function to account for reduced antidiuretic hormone production. The cerebral dysfunction in this patient was thought to be due to hypotension at the time of operation. It is interesting that no hypothalamic disturbance was recognized by Javid *et al.*[1] in their review of neurological complications after open heart surgery.

There was no obvious cause for the cerebral dysfunction in the first case, but it is interesting that polyuria and echolalia began simultaneously and that fluctuations of urine flow coincided with alterations in cerebral function. To have been able to estimate levels of antidiuretic hormone at these times would have been helpful.

Polyuria after open heart surgery may be associated with diabetes mellitus, biochemical changes, such as hypokalaemia and as an exaggerated response to diuretics, and it can lead to peripheral circulatory failure. It is important to recognize polyuria due to diabetes inspidus as it is so amenable to Pitressin (vasopressin) therapy.—We are, etc.,

C. C. EVANS.
J. B. MEADE.
W. A. LITTLER.

Liverpool Cardio-thoracic Surgical Centre,
Liverpool.

REFERENCE

1 Javid, H., *et al.*, *Journal of Thoracic and Cardiovascular Surgery*, 1969, **58**, 502.

Wrong Operations

SIR,—I was very pleased to read Mr. I. W. Payne's letter (5 September, p. 584), and fully agree with all that he says. It is of course of the utmost importance that every care should be taken to avoid operating on the wrong side, or even worse performing the wrong operation on the wrong patient. Like Mr. Payne I have never felt quite happy with regard to the marking of patients prior to surgery. On the one hand it is still possible, as he so rightly points out, to mark in error, and on the other hand when the patients are thus branded do they perhaps wonder if the surgeon has a full grasp of their illness, when apparently he has to depend on a mark to tell him what to do and where to make his cut?

My own custom is to see every patient before being anaesthetized in the anaesthetic room: to check on the notes, to check with the patient, and above all to reassure the patient—this last being of paramount importance. It may be argued that some patients owing to premedication may not be in a position to give a clear answer, but in my experience this is seldom the case. For many years I have established a routine whereby none of my patients are anaesthetized before I have had an opportunity of speaking to them, and apart from serving as a most valuable additional check I believe it to be much appreciated. I am against the practice of starting the next anaesthetic before the last case has been finally completed. This may save a little time with a long list, but surely adds to the chance of error, and as Mr. Payne says the surgeon is in constant need of vigilance and cannot afford to cut corners.

I should make the point I am not against the practice of marking patients, but making a plea that this in itself is not sufficient. The personal approach cannot be replaced by the indelible mark.—I am, etc.,

ANDREW G. BUTTERS.

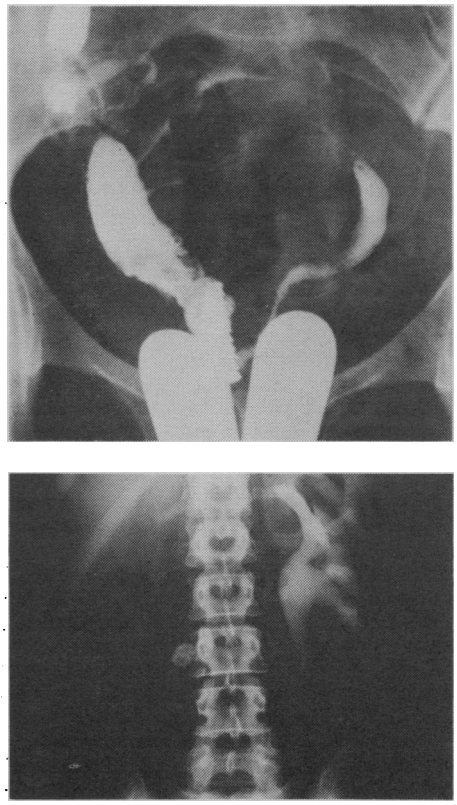
Barnsley,
Yorks.

Unusual Surgical Emergency in Pregnancy

SIR,—Inguinal hernia in pregnancy containing one horn of a bicornuate uterus and associated with a congenital solitary kidney is rare, so I would like to report the following case.

A 35-year-old woman in her fifth pregnancy was admitted as an emergency at 37 weeks gestation because a left indirect inguinal hernia had become irreducible. On admission apart from pain her general condition was satisfactory, and the pregnancy was normal. A large left inguinal hernia was present, and it was tender and irreducible. At operation the hernial sac was found to contain one horn of the uterus, about 8 × 6 cm. size, the left round ligament, and the left uterine tube with the ovary attached. The horn of the uterus and the adnexa were engorged but viable; they were reduced and a Bassini type of herniorrhaphy was performed. Her postoperative progress was satisfactory and she was delivered three weeks later of a live female baby weighing 3,430 g.

A hysterosalpingogram carried out six weeks post partum showed a uterus bicornis unicollis with dilatation of the right horn and free spill of dye into the peritoneal cavity. The left tube was not outlined (Fig.). An intravenous



pyelogram showed an enlarged left kidney with pelvicalyceal dilatation. There was no evidence of a kidney on the right side. The creatinine clearance was then 60 ml./min., and her blood urea 23 mg./100 ml.

Almost every abdominal organ has been described in the sac of an inguinal hernia.[1-3] A serious complication of a bicornuate uterus in labour is that the non-pregnant horn of the uterus can cause obstruction during delivery, but the case described above confirmed the clinical impression that the more complete the uterine duplication the less likely is dystocia.[4] This case illustrates the fact that congenital malformations of the genital and urinary tracts are associated.[5,6]—I am, etc.,

A. MAHMOOD.

Southlands Hospital,
Shoreham, Sussex.

REFERENCES

1 Fusaro, W. J., *New York State Journal of Medicine*, 1946, **46**, 1024.
2 Tunney, R. B., and Hunter, R. E., *New England Journal of Medicine*, 1959, **242**, 1011.
3 Sugarman, G. R., *Journal of the Newark Beth Israel Hospital*, 1961, **12**, 160.
4 Chassar Moir, J., in Munro Kerr's *Operative Obstetrics*, 7th edn. London, Baillier, Tindall and Cox, 1964.
5 Woolf, R. B., and Allen, W. M., *Obstetrics and Gynecology*. 1953, **2**, 236.
6 Chawla, S., Bery, K., and Indra, K. J., *British Medical Journal*, 1966, **1**, 1398.

Value of Osteopathy

SIR,—In a review (6 December, 1969, p. 610) of the book *A Manual of Osteopathic Practice* by Alan Stoddard, Dr. D. A. H. Yates expressed his doubts on the validity of assessing leg length by palpating the iliac crests in the erect position. In a letter (7 February, p. 366) Dr. Yates reported some studies of observer error in measuring leg length by this method. He concluded that "with raises of ½ in. (1·2 cm.) or less the observers were as often incorrect as correct as to which side, if either, was raised. With ¾ and 1 inch (1·8 and 2·5 cm.) all observations were correct."

The following experiment was carried out to test the validity of such an observation, and to find out with what degree of accuracy a known amount of shortening could be detected.

One subject was used. He stood with his back to a good light, his feet were obscured by a blanket, and five observations were made with varying raises under one or other foot: no raise, right foot raised ½ in. (1·2 cm.), left foot raised ¼ in. (0·6 cm.), left foot raised ½ in. (1·2 cm.), and finally left foot raised ⅛ in. (0·3 cm.).

The observer stood behind and assessed the level of the pelvis by palpating the highest point of the iliac crest. The short leg was recorded or the pelvis stated to be level. Seventeen observers each made five observations. The observers were a group of doctors, mostly general practitioners, all with at least two years' experience of manipulative medicine, attending a postgraduate course run by the British Association of Manipulative Medicine.

Raise in Inches	Opinions of Observers		
	Level Pelvis	Short R. Leg	Short L. Leg
No raise	2	4	11
⅛ under left foot	8	6	3
¼ under left foot	9	7	1
½ under left foot	3	14	0
½ under right foot	2	0	15

The results are seen in the Table. With the subject standing naturally, 64% of the observers found a short left leg. A raise of