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 insipidus as it is so amenable to Pitressin (vasopressin) therapy.—We are, etc.,

C. C. EVANS.

J. B. MEADE.

W. A. LITTLER.

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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 post-operative 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 $\frac{1}{2}$ in. (1.2 cm.) or less the observers were as often incorrect as correct as to which side, if either, was raised. With $\frac{3}{4}$ 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 $\frac{1}{2}$ in. (1.2 cm.), left foot raised $\frac{1}{2}$ in. (0.6 cm.), left foot raised $\frac{1}{2}$ in. (1.2 cm.), and finally left foot raised $\frac{1}{2}$ 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
$\frac{1}{2}$ under	8	6	3
$\frac{1}{2}$ left foot	9	7	1
$\frac{1}{2}$ foot	2	14	0
$\frac{1}{2}$ 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

$\frac{1}{8}$ in. (0.3 cm.) under the left leg appeared to level up the pelvis. It seems, therefore, that a raise of $\frac{1}{8}$ in. can be detected, and $\frac{1}{8}$ in. (0.9 cm.) was observed with an accuracy of 82%—I am, etc.,

J. D. MILLER.

Welling, Kent.

Fat Embolism

SIR,—In your article on fat embolism (29 August, p. 476) you mention tracheostomy, hypothermia, low-molecular-weight dextran and vasodilatation, clofibrate, and antibiotics. You then suggest that intravenous hydrocortisone is sometimes useful to reduce inflammatory oedema of the lungs. In this connexion you point to the paper by A. P. J. Ross¹ in which he argues that cerebral damage and death in cerebral fat embolism are usually due to hypoxia caused by pulmonary alveolar oedema.

I suggest that if corticosteroids are effective in this respect they should be used in large doses at the earliest possible opportunity in order to prevent this complication. A more suitable preparation would be dexamethasone 10 mg. intravenously followed by 4 mg. 4-hourly intramuscularly.

Since this treatment could do no harm it is worth a trial.—I am, etc.,

A. W. FOWLER.

Bridgend General Hospital,
Bridgend, Glam.

REFERENCE

- ¹ Ross, A. P. J., *Annals of the Royal College of Surgeons of England*, 1970, **46**, 159

Electrocardiography and the Family Doctor

SIR,—After reading Dr. D. Short's article on electrocardiography and the family doctor (28 February, p. 560), we decided to send a questionnaire to all the general practitioners in East Suffolk to ask them whether they would like to be able to refer their patients to Ipswich for an E.C.G. One hundred and twenty letters were sent and 79 replies received.

Seventy-eight per cent. of those replying wanted open access to an E.C.G. service, 9% did not at all, and a further 13% did not because they owned their own E.C.G. machine. Most doctors wanted the result quickly—within three days—and only six thought a reply within seven days would suffice. Nearly all wanted the report in the form of the tracing plus a cardiologist's comment. Ninety-two per cent. thought that if they could use the E.C.G. service they would ask for fewer outpatient and domiciliary consultations. More than half, however, thought that they would use the service once a month or less; only three reckoned on needing it more than once a week. These results appeared to be largely uninfluenced by the doctor's age, his practice size, and number of partners and his distance from Ipswich—which might be up to 35 miles (56 km.).

There is no doubt that as medical screening and health checks become more popular and as patients and doctors become more knowledgeable the need for all doctors to

have E.C.G.s done will increase. Our results show that most doctors are aware of this; it remains to solve the logistical problems of having good quality tracings made quickly and economically which can then be read accurately.

We are very grateful to the doctors who replied for filling in yet another form about themselves, and to Dr. Ian Tait for his helpful comments.—We are, etc.,

C. F. TREDGOLD.

S. L. BARLEY.

Ipswich and East Suffolk Hospital,
Ipswich, Suffolk.

Cancer and the Pill

SIR,—Dr. P. Strickland (18 July, p. 165) expresses concern over the possibility that the use of oral contraceptives may be causing an increased incidence of breast cancer. While I agree that we must keep a careful watch for evidence of increased neoplastic disease among women using the pill, a recent study of mortality trends in Ontario women of child-bearing age has revealed no increase in the mortality from breast cancer during the past few years, despite the widespread use of oral contraceptives.¹

It is, of course, possible that improvements in the treatment of breast cancer have prevented the death rate from rising despite an increased incidence of the disease, but this seems unlikely in view of the depressing stability of the death rate from this disease over the past few decades.²—I am, etc.,

T. W. ANDERSON.

School of Hygiene,
University of Toronto, Canada.

REFERENCES

- ¹ Anderson, T. W., *Canadian Medical Association Journal*, 1970, **102**, 1156.
² McKinnon, N. E., *Canadian Medical Association Journal*, 1955, **73**, 614.

Upgrading V.D. Departments

SIR,—Apocryphal of the recent correspondence on this subject (1, 15, and 29 August, pp. 286, 408, and 529; and 5 September, p. 589) may I point out that mooted the change of the name of venerology to genitourinary medicine is not a new one.

On 15 May 1914 Sir William Osler was one of the witnesses called to give evidence to the Royal Commission on Venereal Diseases.¹ He was questioned by Lord Sydenham of Combe. During the course of being examined he quoted his famous aphorism: "There is only one disease you require to know thoroughly. Medicine is a very easy art and an easier science. It is the only one in which you have to know a single disease. If you know syphilis and know it thoroughly you get all the rest on the way. . . ."

Then quoting from the minutes: Q. "As far as the routine of the curriculum existing in this country is concerned, do you think there is sufficient as regards these diseases?" A. "No." Q. "But you think it would be impossible on account of the overloading of subjects to increase the time?" A. "Yes for special subjects, but the difficulty is that these diseases have been more or less tabooed in our general hospitals to which

the students go. If each medical student had to pass through a venereal or genitourinary outpatients clinic and had to serve in the syphilitic department, he would get his education in those diseases very thoroughly and very practically."

Q. "Do you think that every general hospital should establish an outpatient clinic for dealing with these diseases?" A. "Yes; but I would not have it specially for venereal diseases. I would have it a genitourinary clinic. There are certain advantages in that, because then you do not taboo it. A great many people who would not go to a special venereal clinic would go willingly to a genitourinary clinic."—I am, etc.,

M. A. WAUGH.

Department of Venereology,
West London Hospital,
London W.6.

REFERENCE

- ¹ Royal Commission on Venereal Diseases. *Appendix to Final Report*, p. 58. London, H.M.S.O., 1916.

G.P.s in the Hospital

SIR,—I have every sympathy with Dr. W. A. Roxburgh (5 September, p. 589). The Royal College of Obstetricians and Gynaecologists has devised a petard and the regional boards are hoist with it. In one metropolitan regional hospital board there are three brand new maternity hospitals which are threatened with closure because they are remote from the district hospital. They could all be staffed by general practitioners provided that the said general practitioners have got the Diploma of Obstetrics, which ensures that they have done a resident house appointment with all that that implies. Consultant cover in some areas could be difficult, but surely it is not beyond the wit of the Department to devise some scheme for making cover in emergencies attractive to the consultant.—I am, etc.,

C. KEITH VARTAN.

London S.E.3.

Alcohol and Phenformin in Diabetes

SIR,—I have recently seen a patient with phenformin-induced acidosis whose presentation so resembled that of Drs. G. G. Shirriffs and P. D. Bewsher's case (29 August, p. 506) that I think it worth reporting.

The patient was a 67-year-old retired seaman, a habitual whisky drinker and known to be diabetic for 10 years. At first controlled by diet alone, he had later been given phenformin and was taking 50 mg. three times a day at the time of his illness.

One evening he went to a party after skipping his tea but taking his usual 50 mg. of phenformin. "Several whiskies and a few beers" later he was seized with a sudden and severe abdominal pain, felt cold and sweaty, and immediately left for home. Taking to his bed, he then felt pain across the lower chest and later in the back. He spent a restless night, moaning and complaining of blurred vision. The next morning he was seen by his general practitioner, who arranged his emergency admission to hospital. The patient meanwhile insisted on a