pleural aspirate showed only inflammatory cells, mainly lymphocytes. No malignant cells were seen. He had heavy albuminuria, and the urinary deposit showed many red blood cells with a few hyaline and granular casts. His serum electrolytes were normal, but his blood urea was 179 mg./100 ml., and his serum cholesterol 320/100 ml. The serum albumin/globulin ratio was reversed (albumin 2.2 g./100 ml., globulin 6.4 g./100 ml.), and electrophoresis showed the gammaglobulin fraction to be approximately twice the normal value. Leptospirosis, chemical poisoning, polyarteritis, Henoch-Schönlein purpura, brucellosis, and infectious mononucleosis were excluded. Sera collected 3 and 18 days after admission gave complement fixation titres respectively of 64 and 32 to mumps S (soluble) antigen and 1,024 and 2,048 to mumps V (viral) antigen. Mumps virus was isolated from a specimen of urine collected 17 days after admission.

Following the removal of 1,100 ml. pleural fluid his orthopnoea was completely relieved, but in the following three days he had three episodes of severe bronchospasm, in each case immediately relieved by aminophylline and frusemide intravenously. By the fifth day he was symptomless, and during the following 24 days his blood urea slowly fell to 82 mg./100 ml. and his bilirubin to 0.5 mg./100 ml. The pleural effusion did not recur, and his serial E.C.G.s remained unchanged. However, the oedema of his legs persisted; his urinary protein loss rose to 12 g. daily and the serum albumin fell to 1.4 g./100 ml. He was put on prednisone 20 mg. t.d.s., with a reduction in urinary protein loss to 1 g. within five days. Thirty days after admission he developed severe cellulitis with gross oedema of his right leg, which clinically responded to antibiotic therapy. Following this infection his renal function rapidly deteriorated, the blood urea rising to 250 mg./100 ml. and his serum potassium to 7.1 mEq/l. There were, however, no E.C.G. changes characteristic of hyperkalaemia. Despite all therapy his condition deteriorated over the following week and he died 48 days after admission.

This patient illustrates the generalized nature of virus infections, which may manifest themselves by affecting any organ or system either singly or in combination. Myocarditis is recognized as a possible manifestation of mumps infection,¹ and hepatitis is included in the list of sequelae compiled by Trimble.² Nephritis as a complication of mumps has been recognized since 1905,³ but virological confirmation⁴ awaited the development of adequate laboratory techniques. Four fatal cases have been described,^{5,6} and recently two non-fatal cases of nephritis following mumps infection have been recorded (23 December 1967, p. 721).⁷

Most of the cases of mumps nephritis previously described have occurred in children or young adults following parotitis. The case reported here is of special interest, as the infection occurred in a middle-aged patient who gave no history of parotitis or neck swelling. Though it is not possible to ascribe the original attack of hepatitis to mumps virus, the serological tests indicate that mumps infection had occurred some weeks prior to hospitalization. It is almost certain that mumps virus was the agent responsible for his final illness.—We are, etc.,

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REFERENCES

- McKendrick, G. D. W., in *Price's Textbook of the Practice of Medicine*, 10th edition, ed. Sir R. Rodley Scott. London, 1966.
- Trimble, G. X., *Canad. med. Ass. J.*, 1967, 97, 1171.

- Miller, J. A., *Med. News (N.Y.)*, 1905, 86, 585.
- Utz, J. P., Houk, V. N., and Alling, D. W., *New Engl. J. Med.*, 1964, 270, 1283.
- Dutta, P. C., *J. Obstet. Gynaec. Brit. Emp.*, 1935, 42, 869.
- Hughes, W. T., Steigman, A. J., and Delong, H. F., *Amer. J. Dis. Child.*, 1966, 111, 297.
- Masson, A., and Nickerson, G. H., *Canad. med. Ass. J.*, 1967, 97, 866.

Undressing the Patient

SIR,—Blood-pressure readings may be recorded both accurately and expeditiously by applying the cuff of the sphygmomanometer over such layers of clothes as will transmit a palpable arterial pulsation.—I am, etc.,

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Surgical Induction of Labour

SIR,—In your report of the 18th British Congress of Obstetrics and Gynaecology (10 August, p. 368) you state "Professor J. H. M. Pinkerton (Belfast) pointed out that 10% of surgical inductions of labour failed and caesarean section became necessary and did not involve any special risk."

We do not accept that caesarean section after failed induction carries no special risk, and since that Congress have shown that the figure of 10% can be greatly reduced by the routine use of intravenous synthetic oxytocin infusion at amniotomy. Our failure rate was 3.3% in the first 150 cases reported.¹ In the first six months of 1968 a further 184 cases have been induced in this way with only five failures—that is, 2.7%. The foetal and maternal morbidity have remained particularly low and similar to our initial report.

This method of induction of labour is now standard practice in this unit and in our view is the best available. As the figures show, there is a startling reduction in failures.—We are, etc.,

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REFERENCE

- Garud, M. A., and Simmons, S. C., *J. Obstet. Gynaec. Brit. Cwlth.*, 1968, 75, 702.

Primary Non-specific Ulcer of Ileum

SIR,—I was interested to read the report by Mr. M. J. Shah (24 August, p. 474). The following is an account of a similar but more chronic case, again presenting with rectal haemorrhage.

A white male initially presented at another hospital in 1961 (then aged 22 years) with melaena. Following transfusion he recovered and all investigations proved negative. He remained symptom-free until March 1968, when he presented here with further loss of clotted dark red blood. Apart from pallor and tachycardia there were no significant clinical features. Haemoglobin concentration was 4.6 g./100 ml. Again full investigation was negative and he responded to transfusion. While considering an advised laparotomy he was readmitted in June 1968 with further loss of dark red blood. The haemoglobin level on this occasion was 10.8 g./100 ml. Again he responded well after transfusion. At

elective laparotomy ten days later a narrowed, thickened segment of ileum, 1.5 cm. long, was discovered about 120 cm. from the ileo-caecal valve. Proximal to this the ileum was dilated for about 20 cm. Resection with anastomosis was performed.

Macroscopically the narrowed segment exhibited an ellipsoid ulcer 2 cm. x 1 cm. in size with its long axis lying transversely. There was surrounding induration and puckering of serosa. In the ulcer base were a few haemorrhagic spots. Macroscopically the lesion was a non-specific benign chronic ulcer. There was no evidence of any Meckel's diverticulum or ectopic gastric mucosa.

This case is different from Mr. Shah's in its chronicity. Both are unusual in that they presented purely with bleeding. From the reports quoted by Mr. Shah only two cases were recorded with a history longer than seven years, and all the chronic cases invariably presented primarily as perforation or obstruction, with or without episodes of melaena. It would seem that early laparotomy should be considered in unexplained cases of melaena, especially in the younger age groups.

I wish to acknowledge assistance from Mr. D. H. Mackay, Dr. F. Wemyss Smith, and Dr. C. A. K. Bird.

—I am, etc.,

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Seat Belt Injuries

SIR,—Your leading article (6 July, p. 4) reviewed some current literature on the safety and efficiency of seat belts. Very properly, the writer was at pains to point out that most of the reports quoted dealt with American-type (large) automobiles and their usual (lap strap) harness. In passing, it is relevant to comment that under recent federal safety regulations in the United States the addition of a shoulder strap is now specified.

I should like to draw attention to perhaps the largest single survey of this problem (obtainable from Volvo, Sweden), carried out on European cars and European-type lap-and-diagonal harness and therefore more directly applicable to British conditions. Included in the survey carried out by Mr. Nils Bohlin were 300,000 cars in the 1½-litre class made by one Swedish manufacturer (Volvo) who has included 3-point seat belts in all his cars as standard fittings since 1959. The material is likely to be complete, because under their local five-year guarantee Volvo offer to pay for all accident damage repairs to their cars costing more than £75. Although over 98% of the cars featured this standard harness, only 25% of drivers and, even more surprisingly, 30% of front passengers were actually wearing them at the time of the crash. In all, the investigation covered 28,750 reported accidents (collisions with repair costs of less than £75 not included), involving a total of 42,813 persons, of whom 2,445 received slight or severe injuries and 57 were killed.

Had safety belts given no protection, one would expect injuries in unbelted drivers and front passengers compared with those strapped to be in a ratio of 3:1, justifying a prediction of 16 or 17 belt-wearers among the 57 killed. In fact, there were only three killed while wearing their belts, and all while travelling at over 65 m.p.h., while in unbelted occupants very severe injuries were reported at speeds as low as 12 m.p.h. Belted, less