

BRITISH MEDICAL JOURNAL

DATE

FEB 1973

LIBRARY OF THE
BRITISH MEDICAL ASSOCIATION

SATURDAY 27 JANUARY 1973

LEADING ARTICLES

- Ethical Criteria page 187 Glucagon and Growth Hormone page 188 Gastric
Decompression after Abdominal Surgery page 189 Legal Aspects of V.D. in Teenagers
page 190 New Virus Infections page 190 Antenatal Injury page 191
Controlling Inflation—Second Stage page 191

PAPERS AND ORIGINALS

- Bronchial Hyperreactivity to Prostaglandin F_{2α} and Histamine in Patients with Asthma
A. A. MATHÉ, P. HEDQVIST, A. HOLMGREN, N. SVANBORG 193
- Interferon Studies with Japanese and U.S. Rubella Virus Strains JUDITH E. POTTER, J. E. BANATVALA, JENNIFER M. BEST 197
- Body Temperatures in the Elderly: A National Study of Physiological, Social, and Environmental Conditions
R. H. FOX, PATRICIA M. WOODWARD, A. N. EXTON-SMITH, M. F. GREEN, D. V. DONNISON, M. H. WICKS 200
- The Dip-slide in Urology F. R. JACKAMAN, J. H. DARRELL, R. SHACKMAN 207
- Correction of Adverse Response to Suxamethonium of Susceptible Pigs DAVID LISTER 208
- "Twin" Intracranial Aneurysms Causing Subarachnoid Haemorrhage in Identical Twins B. FAIRBURN 210
- Bilateral Pneumothoraces and Subcutaneous Emphysema: A Complication of Internal Jugular Venepuncture
SALLY ARNOLD, R. S. FEATHERS, ELIZABETH GIBBS 211

MEDICAL PRACTICE

- Responsibility in the Use of Medical Information for Research STATEMENT BY THE MEDICAL RESEARCH COUNCIL 213
- Clinicopathological Conference: Essential Malignant Hypertension with Renal Failure and Persistent Australia-
antigenaemia
DEMONSTRATED AT THE ROYAL POSTGRADUATE MEDICAL SCHOOL—ARRANGED BY PROFESSOR C. T. DOLLERY AND PROFESSOR C. V. HARRISON 216
- A New Look at Infectious Diseases: Whooping Cough W. M. JAMIESON 223
- European Counterparts: Two Radiologists—Holland and Britain FROM A SPECIAL CORRESPONDENT 225
- Any Questions? 227
- Personal View W. DEWI REES 228

CORRESPONDENCE—List of Contents 229

BOOK REVIEWS 242

NEWS AND NOTES

- Epidemiology—Escherichia coli Gastroenteritis 244
- Medicolegal—Right of Fetus to Sue 244
- Medical News 245

OBITUARY NOTICES 239

SUPPLEMENT

- General Medical Services Committee 23
- Common Market Medicine 27
- Committee on Overseas Affairs 27
- Dynamizing G.P.s' Pensions 28
- Association Notices 28

CORRESPONDENCE

Correspondents are asked to be brief

Breech Management with Fetal Blood Sampling W. G. Mills, F.R.C.O.G.; D. J. S. Hunter, M.R.C.O.G.; P. Donnai, M.R.C.O.G., and A. D. G. Nicholas, F.F.A. R.C.S. 229	Aleutian Mink Disease L. Herzberg, M.R.C.P. 233	Hemifacial Spasm R. J. V. Battle, F.R.C.S.; M. S. Harrison, F.R.C.P.ED., F.R.C.S.ED. 235
Congenital Malformations and their Control H. A. Wendel, M.D. 230	Conscience of the Profession A. J. Barson, M.D. 233	Radiotherapy and Carcinoma of the Parotid D. H. Patey, F.R.C.S. 236
Test of Sensitivity of Staphylococci to Methicillin J. G. Kensit, M.B. and N. A. Simmons, M.R.C.PATH. 230	Side Effects of the Pill Kathleen M. Huntington, M.B. 233	Dr. F. A. Cook's Diaries G. Dove, M.B. 236
Chlorprothixene and Obstructive Jaundice D. G. S. Ruddock and J. Hoenig, M.R.C.P. 231	Anaesthesia by Acupuncture M. A. E. Ramsay, F.F.A. R.C.S. 233	Hypotension and Methylmethacrylate Cement R. H. Ellis, F.F.A. R.C.S. 236
Hodgkin's Disease: A Clue or a Fluke? Jean M. C. Clark, M.B. 231	Congenital Tuberculosis Successfully Treated D. C. Gordon-Nesbitt, M.R.C.S., and G. Rajan, M.R.C.P. 233	ABO Blood Groups and Sex Ratio at Birth T. M. Allan, M.B. 236
Thiocyanate Metabolism in Human Vitamin B₁₂ Deficiency A. G. Freeman, F.R.C.P. 232	Problems with Ketamine Anaesthesia Captain K. C. MacIntosh, M.B. 234	Hazardous Wastes P. J. Horsey, F.F.A. R.C.S. 237
Special Risks in the N.H.S. G. H. Hall, F.R.C.P. 232	Drugs in Infertility E. W. Barnes, M.R.C.P., and others. 234	Contraception and Infertility H. P. Dunn, F.R.C.O.G. 237
Fatal Injuries after Car/Lorry Collisions C. J. Wicks, M.B.; F. Kellerman, M.D. 232	Nutritional Value of School Meals Susan M. Bateson, B.A., and M. C. Bateson, M.R.C.P. 234	Tubal Sterilization and its Reversal E. A. Williams, F.R.C.O.G. 237
Making Hospital Geriatrics Work Eluned Woodford-Williams, F.R.C.P.; F. A. Binks, M.D. 232	Referring Patients for Electrolysis I. W. Caldwell, F.R.C.P. 234	Consultant Negotiations C. E. Astley, F.R.C.P. 237
Sheep's Head as a Source of Orf Infection J. Savage, M.D. 233	Childhood Leukaemia and Pregnancy Viraeamia C. M. D. Edmonds, D.P.H. 235	Future of the B.M.A. R. A. Keable-Elliott, M.R.C.G.P.; P. M. Healy, M.R.C.G.P. 238
	Measles Vaccination and Tuberculin Test H. G. Calwell, M.D. 235	Nine Out of Three R. V. Clark, F.R.C.S.ED. 238
	Nitrazepam and the Elderly F. O. Wells, M.R.C.G.P. 235	Fourteen Out of Seven T. G. Reah, F.R.C.P. 238

Breech Management with Fetal Blood Sampling

SIR,—The admirable report of Dr. B. W. Eliot and Mr. J. G. Hill (23 December, p. 703) will be of great value to obstetricians working in units where the fetus can be monitored in labour by continuous cardiography and blood sampling. It will set a useful guide line for the sometimes difficult decision as to when labour should be curtailed by recourse to caesarean section.

For obstetric and midwifery staff in other units there will still be the traditional problem of how far the passage of meconium should be taken to indicate fetal asphyxia in cases of breech delivery. It is stated in the report that three out of 28 patients underwent section for fetal distress in the first stage of labour. It would be interesting to know the grounds for these decisions and also to have a much larger series with the incidence of visible meconium plotted against the fetal pH in the first stage of labour.

One further comment. It is accepted that serious intracranial haemorrhage is due to a combination of cerebral venous congestion and trauma to the after-coming head. The venous congestion may be due largely to asphyxia but it may be temporarily exacerbated by the delivery of the fetal body through a narrow pelvic outlet or a tight vaginal introitus. In these circumstances much of the fetal blood will have been "milked" upwards, increasing pressure in the superior vena cava and thus in the intracranial venous sinuses. Consequently, however urgently it may seem necessary to deliver the baby, it is even more essential to allow a brief interval after delivery of the fetal shoulders for the excess intracranial blood to flow back into the extremities. It is also advisable whenever possible to es-

tablish fetal respiration, and thus to diminish the asphyxial element of cerebral congestion, before extracting the head with forceps.—I am, etc.,

WILFRID G. MILLS

Birmingham Maternity Hospital

SIR,—Dr. B. W. Eliot and Mr. J. G. Hill are to be congratulated on their most interesting article describing pH changes in the fetus during breech delivery (23 December, p. 703). It seems to me, however, that they failed to take into account the possibility that the fall in pH seen in the fetus during the second stage of labour in a breech delivery may in fact be due to placental bed retraction. If cord compression were responsible, I would expect the pH of the fetus to fall more rapidly towards the end of the delivery than at the beginning. The greatest retraction of the placental bed, however, will occur at the beginning of the delivery as the body of the fetus leaves the uterus and is delivered to the umbilicus, and I would therefore expect the greatest fall in pH to occur at this time, as the authors reported. From that point to the delivery of the head there will be only very slight further reduction in the placental bed area and one would therefore expect only a small further reduction in fetal pH. The fact that the greater the size of the fetus, the greater the fall in pH also suggests that reduction in placental bed area during delivery is the cause of the pH changes reported.

Dr. Eliot and Mr. Hill do, however, so rightly underline the very close monitoring of the breech delivery that is required, but unfortunately they do not describe the fetal

heart rate patterns that were associated with the pH changes they observed. It would be most interesting to know whether the pH changes that indicated immediate intervention occurred without there being a similar warning from the fetal heart rate pattern.—I am etc.,

DAVID J. S. HUNTER,

Nuffield Department of Obstetrics and Gynaecology, University of Oxford

SIR,—We found the paper by Dr. B. W. Eliot and Mr. J. G. Hill (23 December, p. 703) concerning the changing fetal pH in the second stage of labour most interesting. However, the high incidence of fetal acidosis in this series prompts us to communicate in preliminary form the results we have obtained from a study of 93 breech deliveries by the vaginal route when epidural analgesia was used.

The umbilical vein pH was measured immediately after completion of the delivery in 42 cases and in five cases only was the cord pH 7.20 or below. The average length of labour and fetal weights were similar to those quoted in the above paper. It is our concern that compression of the buttock and the associated venous stasis may contribute to a falling buttock pH and not reliably reflect the fetal condition. In practice therefore we prefer to monitor the fetal heart continuously, using an electrode attached to the buttock, during breech deliveries. The observations of Shelley and Tipton¹ with regard to the relationship between fetal heart rate and Apgar score seem to hold good for breech presentations as well.

Epidural analgesia, although of controversial value in breech delivery, is in our experience of considerable help during