in the left ear. She became delirious and had difficulty in breathing. When seen at 1.30 p.m. the acute attack was rapidly diminishing and the patient was relatively coherent, so the foregoing history was obtainable. Examination showed typical urticarial weals all over the body, but particularly on the neck and the flexor surfaces of the arms. The face was very swollen in both infraorbital regions, and the eyelids oedematous and almost closed. The deafness was quite severe and it was necessary to shout.

A diagnosis of penicillin sensitivity was made, and in view of the severity of the symptoms a medical colleague was called in consultation, when "benadryl," 50 mg. four-hourly, was prescribed. By evening the patient was much brighter, eyelids less swollen, and skin eruptions reduced; the dyspnoea, presumably due to oedema of the glottis, and the deafness, due to catarrhal blocking of the eustachian tube, were still present. All symptoms, however, had gone by the second post-operative day. At no time was there the slightest pain, swelling, or any other ill effect in the operative area. It was subsequently discovered that the patient's family physician had noticed that any injections which he had had to give her from time to time always left a red weal at the site of the injection, but she had not thought it important enough to mention.

Aseptic precautions were observed throughout, and the penicillin used was the crystalline variety put up by one of the best-known firms. The local anaesthetic has been used for some considerable time and has never produced any reactions, and, in any case, in my experience a hypersensitivity to local anaesthetics or their adrenaline content usually produces its reaction in less than five minutes after injection. No such condition was encountered in this case, and it is felt that it is a true hypersensitivity to penicillin. I am grateful to Dr. Norman Jackson for his help in confirming the diagnosis and treatment.

—I am, etc.,

Dublin. ADRIAN COWAN.

Physiotherapy

SIR,—The Council of the Chartered Society of Physiotherapy has read with great interest the annotation on physiotherapy (Dec. 25, 1948, p. 1114). The Society welcomes the support of your *Journal* in stressing the importance of strict adherence by chartered physiotherapists to their ethical by-laws and also in reminding the medical profession of the assistance they can and should give in this matter.

The Council feels that an amplification of one aspect of the annotation might be helpful, as some members of the medical profession may not have been aware of the Society's intention in introducing a question into the final examination which can be construed as requiring physiotherapists to "prescribe" treatment. Candidates are required to demonstrate methods of treatment which may be applied in certain conditions, and the purpose of the question in this form is merely to give candidates the opportunity of demonstrating methods of treatment which they are accustomed to using.

The medical profession can be assured of the desire on the part of the Chartered Society to secure that closer co-ordination of medicine and physiotherapy to which the writer of the annotation refers, and it is hoped that concrete proposals will result from this suggestion.—I am, etc.,

W. S. C. COPEMAN,
Chairman of Council,
London, W.C.1. Chartered Society of Physiotherapy.

Continuing Streptococcal Disease

SIR,—I was very much interested in the leading article (Jan. 22, p. 144) under the heading of "Continuing Streptococcal Disease." I have for the past twenty years been engaged both clinically and experimentally on the subject of chronic streptococcal infection as a disease entity, and have described this condition as "the pre-rheumatic state" in various publications since 1932. I feel that this is in fact a better term than that of "post-streptococcal state" as postulated in the article in question.

There is one point which to my mind is important, and which does not appear to have received due attention—namely that those who have become victims of "continuing streptococcal disease" following upon acute streptococcal infection were already previously "streptococcus-prone," if one may use this term to denote a subnormal resistance to streptococcal infection, as a close examination of their previous medical and family history will show.

There is accumulating evidence to suggest that the "streptococcus-prone" individual has a constitutional and hereditary tendency as much as, if not more so than, the tuberculous subject. Recognition of the streptococcal subject in the early and pre-sensitization stages enables adequate protection to be given by careful immunotherapy from the disasters which are liable to follow upon sensitization by acute attack.—I am, etc.,

London, W.1. J. D. HINDLEY-SMITH.

Cough Fracture of Ribs

SIR,—The interesting papers on this subject in the *Journal* of Jan. 22 bring to notice a condition which, though no doubt rare, probably occurs far more frequently than is generally supposed. This is, in fact, Dr. Raymond C. Cohen's view (p. 133). The reason that the fracture is overlooked is that both radiologist and physician miss the ribs for the lungs. This fact and the suggestive symptom of something "giving," which was mentioned by Dr. J. W. Paulley and his colleagues (p. 135), were illustrated by a case seen recently.

A male chronic bronchitic, aged 59, felt something "go" in the back of his right chest at the end of a bout of coughing. Persistent pain was aggravated by breathing. It was intense for three weeks and bearable thereafter. I saw him four months after the onset: even then he dare not sneeze or blow his nose without "hugging his ribs." Apart from signs of bronchitis and emphysema he also exhibited exquisite tenderness over the sixth and seventh right ribs posteriorly. The first *x* ray taken soon after the onset of pain showed, though faintly, a fracture of the fourth right rib. A further picture taken four months later revealed also a break of the 6th, 7th, and 8th ribs. Full recovery followed control of the cough by codeine and of the chest movement by strapping.

—I am, etc.,

London, W.1. A. H. DOUTHWAITE.

Cough Fracture in Late Pregnancy

SIR,—I was most interested in the article by Drs. J. W. Paulley, D. H. Lees, and A. C. Pearson on the above subject (Jan. 22, p. 135), as it brought to mind a case of mine about twenty years ago when I was in practice near Liverpool. As I have no notes on the case I must rely on memory.

A multipara (one), in her late twenties, had engaged me for her confinement, but at about the eighth month contracted whooping-cough, presumably from her own child, who was suffering from the same complaint. I was called to her in the early hours of the morning, to find her complaining of severe pain in the left side of the chest following a bout of coughing when in bed. I found that two ribs were fractured (? eighth and ninth), but the patient was emphatic that the two did not fracture at the same time, but that she felt the second one crack with a subsequent bout of coughing about twenty minutes after the first. I had her admitted to Walton Hospital, where she made an uneventful recovery and had, I believe, a normal delivery at full term. Her history previous to this was good, and she had no chronic chest condition. I attended her and her family for several years after this, but she never complained of her old injury or had any pulmonary complications.

—I am, etc.,

Menai Bridge, Anglesey. F. A. EVANS.

Dystocia after Amputation of Cervix

SIR,—I read Mr. Walter Calvert's memorandum on dystocia after amputation of the cervix with very great interest. As an obstetric house-surgeon I had a case which has taught me to treat pregnancy following colporrhaphy with very great respect. I cannot give full details now as the records are no longer available to me, but here are the main facts for what they are worth.

In the early afternoon a woman aged about 40 was admitted in advanced first stage of labour on account of a transverse lie. On examination the membranes were found ruptured, the cervix half dilated and rather tense, and the right shoulder presenting. The consultant obstetrician was immediately summoned, and an internal version was performed by him under deep anaesthesia. I was instructed to ease the labour with pethidine and to conduct the delivery personally. Three or four hours later the breech reached the perineum, and all went well until the shoulder-blades appeared, when progress ceased.

On examination, a thin, tight, unyielding rim of "cervix" was found to be gripping the baby just below the shoulders and both arms were extended. Rotating the body made it possible to draw down one arm, but the other remained out of reach despite this manœuvre. Realizing that every second counted now, increasing