taminated; and in an effort to prevent this, one finds oneself standing helplessly in a corner with arms at approved angles while the patient carries on as best she can. Our aim in rural obstetrics can only be antisepsis. Good antisepsis is better than contaminated asepsis. My midwives I train merely to keep away, and I relegate them to the north end of the patient. Most are capable of giving chloroform under supervision. Soap, water and alcohol is sufficient scrub-up for uncomplicated cases, and can be repeated as often as contamination occurs. Iodine can be added when pelvic examinations or other surgical interference is necessary. Liberal amounts of lysol provide a Listerian atmosphere!

What are the results of my heresy? In 154 unselected deliveries, including forceps, internal versions, etc., I have had one post partum infection. This occurred in a placenta prævia on the third day following an internal version and extraction. Her temperature reached 101 4/5° F., and quickly subsided after a large dose of penicillin intramuscularly, calcium penicillin and sulfadiazine by mouth, and ergotin gr. iii b.i.d. orally. In fact, contrary to university teaching, home obstetrics is not fraught with post partum temperatures. To the criticism that my follow-up care is not sufficient to display minor or major infections, I have to admit this is so. Nevertheless, the figures stand, with no green plots as a backdrop.

The drugs used in the above case are also open to criticism. Intravenous nembutal is not new in obstetrics, but evidently has been largely superseded by newer, less effective drugs which permit of telephone prescription. Nembutal, given intravenously is my preferred sedation in multipara. It provides an often much-needed relaxation for 10 to 15 minutes. Progress of labour is more rapid after its use. Comfortable sleep between pains is an almost constant feature. Excitement is minimal. A smaller amount of terminal anæsthetic is necessary, I have seen no troublesome asphyxia in the child resulting from it, as the effects are almost completely dissipated in ½ to ¾ hour. I fear no post partum hæmorrhage as a result of its use. I use it routinely.

Chloroform is the smoothest, the safest and the most effective anæsthetic available to a general practitioner in rural Canada. There are precautions to be observed. It is not poured like ether as I have seen it used in hospitals. It is not used for prolonged anæsthesia—ten or fifteen minutes is adequate for most obstetric uses where third stage anæsthesia is necessary. Possibly the prolonged use of chloroform anæsthesia and the earlier injection of nembutal may have jeopardized the life of the vertex presentation in the above case. However, there is not much room left in a pelvis for an umbilical cord when two large babies are engaged simultaneously.

The use of pituitrin in the above case is not too far out of line. I use it frequently, however, during the second, and even the first stage of labour. Some prerequisites are necessary. The head must be engaged, and the cervix at least two fingers dilated by rectal examination. The chloroform drop bottle and mask must be at hand. The first dose must not be more than one minim of pitocin, 10 international units to the c.c. It can be repeated at half-hourly intervals.

Finally, constant bedside attendance by the doctor is necessary for the safe and effective use of any of these drugs. I have spent as long as sixteen hours with one patient, though in these cases frequently storms and bad winter roads help to restrain my impatience to be home. It is unpleasant to fight one's way home over winter roads only to have to turn about and fight the elements all the way back again.

PALINDROMIC RHEUMATISM

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The first case of palindromic rheumatism was noted by Hench in 1928, and published with a series of other cases as a "new" disease by Hench and Rosenberg in 1941. It is apparently a rather rare affection of the joints and pariarticular tissues: at the Mayo Clinic five or six cases were observed yearly amongst the 4,000 to 4,500 cases of articular and muscular diseases of all types seen yearly by the Clinic's consultants on diseases of the joints. As in all "new" diseases the rate of recognition, and with it the rate of apparent incidence, will probably increase as time goes on. It seems to be worth while to add the present case to the small series of already published records.

Miss A.L., was seen first with relevant symptoms in November, 1945, at the age of 18. Her complaints at that time were swelling and tenderness of the right

wrist and both ankle joints. As part of her occupation she had handled heavy containers, and thought that she had sprained her wrist; the swelling of her ankles she noticed subsequently after a dance. At the time of the examination there was some slight puffiness of the right wrist; both ankle joints were noticeably swollen; there was non-pitting œdema and a bluish-red discoloration, especially on the anterior aspect of both joints. Both wrist and ankle joints were moderately tender. Otherwise, a physical examination did not reveal any abnormality. The temperature was normal, so was also the sedimentation rate (2 mm. in one hour, Westregren).

Her past history was entirely negative, in early childhood she had had varicella and measles, underwent a tonsillectomy and adenectomy in 1930, and again an adenectomy in 1943. There was nothing suggestive of allergy in her personal history. Emotionally she was somewhat unstable, and had a family background of very considerable emotional instability both on the paternal and maternal side. Her mother had suffered from seasonal asthma for many years, but repeated thorough investigation had never given a satisfactory or unequivocal result as to the nature of the responsible allergen.

The patient was advised to keep a week's bedrest, and the swelling of wrist and ankles subsided quickly.

After being up and about for a few days she presented herself again with swelling of the ankles. There was only slight pain, but considerable tenderness to touch. Again, physical examination revealed nothing, and the sedimentation rate was, again, normal. The patient kept another two weeks' bedrest, with the same immediate good result as before, only to be followed by recurrence of swelling and tenderness of the ankles as soon as she was ambulatory again. A careful search for the possible cause and nature of the rather puzzling condition was now made. As before, a thorough physical examination was negative with exception of the already described changes in the joints; the temperature stayed consistently normal; repeated sedimentation rates were entirely within normal limits; Mantoux and blood Wassermann test negative; blood and urine culture no growth; x-ray films of all teeth, the sinuses, chest, and affected joints normal. Blood count: 5,020,000 erythrocytes, Hbg. 13.5 gm. (photoelectrically), total leucocytes 7,450. Differential count: unsegmented 2%, polymorphonuclears 42%, lymphocytes 48%, monocytes 5%, eosinophiles 2%, basophiles 1%. No abnormalities observed on red or white bloodcells or platelets.

With hesitation the condition was labelled tentatively as a case of "atypical rheumatism". The patient was advised to keep a prolonged period of bedrest, and to stay under observation for further developments. A consultant re-evaluated the x-ray films and agreed that they were normal; the laboratory tests were repeated with the same negative result, and in addition an agglutination test for brucella was found to be negative. The consultant discharged the patient with the diagnosis of rheumatic fever, but took pains to emphasize that the clinical picture offered was quite atypical, and that the constantly normal sedimentation rate did not fit very well the diagnosis of rheumatic fever. Bed rest for two months and salicylates were prescribed. On her way home from the consultant circumstances necessitated the patient to walk a considerable distance while the outside temperature was below zero; her ankles promptly became quite swollen, and there was a considerable amount of pain. Swelling and pain subsided again after bedrest, and after two months' stay in bed, during which period there were no symptoms whatsoever, the patient resumed again her activity without untoward result. In July, 1946, she underwent appendectomy for an acutely inflamed appendix, and with the exception of some quite pronounced psychosomatic complaints she made a quick and uneventful recovery.

In December, 1946, she presented herself again with swelling of the right ankle joint; there was some bright red mottling of the skin overlying the affected area; the sedimentation rate and temperature were normal as ever. No medication was given, and the patient was advised to carry on with her usual activities. The swelling subsided within one week, and did not recur.

It was felt that this case offered something of a challenge as to diagnosis, and that its disposal as "atypical rheumatism" was quite unsatisfactory. It was, figuratively speaking, filed away in the mental compartment for undiagnosed and interesting cases.

While going over some current literature the recent case report of Hopkins and Richmond[1] was encountered, and it was at once connected with the above case. It seemed to offer a satisfactory solution to the diagnostic puzzle, and further reference to the original publications of Hench and Rosenberg and other papers quoted by Hopkins and Richmond confirmed the diagnosis of palindromic rheumatism beyond doubt.

The present case does not offer any further clue to the rather obscure etiology of palindromic rheumatism, nor does it deviate much from standard pattern. The normal sedimentation rate, the relative lymphocytosis, the beneficial influence of rest, the absence of radiological changes in the joints, also the psychosomatic component and the history of familial allergy have been described in previous cases. The rather outspoken seasonal incidence of attacks in our case is somewhat unusual. The cutaneous eruptions observed by us do not fit into the picture of palindromic rheumatism, but would rather make one think of angioneural arthrosis. However the whole question complex of angioneural arthrosis (Solis-Cohen) and allergic rheumatism (Kahlmeter) versus palindromic rheumatism seems to be so obscure and controversial, that it seems almost impossible for the non-rheumatologist to approach this problem at all.*

A therapeutic attempt with pyribenzamine or benadryl may be of advantage in similar cases, as there seems to be at least an allergic component in many of these cases.

REFERENCE

1. HOPKINS, J. J. AND RICHMOND, J. B.: Palindromic rheumatism, *Ann. Int. Med.*, 26: 454, 1947. (Contains further bibliography.)

* Just before sending this paper to print (June, 1947) the patient reported by letter that she has had another attack of swollen and painful ankles.