(medical and surgical) treated in that time there were 41 cases of proved peptic ulceration and 7 of carcinoma of the stomach, most of these latter arising in an ulcer. It is true that these are few, but this year the numbers admitted for peptic ulceration have increased markedly. The type of patient in whom it occurs is still the same, mostly of the peasant class, though more of the "chief" class and clerks are being seen. I am not sure yet whether the incidence is rising, or whether successful treatment encourages others to come.

Most of the ulcer patients come from tribes who make a habit of indulging in one vast meal at the end of the day, and take practically no food the rest of the day. A good many of them are steady pipe-smokers and many are of the highly strung type. The 48 cases are too few to be significant, but they are proved cases of peptic ulceration and carcinoma of the stomach. It is said that 10% of the British population suffer from peptic ulcer, but in East Africa it would be difficult as yet to assess the figure. The numbers passing through our hands so far do not suggest anything approaching this high figure, but we have not got a practitioner in every village. However, it was interesting to find that even in this very short series the ratios of duodenal ulcer to gastric ulcer, and the sex incidence, are almost identical with the average of the United Kingdom.—I am, etc.,

Kampala, Uganda. C. J. S. SERGEL.

Cardiac Arrest During Operation

SIR,—The authors of "Acute Circulatory Failure During Surgical Operations" (September 6, p. 533) rightly emphasize the difference between cardiac arrest due to anaesthetic hazards, such as asphyxia and chloroform poisoning, and heart failure due to surgical hazards such as blood loss and traumatic shock. The cardinal feature of the latter group is lack of venous return to the heart, and the futility of treatment by cardiac massage is brought home to the surgeon who palpates the heart in these cases. The heart is a flabby empty bag which is in urgent need of blood both to stimulate it to beat and to nourish it. Alexander and Hewer in their medical memorandum on "A Treatment of Cardiac Arrest" (September 6, p. 546) touch on the vital factor—namely, the need of the heart for a volume of fluid—and suggest the intraventricular injection of saline as a first line of treatment. A recent experience suggested another way of rapidly restoring the circulating blood volume. Esmarch's rubber bandages are rapidly applied in tight overlapping spiral turns from the toes to the groins of both lower limbs. In this way a considerable volume of blood and lymph is transferred in a very short time to where it is urgently needed.

Case History.—Mrs. C. B., aged 74, admitted with fracture of the neck of the femur. A Smith-Petersen nail was inserted under a low spinal analgesic. During the later stages of the operation she became restless, with sighing respirations, and, while the nail was being driven home, the anaesthetist reported cardiac arrest. Artificial respiration with oxygen and intracardiac injection were tried unsuccessfully. Cardiac massage was resorted to, and two fingers were inserted through an opening in the diaphrgam. The heart was felt to be empty and lifeless and did not respond to massage. As a last resort Esmarch's bandages were wound tightly from toes to groins and then further tightened to occlude all circulation in the lower limbs. Almost at once the heart began to beat strongly. After a rapid infusion of fluid into an arm the bandage tourniquets were removed at intervals and the patient returned to the ward. The pulse remained good until the patient died in cerebral coma 12 hours later.

No originality is claimed for this modification of an ancient method of treating shock, but I do not know if it has been tried before in cardiac arrest under anaesthesia. I am sure this patient would have survived if I had tried exsanguination of the limbs first instead of fussing about with injections. It is not my intention to advocate a trial of this treatment in all cases, but only where there is reason to believe that there is a failure of venous return. Even in these cases there should be no delay in preparing for cardiac massage.—I am, etc.,

Winford, nr. Bristol. A. W. FOWLER.

Sensitivity to Streptomycin and P.A.S.

SIR,—Surgeon-Lieutenant D. G. Julian (August 30, p. 476) described a case, claimed to be the first reported, of simultaneously acquired sensitivity to streptomycin and to sodium P.A.S. in a patient suffering from pulmonary tuberculosis. The following is a report of a case of simultaneously acquired sensitivity to streptomycin and to P.A.S. in a patient suffering from renal tuberculosis.

A man aged 34 years, suffering from unilateral renal tuberculosis, was admitted to hospital in May, 1952. Prior to a nephrectomy, a preliminary course of streptomycin, 1 g. daily, and P.A.S., 20 g. daily in four doses, was commenced on July 15, 1952.

On August 15 he developed symptoms of shivering, headache, and generalized aching, suggestive of impending influenza, although the temperature remained within normal limits. On August 19 he developed an erythematous rash on the legs; the temperature averaged 100° F. (37.8° C.) and the pulse rate 120 per minute. By the following day the rash had extended to cover the whole body and was extremely itchy. Chemotherapy was discontinued and "benadryl," 100 mg. twice daily, commenced. By August 22 the symptoms had subsided.

In order to determine to which of the agents he had become sensitive it was decided to withhold the benadryl and use one drug only. The patient was sure that streptomycin had been the cause, and in the absence of a better reason it was decided to try P.A.S. first. Shortly after he had received the second dose an itchy erythema appeared again on the legs and he complained of intense headache. No further P.A.S. was given and benadryl was recommenced. The symptoms had subsided completely by the next day (August 23). Benadryl was continued, and on August 24 P.A.S. was restarted in half-strength doses. After the third dose the erythema and headache returned.

The patient had now changed his mind as to the cause of his symptoms. However, he was a little apprehensive, so on September 8 he was given 1 ml. of sterile water, under the impression that it was streptomycin. On September 9, at 10 a.m., he was given streptomycin 1 g. By 5 p.m. the itchy erythema was again present on the legs and the head ached. On September 10 10% of the total white cell count of 6,400 per c.mm. were eosinophils.

There is no question of accumulation of the drugs in the body due to impaired renal function, as all the subsequent reactions occurred on the first days of the test doses. The blood urea estimations were normal before, during, and subsequent to the sensitivity reactions. It is noteworthy that the patient had not expected a reaction from the first trial of P.A.S. and that his slight apprehension of a trial of streptomycin had been completely allayed after the first day when sterile water had been substituted.

The conclusion is that sensitivity reactions to streptomycin and P.A.S. may be identical and that in this case the occurrence of a state of sensitization to both drugs developed simultaneously.

I wish to express thanks to Mr. W. M. Borthwick for his help and criticism and to Dr. M. A. Foulis, physician-superintendent, Robroyston Hospital, Glasgow, for his permission to publish this case.—I am, etc.,

Millerston, Glasgow, E.1. PETER MACPHERSON.

E.C.T. for Prolonged Stupor

SIR,—Dr. P. H. Mitchell's interesting article (September 6, p. 535) shows the need for further investigation of the causes and treatment of cases of stupor. Some of these cases can be fatal within a short time, and it is not generally realized that early and energetic treatment can often effect an early recovery. It may be beneficial to carry out a preliminary diagnostic test. The intravenous injection of about 0.3 g. of sodium amytal in a 2.5% solution will often enable a patient to speak to the psychiatrist. Sometimes a patient talks quite rationally and asks if the doctor thinks he can cure him, while at other times the patient refers to his delusions and appears to be mentally deteriorated. Twenty per cent. of carbon dioxide in oxygen has also enabled a man who has been stuporous for some months to speak rationally for 20 minutes. Fasting blood sugar should also be estimated to exclude hyperinsulinism.

Professor Lopez Ibor at the World Congress of Psychiatry in Paris, 1950, in summing up the indications for the various

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physiological treatments (*Proceedings*, **4**, 90), mentions that convulsive therapy offers the sole possibility of saving severe cases and that insulin coma can be very dangerous in severe instances of catatonic stupor. He emphasizes, however, the need for giving E.C.T. either two or three times for the first two days or at least once daily for several days. The following is a fuller account of a case which I published in 1948 (*Proc. roy. Soc. Med.*, **41**, 575).

A married woman, aged 51 and menopausal, was first seen on May 13, 1947, with a history that for five months she had become silent and depressed. She had talked about suicide, and razor blades were found secreted in her bed. She had suffered previously from mild rheumatoid arthritis. Her blood pressure had gone up from 165/95 to 190/120. She had been given two electrical treatments by another doctor and seemed a little better after each one of them. She was, however, sent to a dietetic home for some weeks and there developed delusions.

On examination the patient was very silent and in a state of terror. She whispered that she heard voices of people who were threatening her. When seen some hours later she was in a state of stupor and waxy flexibility, in which she remained. Next day she made a determined attempt, in a state of catatonic excitement, to throw herself from a window in response to voices. The patient then became quite inaccessible. She had 23 treatments with electronarcosis, 12 of which were on successive days. At the end of that time the patient had gradually become more accessible. Her attitude when she came out of the stupor was that she desired to discuss certain intimate problems relating to her emotional life which she believed were connected with the onset of her illness. The patient experienced great relief. She made a complete recovery and has been in perfect health ever since.

The interest of this case lies in the combination of the endocrine and psychogenic factors in its causation and also the combination of depressive and schizophrenic symptoms. The patient made little progress until the treatment was given every day. She states that she has had no memory disturbance since the treatment. This shows the advantage of using low-tension cerebral treatment which can be given every day without subsequent ill effect. It is easier for the patient if thiopentone and a curare-like drug are given before each treatment. If such therapy is given, a high proportion of stupors will clear up within a matter of weeks instead of years as in the case reported.—I am, etc.,

London, W.1. A. SPENCER PATERSON.

An Unusual Case

SIR,—The following case appears to me to be sufficiently remarkable to be recorded. On May 5, 1952, I was called to see a lady aged 73 years. She had a typical attack of hay-fever—nasal, pharyngeal, and upper respiratory. Antihistamine tablets were prescribed and gave prompt relief. She was a hay-fever subject, and was advised to take the tablets, up to one or two daily, when symptoms occurred. She was seen at three or four daily intervals until May 22, when she appeared to have a mild attack of influenza. After three days in bed she got up and was allowed out on May 28. On June 1 she had a rigor with a temperature of 102.6° F. (39.2° C.). She was given a penicillin injection on three consecutive days, by which time the temperature became normal. After about one week she was better, but kept upstairs for another week, after which she gradually got about and began to go out.

The symptoms of this attack were as follows: It commenced with an attack of yawning, soon followed by malaise, with pain and tenderness across the back of the shoulders and extending less severely down the spinal area to the sacrum, where it was more severe again; then the rigor came on, lasting for nearly an hour and with rapid rise of temperature; this was soon followed by nausea and vomiting. On examination the only physical signs were tenderness across the shoulders and along the costal margin, especially on the right side. Heart, lungs, urine, etc., were all normal. The symptoms subsided in about three days except the nausea, which persisted for over a week. A tentative diagnosis of cholecystitis was made. By June 19 the patient seemed well.

On June 27 another rigor occurred. Penicillin was given as before, and the temperature became normal in three days. The course of this attack was similar to the first, but, feeling puzzled, I called in a physician, who agreed with the tentative diagnosis of cholecystitis. On July 7, before an *x*-ray examination had been arranged, a third attack of rigor and illness exactly repeating the others occurred. No penicillin was given, and the attack pursued the same course as the others. On July 9 she was admitted to hospital, where she remained until July 28, during which time there were no signs or symptoms and all *x*-ray examinations and blood and urine tests were normal. She was discharged home as fit and she seemed well. On July 30 I saw her at 5 p.m. and she seemed quite well, but at 3 a.m. on July 31 she had another rigor and attack just like the former ones. On August 1 a pathological investigation showed the blood to be within normal limits and the urine suggested a possible pyelitis. On August 4 there was another similar rigor attack.

It occurred to me that on the occasion of each of these rigor attacks she had taken five or six hours previously one of the antihistamine tablets. When seen at 5 p.m. on July 30 she said she seemed well except for a slight running of the nose. During that evening she took one of the tablets and the rigor occurred at 3 a.m. On August 4 she took a tablet at 5 a.m. and had a rigor at 9 a.m. She seemed recovered in a few days and began to get up on August 8. On August 12, at 1 p.m., she seemed well and had no physical signs. In the afternoon she went out for a short walk and returned home to tea, and at 6 p.m. her sister advised her to go to bed and accompanied her upstairs. She sat in a chair and said she felt very tired and was therefore helped on to the bed, where she died in a few seconds.

Her sister is a recently retired ward sister from a London teaching hospital, and she confirmed and recorded the details of the attacks since the patient's return home from hospital. At a post-mortem examination there was marked bloodlessness and extensive ante-mortem thrombosis in the pulmonary arteries, and the lungs were dry. Nothing else abnormal was found except some old compression of the liver causing a thin edge to extend slightly below the costal margin. Special attention was given to gall-bladder, kidneys, adrenals, and inner surface of the colon, all of which were normal. The heart was rather feeble, not enlarged, and showed no valvular or coronary disease.—I am, etc.,

Worthing. W. O. PITT.

The Couvade

SIR,—This ancient custom may not so very long ago have been illustrated in various parts of this country, as that "very knowing, overflowing" practitioner, Mrs. Sairey Gamp, appears to me to have had at least one case of it in her own practice. She speaks of it very circumstantially towards the end of her historic quarrel with that other, but lesser, member of the nursing profession, Mrs. Betsy Prig. "I have know'd that sweetest and best of women," said Mrs. Gamp, shaking her head, and shedding tears, "ever since afore her first, which Mr. Harris who was dreadful timid, went and stopped his ears in an empty dog-kennel, and never took his hands away or come out once till he was showed the baby, wen, bein' took with fits, the doctor collared him and laid him on his back upon the airy stones, and she was told to ease her mind, his *'owls was organs. . . .*"

These last three words in italics (mine) make me think of the couvade. I have had in my own practice a case or two of the morning sickness in husbands and other common enough accompaniments of pregnancy in their wives—but that was so long ago as to give me the feeling of having been an accoucheur at the time of the unforgettable Sairey.—I am, etc.,

London, S.W.3. A. R. EATES.

A Case of Psittacosis

SIR,—In view of the recent article entitled "Psittacosis in a Family," by Drs. B. K. Ellenbogen and C. M. Miller (July 26, p. 189), I felt it would be interesting to put on record an isolated case of psittacosis, which occurred recently in general practice.

The patient, a barman aged 32, was first seen on July 21, when he complained of aching all over, shivering, and sweating, and had a temperature of over 103° F. (39.4° C.). There were no physical signs, and he was treated symptomatically at first. On July 22 blood was taken for agglutinations and smears for malaria parasites, all of which proved

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