drug addicts prompts us to report a case we have recently managed.

A 25-year-old methadone addict who had been injecting his femoral veins for the past year was admitted after inadvertently puncturing his left femoral artery (day 1). At the time of injection he noted severe shooting pain from groin to foot. During the course of the next three days he developed fever and a tender swelling in the left groin. On examination there was swelling and oedema of the left groin and thigh, with prominent psoas spasm. The distal pulses were normal and there was no oedema of the leg or foot. For four days the case was managed with ampicillin and flucloxacillin, but this failed to suppress the remittent pyrexia. Drainage of the infected haematoma was performed on day 7 and *Staphylococcus aureus* was cultured from wound swabs. The following afternoon there was a brisk haemorrhage from the wound and five units of blood had to be transfused. On day 10, while the wound pack was being removed in theatre, a profuse haemorrhage occurred. Exploration of the groin and thigh showed that a 3-cm length of femoral artery distal to the profunda femoris had sloughed; the venous system was intact. The superficial femoral artery had to be ligated 3 cm below the inguinal ligament and the patient was transfused with nine units of blood.

Subsequently his fever resolved by lysis. Circulation of the left leg and foot remained satisfactory, though the distal pulses did not reappear.

This case is reported in detail to draw attention to a further potentially fatal complication of "main-lining."

We wish to thank Professors M. D. Milne and H. Ellis for permission to report this case. —We are, etc.,

C. P. WILLOUGHBY
ELIZABETH EVANS
T. A. M. STOKER
ROGER GABRIEL

Westminster Hospital
London S.W.1

Longevity of Women G.P.s

SIR,—It is quite true that I did refer, in a slightly light-hearted way, to the relative longevity of male and female doctors, but my remarks were indeed based on actuarial evidence.

I would say, therefore, in reply to Dr. J. G. Denholm (14 April, p. 119) that no valid conclusions can be drawn from a study of obituaries in the *B.M.J.*; statistically, the figures are meaningless. The position has been succinctly summarized by Mr. Alistair Low, consultant actuarial adviser to the B.M.A. He has written (personal communication) with reference to the N.H.S. superannuation scheme: The argument has been put forward that female members' contributions to the scheme should be lower than those of male members. In fact, the extra cost in respect of male members arising from the automatic provision of widow's pensions is, broadly speaking, offset by the greater life expectancy of female members, whose own pensions are therefore substantially more expensive to provide than those of male members. No real case can be made, therefore, on financial grounds, for a reduction in female members' contribution rate below that of males."

It was in the light of this knowledge that my remarks in the General Medical Services Committee debate were made.—I am, etc.,

ROBERT A. KEABLE-ELLIOT

Ibstone, Bucks.

Secondary Postpartum Haemorrhage after Caesarean Section

SIR,—Secondary postpartum haemorrhage from dehiscence lower-segment caesarean section incisions is certainly not a common condition, but it is perhaps not so rare as the absence of references to previous reports in the article by Messrs. John Macvicar and R. M. Graham (7 April, p. 29) would imply. There have in fact been at least two earlier publications^{1,2} describing a total of six cases of this type. Two¹ of these six cases were successfully treated by packing the uterus alone. Of the other cases,² two were treated by supravaginal hysterectomy after severe haemorrhage had recurred after removal of uterine packs (in one instance 75 days after the original caesarean section), one by internal iliac artery ligation after packing the uterus had failed to control bleeding, and one by supravaginal hysterectomy as the initial procedure. Although packing the uterus usually controls haemorrhage in the first instance, there is evidently a high risk of recurrent bleeding after removal of the pack, and immediate hysterectomy as practised by your contributors is probably the safest procedure in these cases.

It is remarkable that a Shirodkar suture was in situ in one of my patients as well as in one of those described by Messrs. Macvicar and Graham. The odds against this being coincidental must be very high and in my view the association is more likely to be with uterine distension due to defective drainage than with infection. In this regard your contributors' assertion that drainage in their case was not impaired appears to be contradicted by their earlier statement that "the Shirodkar suture was removed . . . and obviously much blood and clot had been dammed back in the uterine cavity." Indeed, I would suggest that defective drainage could well have led to the infection they observed.—I am, etc.,

R. F. HEYS

Halifax General Hospital,
Halifax

¹ Hanford, D. P., and Weed, J. C., *Obstetrics and Gynecology*, 1953, 1, 317.

² Heys, R. F., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1963, 70, 647.

Fatal Paralytic Ileus Due to Strongyloidiasis

SIR,—We read with interest the report by Dr. J. B. Cookson and others on a fatal case of paralytic ileus due to strongyloidiasis (30 December, p. 771) and would like to report a similar case seen recently.

The patient, who was a 2-year-old boy, came from French West Africa six days before admission. For four weeks he had had diarrhoea, ankle swelling, and anorexia. His parents and two brothers were well. He was dehydrated and emaciated, with pitting oedema of both feet and a swollen, non-tender abdomen. There was no clinical evidence of ascites and no significant lymphadenopathy. Microscopical examination of the stools showed an exceptionally heavy infestation with strongyloides larvae and trichuris ova. No pathogenic organisms were isolated on culture.

After admission he started vomiting, his temperature fell to 35°C, and his blood sugar at that time was 33 mg/100 ml. His infestation was treated with intragastric thiabendazole and he was fed parenterally. His bowel sounds six days after admission were hyperactive, but the following day were absent. At the same time large amounts of fluid were aspirated from his nasogastric tube and his abdomen became grossly distended. A diagnosis of paralytic ileus was made. Soon after, his respiratory rate increased and there were signs of pneumonia at his right base. He was then started on cephalothin. A blood culture at that time grew klebsiella. His condition continued to deteriorate and the following day he had a cardiac arrest and attempts at resuscitation were unsuccessful.

Permission to make a postmortem examination was refused. The sudden onset of the patient's paralytic ileus, gross abdominal distension, and klebsiella septicaemia suggest the severe invasive form of strongyloidiasis.—We are, etc.,

J. D. FRENGLEY
P. N. TREWBY

St. George's Hospital,
London, S.W.17

Short-term Service Abroad

SIR,—I write in response to the intermittent correspondence appearing in your columns concerning medical practice in the Republic of South Africa.

I fear that British doctors contemplating short-term service in developing countries may be put off South Africa because of the apartheid question. In many ways the emerging homelands of the Transkei and Kwa-zulu (Zululand) are eminently suited for such service by English-speaking doctors. This is especially so for those with families, for in this land, unlike many in the "third world," law and order prevail. The medical needs of the Bantu population are great and present a fascinating challenge to those tackling the problems involved. In many places facilities have been established, but shortage of doctors threatens their closure. This is an acute problem in the Transkei at the moment.

Most hospitals in the homelands are mission-sponsored and government-financed. A medical officer is paid a salary of about £4,000 per annum. Housing is provided. The climate is sunny but not too hot for comfort. Beautiful countryside, interesting flora and fauna, and proximity to a totally different culture all add to the quality of life. The people are very friendly, with a good sense of humour. Language is not a serious problem as all trained nurses speak English well and can act as interpreters.

I appeal to those thinking of undertaking service abroad to consider South Africa. Surely sanctions of money or manpower can only retard the Africans in their development.—I am, etc.,

S. J. JENNINGS

Catherine Booth Hospital,
P.O. Posini,
Via Gingindlovu,
Zululand, R.S.A.