There is no greater anxiety in general practice than a worrying maternity case, and we are only too thankful for the modern improvements in hospital facilities for suitable cases. But we do not want to hospitalize unsuitable cases—normal cases. No obstetrician, hospital or general practitioner, starts by being old and experienced. I suggest that, to get on the general-practitioner obstetric list, if such a list is necessary, the candidate (a qualified registered practitioner already) should summon an obstetric consultant or registrar to supervise a number of domiciliary confinements—and, *per contra*, that in order to obtain the M.R.C.O.G. a candidate should have attended or supervised a number of domiciliary confinements.—I am, etc.,

Crowthorne, Berks.

H. D. FORBES FRASER.

SIR,—With reference to the letter by Dr. D. S. Foster (*Journal*, May 11, p. 1120), I quote: We must not be hide-bound by traditional ten-day lying-in periods."

We in this rural Canadian general practice clinic have had the experience in the past five years of converting our practice of obstetrics from home confinement to a small cottage hospital—35 beds. The tendency in North America has been in this direction for the past 25 years or more. The process is so nearly complete now that some of our large teaching hospitals have discontinued their home obstetrical services entirely. Five years ago in this very rural district home confinements were the rule. Last year fewer than 5% of our cases were delivered in the home. There is no doubt in my mind that hospital delivery is safer for both mother and child. My records are too eloquent on this point. The tendency to hospital delivery has been the main factor in lowering our maternal and perinatal death rates. Public health authorities agree on this point, and the Government-supported post-war hospital building programme is rapidly producing the necessary beds.

In our local hospital we depart rather radically from what seemed the rule in the U.K. two years ago. Our mothers are up and about 12–24 hours after delivery. Breast-feeding is gently discouraged for various reasons, some of them social—i.e., the unwillingness of Canadian mothers to continue breast-feeding for more than a few weeks—and others medical—i.e., the stubbornness of staphylococcal breast abscesses. The majority of mothers are discharged on the fifth post-operative day, a few on the fourth. These mothers go home feeling fit to cope, and few have much home help except from neighbours. The babies begin solid feeds at one month or earlier, and most double their birth weight in three to four months. At four months the baby is having milk, cereal, vegetables, fruit, egg, and meat. By six months they have had three combined diphtheria, pertussis, and tetanus shots. Antenatal, natal, and postnatal care in Canada is still in the hands of the medical profession. There is no midwife system.

In conclusion, I must agree with Dr. Foster when he makes a case for hospital delivery as opposed to home care, though I am at a loss to understand why it should be necessary to admit district midwives to already well-staffed hospital maternity facilities. Of course it is no affair of mine—happily—but surely "we must not be hidebound" by traditions.—I am, etc.,

Wakefield, Quebec.

J. H. S. GEGGIE.

SIR,—How refreshing to read Mr. Frank Stabler's profound common-sense answer (*Journal*, June 29, p. 1530) to this vexed question of hospital confinement.

It is not so very long ago that I was one of those junior residents struggling and sweating with breech and forceps deliveries and retained placentas under "remote control." Now, however, I am fortunate to be in a partnership where midwifery is enjoyed and cherished as the essence of family doctoring. We cannot offer our patients caesarean section or replacement transfusion, but we can and do offer them regular and conscientious antenatal care, consultant opinion when in doubt, and personal attention at every confinement. Even for those unforeseen emergencies which can arise in

the course of an apparently normal labour, we feel that with local analgesia, intravenous ergometrine, intravenous plasma, a second partner on the job too, and the confidence and courage to use these techniques, we are still offering our patients the best of services.

Obviously it is not a matter of choosing between the hospital and the home, but between doctors, good ones and bad ones, those who care and those who do not; and if we are bad doctors then surely our teachers, the hospital doctors, should at least share some of the blame. I am pleased that Mr. Stabler, as an obstetrician and teacher of established repute, has been so outspoken. Perhaps his word will carry more weight than the words of inarticulate family doctors.—I am, etc.,

Gt. Yarmouth.

G. HURST.

SIR,—Mr. F. E. Stabler (*Journal*, June 29, p. 1530) is surely right; the attendant matters more than the place, and home confinement with a good general-practitioner obstetrician is as safe as hospital. If the public knew this, the demand for hospital confinement would decrease. Would it not be more economic to tell them, and at the same time raise the average standard of general-practitioner obstetrics to the level of the best, than to build expensive and unnecessary maternity hospitals?—I am, etc.,

Newcastle upon Tyne.

ANDREW SMITH.

Physique and Mental Illness

SIR,—There are two reasons why most physicians find difficulty in accepting the relationship between physique and mental or physical illness. The first is that many methods of classifying human physique have been tried and found wanting, so that at present there is no mutually acceptable method available. The second is that, using the same method of physique classification, the results from different centres conflict rather than harmonize.

Between 1952 and 1956 we attempted to estimate a Sheldon somatotype on the majority of male students entering Leeds University, using both the photographic technique described by Drs. Dupertius and Tanner¹ and the deviation chart of physique introduced by Dr. Parnell,² who has done so much for constitutional medicine in this country. We have now abandoned somatotyping, but published some of our results in the *University of Leeds Medical Journal*.³ As our findings in Leeds were so different from those reported by Dr. Parnell (*Journal*, June 29, p. 1485), the following summary may be of interest.

There was no significant difference between the somatotype distribution of students at Oxford and Leeds. The somatotypes of 71 students who were suffering from psychosis, psychoneurosis, or allied disorders of such severity as to warrant hospital in-patient or out-patient treatment or prolonged attendance at the student health centre did not differ significantly from those of the general student population; certainly mesomorphy was no guarantee against mental breakdown in Leeds, as it seems to be in Oxford; the endomorphic ectomorphs were certainly no more prone to mental breakdown than were other physique types; the 452 physique was just as common amongst the mentally ill as the controls, and the 325 was no more common among the unstable. Dr. Parnell⁴ also found, as you mention in your leading article (p. 1520), that the endomorphic ectomorphs were the best examination performers. In Leeds the best examination performers were mesomorphs or mesomorphic ectomorphs, just as they were the commonest somatotypes in the student population, and we found it difficult to relate examination performance to somatotype.

We are most interested in the relationship between physique and various aspects of health and behaviour. Since 1956 we have been using a method of physique classification which compares individuals with regard to relative fatness, relative weight of the fat-free body or active tissue mass, and relative shape. This method was described at the eighth Conference on Student Health in

British Universities and Medical Schools held in Bristol in July, 1956. We hope to publish our observations as they become available, but in the meanwhile any satisfactory explanation of the differences so far observed between Oxford and Leeds would be most rewarding.—I am, etc.,

Leeds, 2.

S. E. FINLAY.

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Physique and Medicine

SIR,—Apropos of a remark in one of your leading articles (*Journal*, June 29, p. 1520): "Medicine appears to attract those with the same body build that is associated with good all-round achievement in sport and academic life and with the least likelihood of having to consult a general practitioner about mental illness." If so, perhaps this would account for the backwardness of medicine to-day where it comes to the treatment of the whole man rather than the technological manipulation of bits of his anatomy and physiology. Are the physical and mental "hearties" likely to make the best healers? Or to initiate researches the more likely to prove fertile because based on deeper understanding of those fallible men and women who fall ill?—I am, etc.,

Haslemere, Surrey.

H. HARRIS.

Nocturnal Enuresis

SIR,—Mention of successful treatment of nocturnal enuresis by hypnosis in the most interesting articles by Dr. A. Fry (*Journal*, June 8, p. 1323) and Dr. H. Stewart (p. 1320) has prompted me to describe a new method, simpler than hypnosis, of treating this most troublesome complaint.

I started with the same assumption as Dr. Fry, that removal of worry about bed-wetting and installation of hope of recovery are essential for successful treatment, and decided to test the claims of the makers that "oblivon-C" (methylpentynol carbamate) is a specific for nervous tension by giving it to a series of bed-wetters in my practice. The results, summarized in the table, far exceeded my expectations. Some of the patients had already received psychotherapy without any improvement. The position, however, was considerably changed when methylpentynol carbamate was included as an adjunct to the psychotherapy.

Age Distribution in Years	No. of Cases	Previous Treatment (Including Psychotherapy)		No Better	Much Improved	"Dry"
		Yes	No			
0-5 ..	3	2	1	—	2	1
5-10 ..	2	2	2	—	—	2
10-20 ..	4	2	2	—	1	3
20+ ..	1	—	1	—	1	—
Totals ..	10	4	6	—	4	6

Two short histories are given for illustration: (1) Male, aged 7: duration of enuresis 12 months; urine analysis, normal. Dose of methylpentynol carbamate, 200 mg., three times a day for six weeks. Result: gradual improvement with eventual disappearance of symptoms. The patient remained "dry" over a two-month follow-up. (2) Female, aged 15: a known bed-wetter for 12 months but suspected of having concealed the disability for much longer. Forced to go to the surgery by parents and refused urine analysis. A specimen obtained later, however, was normal. Treatment: sulphafurazole tablets, 2 three times a day; mist. pot. cit., $\frac{1}{2}$ fl. oz. (14 ml.), three times a day; methylpentynol carbamate, 200 mg., three times a day. After six days the sulphafurazole was stopped, but symptoms still persisted. Methylpentynol carbamate was continued, and after three further weeks the symptoms cleared up. This was confirmed by the mother, who inspected the bedding daily. The girl

has been symptom-free during a full three-month follow-up period.

Admittedly, this is a small series. But the cases were unselected and the results so good that I felt it worth while to describe them. Methylpentynol carbamate also has the merit of being safe.—I am, etc.,

Leek, Staffs.

G. KAGAN.

Is This a Record?

SIR,—Dr. G. I. Watson's experience of a 3-year-old who swallowed a screw (*Journal*, June 8, p. 1362) prompts me to record a worrying time I had with a 3-year-old girl. She swallowed a 12-sided threepenny-piece on June 14, 1953, at 7 p.m. I saw her two hours later, and as there was nothing abnormal on examination I reassured the mother and arranged to see the child regularly. On June 16, however, she started vomiting everything back, including fluids, and for the first time complained of pain in her throat. I sent her up to the Bromsgrove General Hospital, where Dr. D. I. Harries kindly screened her, and located the coin just below the cricoid. Accordingly I admitted her to the local thoracic unit, where she was examined next day. The report (dated June 18) read as follows: "By now this child will have returned home. We oesophagoscoped her but the threepenny bit proved most elusive and could not be extracted with the forceps. It passed into the stomach, and an x-ray, taken yesterday at noon, suggested that it is already in the colon. I have spoken to her mother and told her exactly what the situation is, and, should she be in the least bit worried, we will see the child straight away."

Unfortunately, the surmise that the coin had left the stomach proved over-optimistic; and as the coin had not appeared by June 25 I took her up to see Dr. Harries again for screening. The coin was found lying in the stomach. At my suggestion Dr. Harries agreed to attempt massaging the coin through the pylorus after I had first administered atropine. This failed, so I next tried atropine methonitrate without success, and finally amyl nitrite. Even inhaling from 3-minim (0.2-ml.) capsules proved ineffective, and the refractory coin remained *in statu quo*. I continued observing the child and reassuring the mother, as the child remained well and happy. On June 29, fifteen days after being swallowed, the coin was passed naturally in a normal stool. The previous day the child had been taken on a Sunday school outing to Barry Island, and had been on the "big dipper." My opinion is that the tremendous excitement or fright might somehow have effected the passage of the coin through the pylorus. I do not know, but I was on the same outing and went on the big dipper myself, and found it a most alarming and hair-raising experience.—I am, etc.,

Bromsgrove, Worcs.

R. A. F. JACK.

Tropical Pulmonary Eosinophilia

SIR,—Dr. A. Wildervanck in his letter (*Journal*, May 11, p. 1119) on tropical eosinophilia (eosinophilic lung) concludes that it would be desirable to do blood examinations for microfilariae in these cases, while treatment with diethylcarbamazine might be considered. Since April, 1956, I have used the latter drug in the treatment of this condition and have published a preliminary report¹ of its curative effect in the first ten cases so treated; a final report on a total of 110 cases is in preparation. The result of this study has shown that diethylcarbamazine has a specific action in patients suffering from eosinophilic lung which can be compared very favourably with that obtained in cases treated with organic arsenicals. Besides symptomatic improvement, clearing of the abnormal radiological picture, and decrease in the elevated erythrocyte sedimentation rate to normality, a distinctive feature is a fall in the circulating eosinophils as occurs with arsenotherapy. This decrease, which begins on the first day of treatment, continues rapidly throughout the first five days and then more gradually till counts below 2,000 eosinophils per c.mm. are finally reached. Three out of 110 cases relapsed, but showed the same response to