in the first trimester? In this way a more balanced picture of the condition may be obtained.

ROBERT BALFOUR

St David's Hospital,
Cardiff CF1 9TZ

¹ Kohn A, Parsons A. *Br Med J* 1978;ii:1216.

What the fetus feels

SIR,—I welcomed Dr H B Valman's excellent summary of early fetal awareness (26 January, p 233). In addition to simple sensory modalities, I am sure that the fetus responds to admixtures of complex sensations and of those hormones that derive from mother—for example, in singing, dancing, and vomiting.

When a mother undergoes ultrasound scanning of the fetus, this seems a great opportunity for her to meet her child socially and in this way, one hopes, to view him as a companion aboard rather than as a parasite responsible for the symptoms of pregnancy. Doctors and technicians scanning mothers have a great opportunity to enable mothers to form an early affectionate bond to their child by demonstrating the child to the mother. This should help mothers to behave concernedly towards the fetus throughout pregnancy and may be expected to increase the bond on childbirth.

ANTON R DEWSBURY

Dudley Road Hospital,
Birmingham B18 7QH

Dislocated and dislocatable hip in the newborn

SIR,—We were interested to read the article by Drs H B Valman and H V L Finlay (19 January, p 164). They correctly emphasise the importance of examining the neonate at a tender age, in a warm room, on a flat surface, and with the child relaxed. Without all of these measures errors in diagnosis will be made. We do not, however, agree that a clicking hip is necessarily normal and needs no follow-up or further examination.

In the Colchester and Chelmsford districts, from 1972 to 1976, we were able to compare two methods of managing such children. In Colchester all children who were found to have clicking hips were treated as though they had a dislocated hip—that is, by splintage for three months. In Chelmsford it was not the policy to treat children who were found to have clicking hips. Despite the screening procedures in these two districts some children with congenital dislocation of the hip continued to present late. No child who had had a clicking hip treated by splintage later presented with a congenital dislocation of the hip. Four children with clicking hips which were not treated later presented with a dislocated hip. In addition, four children who were examined by orthopaedic surgeons and thought to be normal were later found to have a dislocated hip.

In our experience, a child with clicking hip is manifestly at risk if only because of the difficulty which even experts have in successfully diagnosing a dislocated hip in 100% of cases. We feel that all children with a clicking hip should be treated.

DENIS M DUNN
S M O'RIORDAN

Black Notley Hospital,
Braintree, Essex CM7 8NF

Infant feeding in Chinese populations

SIR,—We noted different feeding practices among the 99 Chinese children studied in Glasgow in 1974-6 from those reported by Mr THHG Koh in his article "Breast-feeding in Sarawak" (12 January, p 95). Only one (2%) of the Chinese babies born in Glasgow was breast-fed, while 38 (81%) of those children born in the country of origin had been breast-fed. This would seem to indicate how strongly Chinese immigrants are influenced by the infant feeding practices in the UK. Those Chinese mothers who had given birth in China or Hong Kong and who breast-fed did so on average for at least one year. The reasons given for not breast-feeding were: (a) Inconvenience—70%; (b) Insufficient milk—20%; (c) "Why not when there are so many types of artificial milks to choose from?"—5%; (d) "Unfashionable—we are not living in a village like Hong Kong now"—5%.

In contrast, however, to the change from breast- to bottle-feeding, Western habits had not influenced the Chinese mothers' attitudes to weaning. Solid foods were not introduced to the diets of the Chinese children till one year or later in 20 (43%) of those born abroad and in 21 (43%) of those born in the UK. The type of weaning food used by the mothers we studied was very similar to that reported by Mr Koh—that is, a porridge mixture with the addition of vegetables, meat, and fish.

FIONA HOUSE
K M GOEL

Royal Hospital for Sick Children,
Glasgow G3 8SJ

Postoperative pain

SIR,—Dr P C Rutter and his colleagues (5 January, p 12) have demonstrated that postoperative pain relief is more complete when morphine is administered intravenously rather than intramuscularly. This is one of several papers on this topic which do not seem to have paid sufficient attention to the psychological aspects of pain which may usefully be employed in its relief.

Egbert *et al.*¹ in a well-controlled study, demonstrated that "special care" from the anaesthetist could almost halve the dose of morphine required during the first five postoperative days. This involved preoperative instruction about the nature of the pain to be expected postoperatively, how to relax the muscles of the abdominal wall even when turning over, and about requesting analgesia when necessary. It also involved daily visits by the anaesthetist postoperatively. These patients actually experienced less pain, according to an independent observer, and were discharged on average 2.7 days earlier than the control group.

This result is important, firstly, because any trial of postoperative analgesia should describe in detail any such preoperative discussion with the patient. Secondly, the essential ingredients of Egbert's "special care" could usefully be employed to improve patient care even where facilities for intravenous administration of analgesia are not available. Thirdly, further research is needed to see whether "special care" combined with the new technology would still further reduce the morphine dose; this is necessary as Rutter *et al* report the potentially serious complication of "a

slightly more blunted mental state" with intravenous administration.

An anaesthetist's time is possibly more expensive and less readily available than morphine, but Leigh *et al*² have shown that there is no substitute for a personal visit to reduce preoperative anxiety. This reduction raises the pain threshold and can be quite simply achieved without necessarily involving the anaesthetist.²

Simple solutions should not be ignored when we are faced with the "apparently simple problem"³ of reliable postoperative pain relief. In recent reports of staff-patient communication, a medical student⁴ points out that "anxiety and fear are the inevitable consequences of poor communication between doctors and patients" and a student nurse⁵ reminds us that "recovery from a physical illness may be improved by considering the patient's mental as well as physical well-being."

F H CREED

Department of Psychiatry,
London Hospital Medical College,
London E1 2AD

¹ Egbert LD, Battit GE, Welch CE, Bartlett MK. *New Engl J Med* 1964;270:825-7.

² Leigh JM, Walker J, Janaganathan P. *Br Med J* 1977; ii:987-9.

³ Anonymous. *Br Med J* 1978;iii:517-8.

⁴ Reynolds M. *Br Med J* 1978;ii:1673-6.

⁵ Dunkelman H. *Br Med J* 1979;ii:311-4.

Guidelines to aid ethical committees considering research in children

SIR,—The British Association of Paediatric Surgeons, of which I am honorary secretary, had the opportunity to study and discuss "Guidelines to aid ethical committees considering research involving children" (26 January, p 229) a few months ago. In general we feel that it is a very good document and we would like to support it. However, we are uneasy about the second premise on which the paper is based—namely, "that research should never be done on children if the same investigation could be done on adults."

We feel that this could be unnecessarily restrictive. What is to happen, for example, to the paediatric radiologist who has reason to believe that by an electronic modification of his screening apparatus he can reduce the amount of irradiation during micaturing cystourethrography by 90%? He must, of course, demonstrate that there is no lack of accuracy or clarity. In other words he must set up a formal study of this problem and that will involve children. Is he to wait until his adult colleagues have first of all done this procedure? This hardly seems the way forward for paediatric research.

JOHN CORKERY
Honorary secretary, British
Association of Paediatric Surgeons

Royal College of Surgeons of
Edinburgh,
Edinburgh EH8 9DW

Depot medroxyprogesterone and vaginal bleeding in the puerperium

SIR,—We have read Mr H M Murphy's report on the effect of depot medroxyprogesterone acetate on vaginal bleeding in the puerperium (1 December, p 1400) with great interest and completely agree with his conclusions.

In our experience, a single intramuscular injection of 150 mg medroxyprogesterone acetate administered during the early puerperium is a highly efficacious contraceptive measure, which in that period offers the extra advantages of not affecting lactation or predisposing the woman to thromboembolic complications. Therefore injectable hormones provide a rational approach for doctors wishing to give a contraceptive that will bridge the first postpartum trimester with optimal efficacy. However, as Dr Murphy clearly stresses, when initiated soon after birth (or abortion or miscarriage) the medroxyprogesterone treatment involves the risk of protracting vaginal bleeding without significantly affecting uterine involution. We also found, albeit more or less by chance, that in practice this sign appears to be highly distressing for some women.

For many years it has been our routine practice to delay surgical tubal sterilisation until the first postpartum menstrual period has occurred, at least in non-lactating women. To provide effective contraception during this interval we recommended an intramuscular injection of medroxyprogesterone administered at the time of hospital discharge. However, the results of the psychological evaluation conducted three and 12 months after voluntary sterilisation of 115 females and 70 males (185 couples) showed that the depot injection had led in some of the women to negative reactions which became manifest during the post-operative assimilation process. Even after active counselling and support, several women persisted in attributing their altered bleeding pattern to the sterilisation instead of to the contraceptive treatment. In a few of these women, who bled more or less continuously for more than six months, the concern about the metrorrhagia became pathological to a degree requiring psychiatric care. Consequently, we no longer recommend medroxyprogesterone for contraception in such cases, and though some of our patients in the puerperium still ask for it we delay the first injection until a menstrual period has occurred. If administered no later than on day 8 of the second postpartum cycle, this method has proved to be effective and the bleeding pattern does not differ from that usually observed with interval administration of this depot preparation.

A more recent psychological evaluation of a new series of women sterilised according to the same technique but not given medroxyprogesterone while awaiting partial tubectomy has shown that the adverse psychological reaction and the concomitant difficulties in assimilating the effects of the operation have no longer occurred.

M THIERY
R STAELENS
C SANCTORUM
R L CLIQUET

University Department of Obstetrics,
University of Ghent, and Population
and Family Study Centre,
Brussels, Belgium

Cutaneous manifestations of hydrallazine toxicity

SIR,—We read with interest recent reports by Dr M W Kissin and Professor R C N Williamson (24 November, p 1330) and Dr R M Bernstein and others (19 January, p 156) of cutaneous manifestations of late toxicity to

hydrallazine, and wish to report a case currently under our care.

A 58-year-old man with severe hypertension had a bypass vein graft for left renal artery stenosis in May 1976 and commenced hydrallazine. The maximum dose was 150 mg daily, with a total dose to date of 150 g. In November 1978 he complained of polyarthralgia; the latex test for rheumatoid factor gave negative results. He presented in December 1979 with malaise, fever, bilateral pleuritic chest pains, haemoptysis, and mouth and penile ulcers. In addition he had vasculitic lesions on the buttocks, forearms, and hands, and a deep ulcer over the metacarpophalangeal joint of the right index finger. These have begun to heal since hydrallazine has been withdrawn and adrenocorticotrophic hormone started. At this time he was anaemic (Hb 8.3 g/dl) and had a raised sedimentation rate (114 mm in the first hour, Westergren) and increasing uraemia, with haematuria and albuminuria. The antinuclear antibody test is positive at > 1 in 400 (homogeneous staining), having been 1 in 10 in 1976.

This case fulfils several of the criteria of patients at risk of developing late toxicity to hydrallazine¹ including initial accelerated hypertension, a previously positive antinuclear antibody test, a cumulative dose of more than 100 g, and coexistent autoimmune disease (he has antibody-positive primary hypothyroidism). The cutaneous manifestations in this patient were widespread. With increasing use of hydrallazine, even at low doses, we must be vigilant for the sensitisation effects of such toxicity.

A P BROOKS
J W PAULLEY

Department of Medicine,
Ipswich Hospital,
Ipswich, Suffolk IP1 3PY

¹ Perry HM jun. *Am J Med* 1973;54:58-72.

SIR,—Following the article of Dr M W Kissin and Professor R C N Williamson (24 November, p 1330), we would like to report on a case of the hydrallazine-related lupus erythematosus (LE) cell syndrome associated with extensive ulceration.

In 1971, when she was 21, this patient developed malignant phase hypertension with a blood pressure of 220/160 mm Hg, early papilloedema, and haematuria. Blood pressure control was difficult because of frequent postural hypotension and she was eventually controlled in 1976 on a regimen of 640 mg propranolol, 200 mg hydrallazine, and 10 mg bendrofluzide daily. In 1979 she came under the care of this hospital. After four miscarriages she was pregnant for the fifth time and was admitted for Shirodhar suture. For a few days prior to admission she had had irritation over the left arm and right leg and had small tender areas of purpura. The operation was performed uneventfully. The purpuric rash persisted and the LE cell test was found to be positive. Antinuclear factor was present, but antibodies to DNA were absent. Urea, electrolytes, and blood count were normal, and her hypertension was well controlled. Hydrallazine was discontinued, but her rash became very extensive and painful, and within five days started to vesiculate. Treatment with prednisolone was started at this stage. The rash did not extend any further; but the areas of confluent purpura and vesiculation became necrotic and extensive shallow ulceration developed over the whole affected area, requiring skin grafting. It finally healed completely after three months. The steroid was reduced abruptly at the time of the skin grafting and this precipitated an episode of pericarditis, with a friction rub and cardiographic changes. This settled as soon as the dose of steroid was increased. The blood pressure remained well controlled on 500 mg methyldopa and 10 mg bendrofluzide and the patient was delivered of a

Extensive ulceration associated with hydrallazine.

normal infant at 34 weeks. The LE cell test remained positive for three months after delivery but has now become negative, and her legs remain well healed. Her blood pressure is tending to rise and she requires a larger dose of methyldopa for control.

The remarkable feature about this woman's illness was the rapidity with which the purpura extended and became confluent. There was presumably an extensive underlying arteritis because these areas immediately became necrotic and gradually sloughed. Prednisolone appeared to prevent further extension of the purpura and it is possible that starting it as soon as the diagnosis was made may have prevented so much ulceration from occurring.

R PETTY
D R K MEDLEY

Princess Alexandra Hospital,
Harlow, Essex CM20 1QX

Phenobarbitone and epilepsy

SIR,—We have recently learnt that it is official BMA policy to support the proposed legislation to include all 5,5-disubstituted barbiturates within the schedules of the Misuse of Drugs Act. We would like to comment on the effect that this would have on the prescription of phenobarbitone for the treatment of epilepsy.

Although the necessity to prescribe phenobarbitone has been reduced by more modern antiepileptic drugs, there are still a large number of people whose epilepsy is satisfactorily controlled by this drug. We feel that the inclusion of phenobarbitone within the provisions of the Act would expose many people with epilepsy to unnecessary inconvenience and possibly hazard. Many doctors would feel disinclined to comply with the extra demands of writing a prescription for a controlled drug and would attempt to withdraw phenobarbitone. The fact that many chemists would stop stocking the drug would increase the difficulty in obtaining it and would therefore encourage non-compliance. Furthermore, the concern of the patient over being