and the rear one moving faster than G. On IRC 50 resin chromatography at pH 6 the wide separation typical for Q could be demonstrated (Fig. 1). Haemoglobin A₂ was not increased and the one-minute alkali denaturation test demonstrated less than 2% alkali-resistant haemoglobin. There was a very small amount of haemoglobin in the position of haemoglobin F seen on chromatography. These findings demonstrated the simple Q trait (A+Q) and were not thought to be related to the boy's illness.

The child was given a blood transfusion of 250 ml. of whole blood and progressed well. Three weeks after his admission his haemoglobin was 9.8 g./100 ml. and the jaundice had totally disappeared.

The boy's father had died of unknown causes, and it was possible to obtain blood only from the boy's mother and one of his sisters. The mother again was a case of haemoglobin A+Q, and in the sister nothing abnormal was seen (Fig. 2).

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Spontaneous Delivery of Central Placenta Praevia

In general practice the opportunity rarely arises of witnessing the natural course of delivery in the case of a central placenta praevia. According to Gibberd (1951), "in exceptional cases of central placenta praevia the afterbirth may be delivered in front of the foetus, but it must be very unusual for this amount of placental separation to occur and for the mother to survive the haemorrhage." The following case is reported because under conditions far from ideal a mother survived the course of events set forth by Gibberd.

I must first describe the local geography of my practice, because this had a considerable bearing on the conduct and course of the case. The practice covers an area of about 600 square miles (1,550 sq. km.) around a large bay in the north of Newfoundland. Communications are poor. Mud makes the roads impassable in the spring. The sea, our main travel route, is often blocked by ice drifting in from the Arctic. The nearest hospital with facilities for blood transfusion is 130 miles (210 km.) away.

CASE REPORT

At 5.30 one morning I was called to see a young woman living in a settlement some 15 miles (24 km.) from my clinic. It was stated that she had been losing blood per vaginam for four days, that she was then having labour pains, and that the loss was increasing. I made my way through the ice, arriving in the settlement three hours later.

The patient, aged 22, was in the 36th week of her second pregnancy. She had one child, a girl, delivered normally at full term, weighing 7½ lb. (3,400 g.). In this second pregnancy she had had a threatened abortion at 10 weeks, but had retained the pregnancy. She had been seen on three occasions subsequently, and had been well.

On examination she was seen to be very pale; the pulse was 110 and regular, and the B.P. 120/80. Pregnancy was judged to be at term. The foetal heart was not heard and the foetal head was above the pelvic brim. Strong uterine contractions were occurring every three to five minutes. There was a slight vaginal loss of blood and about 1 pint (570 ml.) of clotted blood had been passed four hours previously.

It was decided to fly the patient to hospital as quickly as possible, since by this time the ice had closed in, and no further move could be made by sea. Morphine ¼ gr. (16 mg.) was given subcutaneously with the object of slowing labour until the patient could be taken to hospital. A telegram was sent for the air ambulance and the husband was asked to make a stand for the intravenous-fluid bottle. He did this very well. It was considered that help would not arrive for six hours, an estimate which proved to be over-optimistic.

The condition of the patient did not deteriorate, although some blood was still being lost vaginally. The force and frequency of the contractions diminished greatly, and she slept well. Pethidine 100 mg. was given at 11.30 a.m., and repeated two and a half hours later. During this time the weather was worsening, and by 2.30 p.m. it was obvious that no aircraft would be able to fly in. It was therefore decided that the patient should be allowed to resume labour despite the hazard. This decision was reinforced by a sudden deterioration in her condition, the B.P. falling to 80/60 and the pulse rate rising to 130 with increased vaginal loss of blood.

The patient went into strong labour and soon the placenta was seen presenting at the introitus. Intravenous administration of dextran was started and preparations were made for an immediate forceps delivery of the aftercoming foetus. But at 5.30 p.m. a stillborn child was delivered spontaneously within the complete membranes and with the placenta closely applied about the vertex. The placenta had been compressed peripherally to the thickness of about ½ in. (1.3 cm.) and was intact. Post-partum loss was about 6 to 8 oz. (170 to 230 ml.).

By this time, however, the mother was very shocked, pulse 130, B.P. 60/?. Ergometrine, 0.5 mg., was given into the intravenous tube. The uterus contracted firmly and there was no further abnormal loss per vaginam. Morphine ¼ gr. (11 mg.) and benzathine penicillin (600,000 units) were given. The mother's condition was poor, but it did not deteriorate until six hours later, when, after 2½ pints (1.4 litres) of dextran had been given, she developed left ventricular failure. This was treated with 0.5 mg. of digoxin, given with the intravenous fluid, which was then discontinued; 0.5 mg. of digoxin was given by mouth. Her condition improved until by daybreak she was no longer in cardiac failure.

She remained fairly well during the next day. Haemoglobin was estimated to be about 40%. B.P. 110/70–120/80, pulse 100, regular. The weather continued to prevent flying, and it was not until 42 hours after her delivery that she could be taken to hospital. In hospital she was given 3 pints (1.7 litres) of whole blood, and made an uncomplicated recovery. She was discharged after 12 days and has since remained well.

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The Mental Health Research Fund's publicity for the next few months will aim at raising funds for research into schizophrenia, an illness which presents the largest single problem in its field. In support of the publicity a pamphlet has been produced to explain this illness in everyday terms. Pamphlets on other major mental illnesses will be produced later. The Fund's address is 39 Queen Anne Street, London W.1 (WEL 1272).