coccal food-poisoning; what evidence we found is negative rather than positive. Nevertheless it would seem that staphylococcal food-poisoning is the commonest cause of the frequent mild cases of diarrhoea, with or without vomiting, met with in general practice.

Summary

Ninety unselected cases of acute gastro-enteritis, occurring over a period of nine months in an urban practice, were investigated. In by far the greatest number of these no pathogenic organisms were found. The commonest specific organism isolated was *Sh. sonnei*. *Pr. vulgaris* was the next most common. Only one case of infection with *Salm. typhi-murium* was found. One case was subsequently diagnosed in hospital as food-poisoning (toxin type).

Arguments are advanced for the belief that staphylococcal food-poisoning is the commonest cause of mild cases of gastro-enteritis.

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Medical Memoranda

Intra-partum Uterine Rupture

Mr. Hodkinson's article in the *British Medical Journal* of February 9, 1952 (p. 308), on this subject prompts me to record my experiences at the Government Hospital, Gatooma, with similar cases during the past two years. This hospital contains some 250 beds for Africans and about 150 to 200 deliveries take place in it every year. Caesarean section is often carried out, since contracted pelves, and especially pelves with contracted outlets, are common. I have averaged about 25 such operations a year during the past five years. Uterine rupture has not occurred in any case in which caesarean section has been carried out, although nearly all these operations have been of the "classical" variety. I attribute this immunity to following the advice of Mr. Victor Bonney to use a layer of non-absorbable sutures in the uterine wall. Our present practice is to use a deep layer of catgut and a superficial layer of nylon. No irritation seems to be set up by the latter, and in a case on which I operated for the second time recently it was extremely difficult to trace the previous scar in the uterus. The following four cases of uterine rupture have been met with.

CASE REPORTS

Case 1.—An African woman aged about 35 was admitted to hospital on January 14, 1950. She had had five previous pregnancies; the first three were normal full-term deliveries of live children, the fourth was a full-term delivery of a stillborn child, and the fifth a four-months abortion. She stated that labour began late in the evening of January 13, and she did not think that the membranes were ruptured. On examination she was shocked and collapsed, and had just come about 40 miles by ambulance over rough roads. No foetal parts could be distinguished through the tense abdomen, and the foetal heart was not heard. Per vaginam there was a foul-smelling discharge, and a shoulder was presenting. The cervix was fully dilated. In spite of all the usual restorative measures the woman died two hours after admission without recovering sufficiently to warrant active treatment. At necropsy it was found that the uterus had ruptured into the left broad ligament, and that the child was still *in utero*. The patient had lost only about a pint (570 ml.) of blood. Death was obviously due to shock and toxaemia.

Case 2.—This patient, an African woman aged about 25, was admitted to hospital on February 1, 1950. She had had two previous pregnancies, both of which terminated normally in live children. The present labour began the evening before admission. The uterus was tonically contracted, no foetal parts were felt through the abdomen, and the foetal heart could not be heard. Vaginal examination revealed that the cervix was three-quarters dilated and a head could be felt high up at the pelvic brim. There was a large caput and the cervix was hanging loosely below it. The patient was profoundly collapsed and pains had ceased some hours before admission. After the usual shock treatment a laparotomy was performed. A full-term dead foetus was found loose in the abdomen. The uterus had ruptured through its left side behind the broad ligament and the peritoneum contained about 3 pints (1.7 litres) of blood and clots. Subtotal hysterectomy was performed. Convalescence was stormy, but the patient eventually made a complete recovery.

Case 3.—An African woman of about 30 was admitted on May 22, 1951. She had had five previous full-term pregnancies, all of which terminated in easy and normal labours. On examination the child was lying in the L.O.A. position and seemed very large. The maternal pulse rate was 80 and the foetal 96. The foetal head was fixed at the pelvic brim, and a large caput reached nearly to the vulva. A catheter drew off 2 pints (1.1 litres) of very blood-stained urine. It was decided that caesarean section was indicated, and a laparotomy was performed in order to do this. To our surprise the uterus was extensively ruptured through the anterior part of the lower segment. The child was still *in situ*. It was removed by enlarging the uterine hole, and a subtotal hysterectomy was carried out in view of the extensive laceration of the lower segment. The child was dead, but the mother made a good recovery after a stormy convalescence.

Case 4.—This woman, who appeared to be about 40 years old, was admitted on September 30, 1951. She had had ten previous full-term pregnancies with easy labours. She was very collapsed. The foetal parts could be felt with difficulty and the head was palpated in the right iliac fossa. Vaginal examination revealed severe bleeding, and the case was thought to be one of placenta praevia. On laparotomy the peritoneal cavity was found to contain about 2 pints (1.1 litres) of blood and clots.

The child was free amongst the intestinal coils, and the uterus was found to have a large rent through its posterior lower segment. The child was removed, dead, and a subtotal hysterectomy was performed. Apart from some trouble with atony of the bladder—a common difficulty in post-partum African cases—the woman made an uninterrupted recovery.

COMMENT

In none of these cases had a caesarean section been performed previously, nor had there been any interference in the present labour so far as is known. All the cases occurred in multiparae, and it is suggested that the cause of the obstructed labour in each case was progressive enlargement of children with each pregnancy. It is felt that a lesson to be learnt is that a good previous obstetrical history should not be allowed to warp one's judgment into expecting that all will necessarily be well with subsequent labours, even with a child in a good obstetric position.

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