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We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Hospitals for sick children

SIR,—In his interesting paper on John Bunnell Davis (5 May, p 1191) Dr I S L Loudon assesses the role of Dr Charles West as a physician of the Universal Dispensary for Children and as the founder of the Hospital for Sick Children, Great Ormond Street. May I make the following comments?

The care for children in the first half of the nineteenth century gained momentum under the influence of social and economic changes. This is best illustrated by the following quotation from Angus Wilson:

"Dickens's long line of living children are the victims of two views of life—the Benthamite, economic treatment of the young as units of memory and learning, a sort of sponge to absorb facts in order that they may take their useful place in a money organised society; or secondly, as the victims of the Calvinistic view of children as limbs of Satan, as unregenerate small mommets. Both views surely have their roots in the eighteenth century. Both deny the Dickensian world of love and imagination."¹

In the eighteenth century children had been considered expendable, and a child's death was considered an act of God. George Armstrong's merit was that he believed that the child's lot could be improved by founding the first Dispensary for the Infant Poor, but he was hostile to the idea of an inpatient hospital for children, as the following quotation shows:

"Several Friends of the Charity have thought it necessary to have a house fitted up for the Reception of such Infants as are very ill where they might be accommodated in the same Manner as Adults are in other Hospitals. But a very little Reflection will clearly convince any thinking Person that such a scheme can never be executed. If you take away a

sick Child from its Parent or Nurse you will break its Heart immediately; and if there must be a Nurse to each Child what kind of an Hospital must there be to contain any Number of them? Besides, in this case the Wards must be crowded with grown Persons as well as Children; must not the Air of the Hospital be thereby much contaminated?..."²

His influence was immense and had its lasting effect on following generations of physicians. The nineteenth century introduced alterations in the status of children, who were now loved for their own sake. Efforts were made for their spiritual and bodily care. The Factory Act of 1833 made child labour under the age of 9 illegal; under 13 not more than 48 hours' work was permitted in one week.³ Trevelyan states: "This enlarged sympathy with children was one of the chief contributions made by the Victorian English to real civilisation."⁴ Charles West was the son of this era, with a strong religious nonconformist background. He was aware of George Armstrong's views. He went to the Continent (Bonn and Paris) in 1835 and to Berlin in 1837 to obtain his doctorate.⁵ It is important to recall that West introduced domiciliary visits when he worked at the Universal Dispensary.

There are therefore many strands in his motivation to found an inpatient children's hospital, of which the more important are, firstly, the changed atmosphere for love and sympathy for the child in the nineteenth century, which West supported with enthusiasm; secondly, his conviction that good treatment of children's diseases was only possible in a proper children's hospital, an experience gained from his domiciliary visits

and studies abroad; thirdly, the existence of children's hospitals in Continental cities, as observed during his travels and studies there; and, finally, his knowledge acquired in England, France, Germany, and Ireland that scientific medicine was on the march and making enormous strides.

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¹ Wilson, A, *The World of Charles Dickens*. Harmondsworth, Penguin Books, 1972.

² Armstrong, G, *A General Account of the Dispensary for the Infant Poor*. 1772.

³ Langdon-Davies, J, *Shafesbury and the Working Children*, Jackdaw No 7. London, Jonathan Cape, 1964.

⁴ Trevelyan, G M, *Illustrated English Social History*. Harmondsworth, Penguin Books, 1964.

⁵ Besser, F S, *Great Ormond Street Gazette*, Winter 1973.

SIR,—Dr I S L Loudon (5 May, p 1191) mentions the frustration experienced by Charles West when he failed to persuade the committee of the Royal Universal Infirmary for Children to make provision for inpatients.

I have found an echo of that frustration in a letter in my possession which he wrote at the time to a Belfast physician, Andrew Malcolm, who had written to West for information about children's hospitals. The letter, dated 24 January 1848, reads:

Dear Sir:

Your very courteous note reached me one or two days ago and I can assure you that nothing would have given me greater pleasure than to reply to your enquiries.

The institution with which I am connected however, though called the Infirmary for Children, is in reality no infirmary, but merely a dispensary, so that no information concerning it would be of any service to you in your enquiries.

Wishing you every success in the object you have in mind.

I am yours faithfully
Charles West

It may perhaps save you some trouble if I add that

much as it is to be regretted there is in London no Hospital for children.

Within two years of writing this letter West had resigned from the Royal Universal Dispensary and, as Dr Loudon relates, was planning a new hospital, which was to be the Hospital for Sick Children, Great Ormond Street. It was opened in 1852 but Belfast had to wait until 1873 for its Hospital for Sick Children and by then Malcolm had been dead for 17 years.

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loss greater than 500 ml) is low; secondly, that in nulliparae the mean blood loss does not differ significantly in the groups studied; thirdly, that a slight but significant ($P < 0.05$) difference in mean blood loss is found in parous women; and, lastly, that irrespective of parity extra-amniotic priming of the uterine cervix with PG gel does not affect the risk of postpartum haemorrhage.

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¹ Calder, A A, Embrey, M P, and Tait, T, *British Journal of Obstetrics and Gynaecology*, 1977, **84**, 264.

Induction of labour and postpartum haemorrhage

SIR,—Together with my fellow staff members, we felt somewhat uneasy after reading a report by Surgeon Commander P R S Brinsden and Mr A D Clark (23 September, p 855) and Mr I Z MacKenzie's recent analysis (17 March, p 750), which indicate that postpartum haemorrhage is to be considered a complication of labour induction. In a recent letter (28 April, p 1147) Surgeon Commander Brinsden and Mr Clark produce additional data confirming their earlier conclusion, underlining that the risk of postpartum haemorrhage is greater in induced primiparae and that it is probably related to the dosage of oxytocin infused.

We asked our computer to provide us with the results of our last two years' activity and strictly adhered to Mr MacKenzie's methodology for the analysis of the data. To augment labour intravenous (IV) oxytocin was used throughout, and the method applied for labour induction (in all the cases electively—that is, at term and with a ripe cervix) consisted in low amniotomy supplemented by IV oxytocin or IV prostaglandin E_2 (PGE_2) when necessary. Finally, preinduction cervical ripening was attempted according to the method proposed by Calder¹: a single dose (0.5 mg) of PGE_2 suspended in 8 ml 5% hydroxyethyl-methylcellulose (Tylose) gel was instilled into the extraovular space through a transcervically placed Foley catheter and the device was left in situ until it was either expelled spontaneously or withdrawn at reassessment of the cervix. Our routine is to inject 0.2 mg IV methylergometrine (Methergin) just before or immediately after the delivery of the anterior shoulder. When IV oxytocin or PGE_2 has been administered (for induction or augmentation of labour) the infusion is discontinued only after completion of the fourth stage of labour.

Our data are summarised in the table. They indicate, firstly, that the overall incidence of postpartum haemorrhage (estimated blood

Relief of postoperative pain

SIR,—I would agree with Dr M Rosen and Professor M D Vickers's comments (12 May, p 1278) on Dr Jeremy J Church's paper (14 April, p 977) to the effect that the patient is the individual who actually experiences pain, and therefore if pethidine or other narcotic analgesics are being given to counteract it the patient should ideally have control of the dosage. Experience with labouring women has indicated that if they have control of the amount of pethidine they are receiving by continuous intravenous infusion they do not take excessive amounts compared with those receiving the drug by intermittent intramuscular injection, but dose and timing are tailored to their personal need.¹

Sleep precedes significant respiratory depression and an arrangement which ensures that administration ceases when the patient goes to sleep has much to commend it. The Cardiff system is based on microelectronic technology whereas the Leeds method involves a spring clamp with a number of simple mechanical safety features, which puts the dose regulation literally within the patient's own grasp. Even if the cost of the Cardiff apparatus comes down significantly, it remains a matter of conjecture whether problems of serious malfunction will be more likely with electronic than mechanical systems—my hunch would be that mechanical ones may prove more robust.

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¹ Scott, J S, *American Journal of Obstetrics and Gynecology*, 1970, **106**, 959.

Ultrasound estimation of gestational age

SIR,—Mr A F J Atkins (5 May, p 1215) is right in emphasising the importance of accurate dating of pregnancies, and an early ultrasound scan is useful not only for this but also for detecting physical abnormalities in time for termination of grossly abnormal pregnancies. We share his surprise at the method which Professor C J Roberts and others (14 April, p 981) reported using, and support the use of a combination of A and B scans to obtain a precise measure of the biparietal diameter (BPD).

Our main concern, however, is with the accuracy of estimating the duration of gestation from an early BPD measurement. The figures of Professor Roberts and his colleagues suggest that the duration of gestation

based on ultrasound BPD was on average about half a week less than that based on the first day of the last menstrual period (LMP). This leads us to wonder whether the authors have made the common mistake (which we have ourselves made in the past) of using a curve that is 0.5 weeks further to the left than it should be. Campbell and Newman's table¹ gives mean BPD by length of gestation (derived from the LMP of women sure of their dates and who delivered spontaneously within a week of the expected date of delivery). It groups the patients by the number of completed weeks, so that for each group the average duration of their pregnancies is half a week more than the figure in the table.

We compared the BPD- and LMP-derived gestational ages in 165 singleton pregnancies in women with reported cycle lengths in the range 26–30 days (inclusive), whose LMP was not an oral contraceptive withdrawal bleed. The BPD was measured at between 15 and 20 weeks' gestation by the combined A and B scan method. For each patient the BPD-derived gestational age was subtracted from that derived from the LMP. There were three cases with differences of 35, 40, and 41 days, which presumably represented delayed ovulation that would have resulted in long cycles. The differences in the other 162 ranged from –18 to +23 days and had a mean of only –0.3, with a standard deviation of 5.3 days. This implies a 95% confidence interval of the duration of gestation derived from a BPD, measured in this way by skilled operators, of ± 10.3 days, which is an adequate level of precision to be useful for many clinical purposes.

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¹ Campbell, S, and Newman, G B, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1971, **67**, 1414.

Overseas aid—urban hospitals or primary care?

SIR,—I am most grateful for the short and obvious answer given by Dr A W Williams in his letter (12 May, p 1286) on the subject of urban hospitals and primary health care in the developing countries. It is unfortunate that Dr J S Yudkin's letter (21 April, p 1087) was based only on the brief information given by Minerva (31 March, p 897) concerning what must be viewed as an integrated health development project.

The rebuilding and equipping of the Mbeya Hospitals were requested by the Ministry of Health in Tanzania as part of a plan to improve health services throughout the southern regions. The Overseas Development Ministry has inputs at all levels of health care in these regions. (1) Villages: An environmental sanitation programme is being mounted in two pilot areas, linked with piped water supplies, with a view to later extension on a district and regional scale. (2) Dispensaries: As part of the national integrated tuberculosis and leprosy programme microscopes and bicycles are being made available to all dispensaries to improve case identification and contact tracing. Land Rovers are also being provided for district TB/leprosy co-ordinators. (3) Health centres: Six new health centres are being constructed in

Postpartum haemorrhage (PPH) and onset of labour in Gent 1976–8

	Nulliparae		Parous women	
	Total	No (%) with PPH	Total	No (%) with PPH
Spontaneous labour ..	650	13 (2.0)	690	8 (1.2)
Augmented labour ..	320	11 (3.4)	251	8 (3.2)
Extra-amniotic PGE_2 gel before induced labour ..	225	6 (2.7)	155	2 (1.3)
Induced labour ..	246	4 (1.6)	377	14 (3.7)

χ^2 test, 3 DF: nulliparae NS; parous women $P < 0.05$.