

In his comment Dr. Millar wonders "if an unrecognized incomplete rupture at the time of a previous delivery might have been the cause in some of the recorded cases of silent antepartum rupture of the uterus." G. FitzGibbon² mentions this factor in the multiparous patient, and in my experience I am aware of at least nine cases where a quiet rupture of the uterus had occurred at about 36 weeks' gestation without necessarily any gross physical signs at the time of the rupture. In cases where the patient has survived rupture of the uterus, subsequent cross-examination with regard to her immediate preceding pregnancy will usually reveal that after possibly a long first stage "a pain not like a proper labour pain affected delivery." FitzGibbon suggested that this was an incomplete rupture of the uterus, and that had labour needed to continue subsequent to this contraction the uterus would have completed the rupture at that time.

In three cases where the condition of rupture was recognized prior to labour it was found that the cervix was well taken up and applied and more than three fingers dilated at the 34th to 36th week of pregnancy, without there having been any suggestion of labour contractions. Unfortunately, in one of these cases the true state of affairs was not recognized, and on the exhibition of "pitocin" to hasten her supposed labour she completed the rupture and died rapidly of shock and haemorrhage in a nursing home, where operative facilities were not available. However, this patient's demise served as a warning for the next patient who was seen fairly soon thereafter, and in her case, suspecting the condition, laparotomy was performed and the lower segment of the uterus anteriorly was found to consist of amnion, chorion, and peritoneum only. During my assistantship in the Rotunda Hospital a case was admitted of a multipara at 36 weeks' gestation in whom the cervix was dilated about half without there having been any labour pains, and on vaginal exploration the feeling was that, on passing the fingers through the open cervix, one came rapidly upon the inside of the anterior abdominal wall. Laparotomy confirmed this finding. The patient had not at any time been shocked, but had come in because she said she did not feel right. The baby was still *in utero* and survived.

Unfortunately in some cases, in which the patient, having had no obvious trouble or difficulty in other pregnancies, has neglected to attend for antenatal care satisfactorily and is first seen in a state of shock immediately after delivery, the rupture has already completed itself. This is the type of patient that is seen by the emergency maternity unit in a state of irreversible shock or death.

These cases are extremely worrying and disturbing when encountered. But the writing is on the wall for those who take a careful, detailed obstetrical history and evaluate the pelvis and the state of the cervix during the last trimester of pregnancy.—I am, etc.,

Brantford, Ontario.

H. FITZGIBBON.

REFERENCES

- ¹ FitzGibbon, H., *Canad. med. Ass. J.* (awaiting publication).
- ² FitzGibbon, G., *Obstetrics*, 1937. Browne and Nolan, Dublin.

Post-operative Urinary-tract Infection

SIR,—In your leading article on the prevention of infection in the urinary tract (August 26, p. 571) you drew attention to the hazard of indwelling catheters following gynaecological operations. Their use is almost universal following operation for repair of the pelvic floor with or without vaginal hysterectomy, particularly if the bladder neck has been elevated to cure stress incontinence. We have demonstrated, in work to be published more fully elsewhere (Third World Congress

of Obstetrics and Gynaecology), that in these cases they are in fact better omitted. Their omission, however, is not sufficient in itself to prevent urinary retention and infection, and is only effective if part of a policy of positive post-operative care in which the traditional routine of vaginal packing, frequent swabbings, bladder drainage, and prolonged immobility is reversed.

A psychological as well as physical assessment of the patient, careful explanation of the rationale of early mobility, and training in pelvic floor, arm, leg, and breathing exercises with emphasis on early restoration of normal function must be an integral part of pre-operative preparation. Post-operatively patients are not given bed pans, except on request on the first evening, and catheterization is not carried out unless necessary. A single injection of "omnupon" gr. $\frac{1}{2}$ (22 mg.) ensures sleep the first night, and subsequently the application of a local anaesthetic aerosol as required gives adequate pain relief in approximately 80% of the cases. The following morning—that is, less than eighteen hours after operation—the patient walks to the lavatory, even after vaginal hysterectomy, and usually micturates normally. Vaginal packs are not used and routine swabbing, which has little purpose except to make the patient even more conscious of her perineum, is not carried out.

The elimination of these routine procedures permits the nursing staff to observe their patients properly and give the sympathy and understanding which is so important in the care of these difficult cases.—I am, etc.,

Dudley Road Hospital,
Birmingham 18.

EDWARD COPE.

Cross-infection from Hospital Baths

SIR,—At this time when hospital design and the prevention of cross-infection are under general consideration one feature appears to have escaped attention. This is the design of ablution rooms. In this country there is a traditional respect for the bath for overall cleansing. It is not denied that frequent baths produce a high degree of social cleanliness; as a pre-operative ablution, however, the bath falls short of the ideal even if it is adequately disinfected between each individual's use. For this purpose the only satisfactory method is a spray, where the soiled water runs at once to waste and the only parts of the individual placed at risk to cross-infection from the previous user are his feet. It is difficult to understand why these are not installed in new buildings. The space required is halved, the requirement of hot water is not greatly altered, and the method of cleansing is similar to that regarded for many years as compulsory for the hands of all those directly concerned in operative treatment.—I am, etc.,

Bridge of Earn Hospital,
Perthshire.

A. IAN L. MAITLAND.

Pythagoras and the Beans

SIR,—For a number of reasons the significance of the Pythagorean prohibition of beans may be questioned. Dr. George Discombe (August 5, p. 385) has mentioned two: that Aulus Gellius claims that Pythagoras frequently ate beans, and that his warning was against venereal excess and not against favism. Plutarch¹ gives another interpretation: "This duty Pythagoras also has enjoined in the form of allegories which I shall now quote and explain. . . . Abstain from beans means that

2893
A.R.E. + H.D.
1961

a man should keep out of politics for beans were used in earlier times for voting upon the removal of magistrates from office."

If Arie² is correct in his suggestion that the origin of the taboo lies in the prevalence of favism in Mediterranean lands, one might expect to find other comment on this. Hippocrates³ was unaware of the association of beans and disease and wrote: "Beans afford an astringent and flatulent nourishment; flatulent because that the passages do not admit the abundant nourishment which is brought, astringent because that it has only a small residue from its nourishment." Cicero⁴ said much the same thing: "For this reason, it is thought, the Pythagoreans were forbidden to indulge in beans, for that food produces flatulence and induces a condition at war with a soul in search of truth." There is biblical reference to beans (2 Samuel, xvii, 28, and Ezekiel, iv, 9) but there is no indication that they may cause illness. The bean was a staple article of diet in Mesopotamia and in Egypt and was used in the *materia medica* of these two countries.⁵

On the present evidence it seems best to accept the view of Sansone, Piga, and Segni⁶ that the first report of favism is that of Manuel Pereira de Mira Franco, of Portugal, in 1843.—I am, etc.,

Wilmslow, Cheshire.

IAN BAILEY.

REFERENCES

- ¹ Plutarch, *De Liberis Educandis*, 17.
- ² Arie, T. H. D., *Oxford med. Sch. Gaz.*, 1959, 11, 75.
- ³ Hippocrates, *Regimen*, 11, 45.
- ⁴ Cicero, *De Divinatione*, I, 30.
- ⁵ Sigerist, H. E., *A History of Medicine*, 1951, vol. I, pp. 249, 340, 402, and 485. Oxford University Press, New York.
- ⁶ Sansone, G., Piga, A. M., and Segni, G., *Il Favismo*, 1958. Minerva Medica, Torino.

SIR,—Dr. George Discombe (August 5, p. 385) rightly says that the reason why Pythagoras forbade his disciples to eat beans was as much a mystery to the ancient writers as it is to us: their suggestions are all obviously guesses or rationalizations, and, though they make interesting reading, there is little reason to prefer one to another.

Recently some light has fallen on the problem as a result of the work of Szeinberg, Sheba, and their colleagues.¹ They have studied the various ethnic groups of Israel in order to discover the incidence of the inherited defect of glutathione metabolism in the red cells, which is now known to occur in people who are prone to favism and to certain other haemolytic sensitivities. Dividing their subjects into Ashkenazi and Sephardi Jews—that is, broadly speaking, Jews of central and eastern European origin on the one hand, and those of Mediterranean and Oriental origin on the other—they found that only the latter group was susceptible to favism and that among its members alone (with only one exception) was the characteristic biochemical lesion found.

Next they divided the Sephardis into subgroups according to their lands of origin, and they found that the Jews from Iraq had a greater incidence of the glutathione anomaly than any other group except those originating from Kurdistan and from Persia. Now, the Iraqi Jews have had more continuity and greater seclusion than almost any other Jewish community; indeed, they were driven into Babylonian exile by Nebuchadnezzar in 586 B.C. As I have pointed out elsewhere,² this is the very century in which Pythagoras flourished, and it is therefore a reasonable assumption that favism existed in the world of his day.

Did Pythagoras himself suffer from favism? There is evidence that, like many who suffer from favism, he could not bear to walk among beans. Accounts of his death^{3,4} relate that when he was being pursued by the people of Croton he came to the edge of a bean field, and rather than set foot in it he was taken, and died at the hands of his pursuers. Whatever the germs of this story are we can take our choice whether we believe that he was stopped by religious scruple or whether he was nauseated by the bean blossom.—I am, etc.,

The Radcliffe Infirmary,
Oxford.

T. H. D. ARIE.

REFERENCES

- ¹ Szeinberg, A., Sheba, C., and Adam, A., *Blood*, 1958, 13, 1043.
- ² Arie, T. H. D., *Oxford med. Sch. Gaz.*, 1959, 2, 75.
- ³ *Suida Lexicon*, 1928–38. Edited by A. Adler. Teubner, Leipzig. See under "Pythagoras."
- ⁴ Diogenes Laetius, *Life of Pythagoras*, VIII, 39.

Schizophrenia in General Hospitals

SIR,—I agree with your correspondents (August 12, p. 453) that my impressions of the treatment of schizophrenia may be fundamentally misconceived. If equally critical of their own views, our differences are not as great as might appear. "A judicious distrust and wise scepticism are the sinews of understanding" (Epicharmus).¹ I can sympathize that anybody who has expended time and trouble to acquire a specialized technique would subsequently "prefer" to agree with evidence that it is useful. The danger, as I see it, is threefold.

Firstly, there is an understandable reluctance to discard such a skill, with all its accoutrement, ancillary staff, team spirit, and reputation, when no similar tangible physical ritual can be substituted. Secondly, enthusiasts tend to find spurious improvement resulting from their therapeutic exercises. Thirdly, genuine improvement may be attributed to treatment when due to other factors, as was the case in the plausibly deceptive conclusions drawn by Drs. Peter Rhode and William Sargant (July 8, p. 67) from study of their treatment of schizophrenia in general hospitals. Specious evaluation has been applied to so many remedies—bloodletting, tar water, malarial therapy, to name a few—that it is fascinating to read Penrose's objective study² of crazes, particularly thallium therapy.

I have no quarrel that larger doses than 5 mg. of trifluoperazine three times a day and other drugs may be necessary in some cases of schizophrenia. I agree that E.C.T. may be useful in some cases where depression is marked, but to say it is indispensable in these or catatonic stupor is more to make a point than propound a truth.

Seventy per cent. of cases of schizophrenia are not in psychiatric hospitals. They are being helped to stay in the community by their families and family doctors—many without drugs, and I doubt if more than a few have the high doses recommended. Before deciding on treatment one would not wish to have oneself, it behoves hospital psychiatrists to ask themselves how the patient has existed with his illness in the community for so long before admission. Often one finds there has been little change in the illness, but domestic, financial, or other social factors have been responsible for admission to hospital. It is much easier to write a prescription for a large quantity of drugs than provide community care correcting such factors. I am not willing to limit my therapeutic effort in any way, but when considering