, transitory synovitis, fugitive or ephemeral coxitis, the diagnosis is made by exclusion of other painful joint conditions.¹

The condition was initially described in 1912² and has been repeatedly described with a variety of suggestions as to its aetiology.^{3,4} Whether the cause is in fact traumatic, infective, allergic, or toxic it is a constant feature that haematological and serum investigations, with the exception of an occasionally raised E.S.R., are unrevealing and radiology in the acute stage shows no abnormalities. Furthermore, the condition is always short-lived, presenting as pain in the hip exacerbated by movement in any direction and after settling with a few days' bed rest there is no short-term residual defect. Initially, bacterial arthritis of the hip was considered a disease limited to childhood^{5,6} but it is now generally accepted that adults are similarly affected,⁷ the diagnosis being made by prolonged symptoms and signs affecting one or more joints and with a positive bacterial culture.

From our observations of two cases we suggest that transitory arthritis in the hip, like bacterial arthritis, is not limited to childhood. A search of the English language literature has not revealed a similar suggestion.

Two women who presented with similar features, were admitted at different times to the accident and trauma unit of the University Hospital of Wales.

The first was a woman aged 55 years with no previous history of major illnesses and no chronic medical condition. She was admitted complaining of severe discomfort in the right hip exacerbated by movement. She pointed to an area 1 in (2.5 cm) proximal to the greater trochanter as the site of maximum pain, and described its gradual onset over twelve hours. General examination revealed no underlying defect. The hip was flexed to 30°, in 0° abduction/adduction and 0° rotation. In-