previous to the onset of his psychosis, and so it is felt that this drug had no aetiological significance in the precipitation or causation of the condition. The patient's total reaction did not resemble that of a toxic confusional state, but had all the characteristics of a manic-depressive reaction type, manic phase. During his stay at the mental hospital he received only one dose of atropine sulphate a day—1/200 grain, hypodermically.—I am, etc.,

RALPH T. COLLINS, M.D.

Jordanburn Nerve Hospital and
Psychological Institute, Edinburgh. June 22.

Liver Atrophy

SIR,—I was very interested to read the report of a case of liver atrophy by Drs. W. M. Millar and Jack Park in the *Journal* of June 24 (p. 1284), as it confirms the conclusions I reached in writing an M.D. thesis on acute yellow atrophy of the liver.

These conclusions were:

1. That liver atrophy is an ultimate product of a metabolic disturbance which may arise under a variety of different circumstances and be due to several aetiological factors.
2. That one of the most important causative factors common to the majority of cases is deprivation of food and fluid, often by vomiting. When this is present the effect of any potential liver cell poison is enhanced, hence the grave effects after even small doses of such agents as chloroform.
3. That in the treatment and prophylaxis of liver atrophy the early use of glucose and fluids, especially intravenously, is of paramount importance.

In the case referred to above vomiting and presumably a prolonged period on low diet seem to have been a feature, though its importance has escaped emphasis. The prompt and vigorous treatment with intravenous fluids and glucose in this case undoubtedly saved the patient's life and prevented the appearance of the grave nervous symptoms associated with acute liver necrosis. While agreeing with Drs. Millar and Park's suggestion that the anaesthetic be chosen with care in any operation on a morphine addict, I would further suggest that preoperative intravenous glucose would be a valuable prophylactic measure whatever the anaesthetic, and especially in those cases where diet has previously been low and vomiting has occurred.

Finally, though I am not questioning the diagnosis in this case, may I point out that the presence of amino-acids and cholesterol in the urine is not conclusive evidence of liver destruction. These substances can and do occur in the urine in other conditions besides liver atrophy, and are often absent even in fatal cases of acute yellow atrophy, though their presence does suggest impairment of liver function.—I am, etc.,

ERIC TOWNSEND, M.D., D.P.H.Ed.

Bournemouth, June 25.

Pelvic Disproportion

SIR,—In reply to Mr. Norman Reece (*British Medical Journal*, June 24, p. 1304) I should like to point out that he has misquoted the biparietal diameter. In my letter (June 10, p. 1202) he will see that by *x*-ray measurement this diameter was 3.3 inches approximately and not 3.65 inches as he has stated. I should like further to support Professor J. M. Munro Kerr (June 24, p. 1303) in his stand for "trial of labour" by citing yet another case of pelvic disproportion with which I had to deal shortly after the one reported in your columns. It is interesting if only on account of the patient's age.

A primigravida, single, aged 47, had the following external measurements: interspinous 10½ inches, intercristal 11 inches, external conjugate 7½ inches. Her height was 4 feet 8 inches. There was considerable uncertainty about her dates. On May 11 I examined her under an anaesthetic. The head was floating and I could not make it fix in the brim. The diagonal conjugate was 4 inches and the whole of the pelvic brim could be easily felt. The ischial spines were prominent and the sacro-spinous ligaments in length equalled the breadth of two fingers. I decided to enlist the help of a radiological colleague. Stereoscopic pelvimetry was done on May 20, with the following report: "Position of head: L.O.A. flexion poor, free, suboccipito-bregmatic 3¾ inches. True conjugate 3¼ inches, transverse 5 inches, obliques 4 inches, interischial 4 inches. Sacrum rather forward. Description of pelvis: small android pelvis. Forecast of labour: Caesarean section elective." Again I decided to allow labour to start of its own accord. On May 31 the membranes ruptured spontaneously and pains started shortly after. An hour later the head was fixed in the brim and normal delivery of a 7 lb. 4 oz. baby was completed five and a quarter hours after the onset of labour.

I can only agree with Mr. Reece when he says that the outcome of labour in these cases is a clinical problem. No matter how arithmetically accurate a radiologist may be, he cannot foretell or assess what the power of the uterus, the degree of moulding and flexion will be in labour.—I am, etc.,

London, W.1, June 26. W. C. W. NIXON.

SIR,—Professor J. M. Munro Kerr's contribution to this discussion is unfortunately important, because his word rightly carries so much weight.

For me his letter (*Journal*, June 24, p. 1303) destroys only a dummy which has been lying flat for some years, and at which I, too, have done some target practice. His search of the literature is bound to be in vain, for there is no "body of obstetricians" in any country as yet who have performed a series of inductions based on cephalometry. The discredited work in this and other countries was based first on clinical findings alone, and later in some cases on clinical findings plus pelvimetry. Further, the method of induction was mainly by tube, bougie, etc., which are, or should be, now entirely displaced by rupture of membranes.

Induction not based on cephalometry is utterly unjustifiable. The object of induction is to be sure of a plastic head of slightly reduced size. Cephalometry offers the only certainty. I have evidence that such controlled series are now being carried out, and I believe that the "tenacity" in this cause will triumph over hitherto justified conservatism. Is not Professor Munro Kerr fighting to capture a position from which all but a few have retreated? I ask only for a fair trial of a new procedure, and am willing to be routed if the results do not justify the method.—I am, etc.,

Bexhill-on-Sea, June 24. L. NORMAN REECE.

Curability of Cancer

SIR,—In your issue of June 24 (p. 1301) no less an authority than Dr. J. Ralston Paterson is quoted as having said that there were only four "curable" types of cancer—of the breast, mouth and lip, skin, and uterus. Surely carcinoma of the rectum satisfies all the criteria of "curability" propounded by Dr. Paterson? It is diagnosed with fair ease in its early stages, and adequate treatment—though the indications for radiotherapy are almost *nil*—offers a reasonable expectation of cure. I think also that the colon should be included in the list, though its ease of diagnosis is more open to question.—I am, etc.,

London, N.6, June 24. R. L. BENISON.

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