Dried Plasma for Domiciliary Midwifery

SIR,—I have read with interest Dr. C. T. H. Whiteside's letter (June 4, p. 1005) on the above, and I feel that I must strike a note of warning. I agree that facilities for resuscitation of patients suffering from post-partum haemorrhage are important, but I feel very strongly that the use of dried plasma will do much more harm than good.

For some years now I have avoided the use of plasma, primarily because I have so often seen it fail. Apart from the dangers of jaundice, which an increasing volume of literature has shown to be very real, the fact is that plasma fails to resuscitate these patients. The woman who has lost blood in the third stage of labour requires above everything oxygen to maintain the integrity of the vital centres in the medulla, and this plasma cannot give her. It will increase the blood volume and perhaps produce a temporary improvement in the circulation, but this is only temporary and rather spurious, and again and again I have seen a secondary collapse from which it has been impossible to rescue the patient.

At a recent meeting of the Edinburgh Obstetrical Society Professor Kellar said that the use of plasma had been given up entirely at the Simpson Memorial Hospital and that in several of the cases on which it had been used unsuccessfully post-mortem examination had revealed suprarenal haemorrhages. Whilst a direct cause and effect association could not be substantiated, none the less, plasma had been entirely replaced by saline and whole blood.

In almost all parts of the country to-day "flying squads" are available in one form or another, with the resources of blood banks behind them, so that in any case where it is necessary it should be possible to undertake transfusion of blood in a comparatively short time, and the patient's condition in the meantime can be maintained if necessary with intravenous saline injections. This, unlike plasma, carries a negligible risk of infection and, moreover, again unlike plasma, is rapidly cleared from the circulation to make way for subsequent blood transfusion. The use of morphine also in these cases will help to delay the development of shock and tide the patient over until blood is available.

May I suggest, therefore, that Dr. Whiteside will find that his results will be much better if instead of plasma in his special bag he will carry two pints of normal saline and will make use where necessary of the emergency services in his area.—I am, etc.,

Inverness.

J. A. CHALMERS.

Surgery at the Front

SIR,—I have read the obituary of Mr. Owen W. Richards (May 21, p. 915), and I think you will find in the records that the first abdominal and chest unit in the forward area was opened by the 26th Field Ambulance, 8 Division, at Bac St. Maur, north-west of Merville, in early September, 1915.

In the winter of 1914-15 I suggested to our C.O., Lieut.-Col. A. Milne Thomson, C.M.G., that the abdominal cases were dying of haemorrhage, and that if operated upon in the forward area results would be better. He gave me permission to perform necropsies, which demonstrated that haemorrhage from the small mesenteric vessels was the chief trouble, in many cases only a small part of the bowel being perforated. First it was suggested that the necessary sterile materials should be sent forward in drums from No. 6 C.C.S., Merville, or the advanced depot of medical stores, as we had not space available in a mobile unit to transport autoclaves, etc. In January, 1915, by permission, I called at the War Office, and on explaining our difficulties was issued with various instruments. In early September, 1915, our unit was moved to a factory in Bac St. Maur, where, besides opening our usual dressing station, etc., Col. Skinner, D.D.M.S. 3rd Corps, ordered us to prepare for an operating unit.

The main weaving shed of the factory had central heating, electric light, and much machinery in it; a portion sufficient for 30 beds was sectioned off by green hessian canvas. An operating room was prepared in a corner of the next shed near a large window. Lieut. J. Fraser, later Sir John Fraser, was attached to us as surgeon, and four nursing sisters also, one a regular. Shortly afterwards Lieut. Fraser was sent to another area and Lieut. Sampson (now a Birmingham surgeon) took his place. This factory was about 5,000 yards from the

front trench, and I believe Col. Skinner had some difficulty in persuading higher authority to allow sisters so near the front.

The abdominal and chest cases were admitted from the whole Corps area, and when fit to move were transported by barge (specially equipped) to St. Omer and the sea. In spite of absence of blood transfusion successful results were obtained at first in 27%, then up to 47%, of all cases operated upon. In February, 1916, the factory was heavily shelled—glass and debris flying in the operating room where an operation was being performed. Of the only three officers of the unit available Lieut. Samson was operating, I (acting O.C.) was assisting, and Lieut. Henry was giving the anaesthetic, so it was fortunate that Col. Skinner was visiting at the time and could at once arrange for the urgent evacuation of the movable cases to a farm 300 yards away. Later, the whole unit moved with the 8th Division to another area. Probably this experience resulted in the higher command not allowing nurses so far forward at a later date. Great praise and thanks were given to the unit for the way in which all ranks carried on the work of the special ward, and for the way in which the movable cases were evacuated, by the A.D.M.S., the D.D.M.S., and the D.M.S. 1st Army. Lieut. Samson received the M.C., and the regular sister in charge of the ward and the operating theatre sister received the R.R.C.

Among the interesting cases were the following: one for-and-aft penetrating bullet wound of the abdomen, not injuring the bowel and with practically no bleeding; the other a 10-in. (25-cm.) accidental bayonet wound of the abdominal wall, through and through but not entering the peritoneal cavity.—I am, etc.,

Mentone, France.

E. ALDERSON.

Women War Captives in Russia

SIR,—With reference to the article entitled "Women War Captives in Russia" by Dr. R. F. A. Dean (April 23, p. 691) concerning the conditions of life of German women in labour camps in the U.S.S.R., I should like to add a few remarks from my own experience.

As a member of the Polish underground army I was deported to Russia in April, 1945, and I stayed in various camps until November, 1947. I found myself among prisoners of war of many nationalities, as well as in camps with a majority of German civilians. I can fully support the evidence given by the said German women, but I should like to point out that no definite and general conclusions can be drawn from such evidence as to conditions prevailing in Russian camps. These conditions vary considerably, not only according to different geographical and local circumstances, but, above all, they depend on the attitude of the Soviet authorities towards the given group of prisoners at the given moment. The German women described in your article were lucky to find themselves in mild circumstances. They estimate the number of deaths in transport on their way to Russia as 2% to 2½% only. This percentage can be increased twenty-fold and still remain true: in the summer of 1945 I personally took part in a medical examination of a group of about 1,000 Estonians who came to Stalinogorsk Camp on their way from East Prussia to central Russia. They had walked about 800 miles, and the death rate among them was over 50%.—I am, etc.,

Wembley, Middlesex.

MIECZYSLAW PESZCZYNSKI.

Threatened Abortion Simulating Ectopic Gestation

SIR,—The following case is reported to illustrate how regurgitation of blood into the Fallopian tubes in threatened abortion may simulate ectopic gestation.

A patient, aged 23, para 2, was admitted to hospital on April 20, 1949, complaining of lower abdominal pain following seven weeks' amenorrhoea, the last menstrual period being on Feb. 22, 1949. The periods had previously been quite regular and of normal amount. On March 7 she had a slight show of dark blood lasting one day, and another show lasting three days immediately prior to admission. The lower abdominal pains, which were mainly in the left iliac fossa, had been present on and off for one month, and she described them as period pains which had now become severe. There had been no vomiting or dysuria.

Abdominal palpation showed generalized tenderness in the lower abdomen, with well-marked guarding in the left iliac fossa. Per vaginam some dark blood was visible, the cervical os was closed,

and movements of the cervix caused severe pain. Bimanual examination of the uterus, which was difficult because of extreme tenderness, showed the uterus to be only slightly enlarged. The right fornix was normal, and on palpation of the left fornix the presence of a small mass was suggested; this was too painful to be accurately defined. Her temperature was 98.4° F. (36.9° C.); pulse 80, blood pressure 120/70. There were no abnormalities in the urine. In view of the history, her lower abdominal pain, and the marked tenderness on vaginal examination, it was decided she was a case of left tubal gestation, and laparotomy was performed on April 20. On opening the abdomen, the uterus appeared to be about 8-10 weeks pregnant; no ectopic pregnancy could be found, but about 2 oz. (57 ml.) of altered blood was noticed in the pouch of Douglas. Careful inspection of the left Fallopian tube showed it to be not enlarged, injected, or swollen, but of a beaded appearance and dark blue in colour due to the lumen being intermittently distended with blood. On milking the tube about 2-3 ml. of dark blood oozed from the abdominal ostium. The right tube appeared normal, but on milking it towards the abdominal ostium two or three drops of dark blood were also produced. The ovaries appeared normal. The pouch of Douglas was mopped out and a normal appendix removed before closing the abdomen.

The patient had a slight loss of blood per vaginam the day following operation, but convalescence was otherwise uneventful. There has been no recurrence of her abdominal pain, and the pregnancy is continuing satisfactory to date.

I consider this patient to be a case of threatened abortion with regurgitation of blood into the Fallopian tubes, causing distension of the lumen and hence producing symptoms and physical signs identical with an early ectopic gestation.—I am, etc.,

Stoke-on-Trent.

H. D. FREETH.

Breast-feeding

SIR,—The modern decline in breast-feeding is commonly attributed either to the ignorance or to the apathy of the family doctor. Many of us, who frequently condone the action of the distraught or unwilling mother in "putting the baby on the bottle," feel that our argument for breast-feeding lacks conviction, knowing the high incidence of breast infection. In recent years breast-feeding has undoubtedly carried with it a considerable hazard to health. In spite of penicillin and sulphonamide therapy breast abscess still occurs too frequently, and we are certainly ignorant of how it does occur.

It was with this problem in mind that I read Dr. F. Charlotte Naish's admirable book, *Breast Feeding*. In discussing mastitis and its prevention, Dr. Naish (pp. 63 and 127) refers to the value to be derived from the study of dairying methods. It appears doubtful, however, whether Dr. Naish and her farmer's wife are referring to the same disease process. The "milk fever" of the dairy farmer has no relation to mastitis, and, to the best of my knowledge, the blood-calcium depletion seen by the veterinary surgeon in "milk fever" has no counterpart in medical practice. The validity of Dr. Naish's deductions is therefore in question, however successful she has been empirically. Dr. Naish has done a notable service in showing what can be done in general practice. It is admiration for her work that has prompted me to point out this flaw in its excellence.—I am, etc.,

Thornton, Fife.

JAMES B. FLEMING.

"Cord Round the Neck"

SIR,—Further to my letter in the *Journal* of May 4, 1946 (p. 701), I have again observed this abnormality in the same multipara with the history of two stillbirths.

The patient (7-para) was delivered on Nov. 4, 1944, by forceps under chloroform of a stillborn female, death being caused by torsion of the cord. On March 29, 1946, she delivered naturally a stillborn male; again death was caused by the cord round the neck. On Sept. 21, 1947, she gave birth to a live-born male child without this abnormality. On June 3, 1949, a stillborn female child was born naturally with the cord round the neck. Again the child had been strangulated.

I venture to suggest that delay in the second stage associated with foetal distress may be attributable to cord round the neck, and, where suspected, should be treated by early caesarean section to ensure a live child.

My thanks are due to Dr. Archibald Neville McLellan for help with this patient.

—I am, etc.,

Harthill, Lanarkshire.

S. H. P. McLAUCHLAN.

Fatal Myelitis after Antirabic Vaccine

SIR,—Dr. I. Ansell (Aug. 14, 1948, p. 338), describing a fatal case of myelitis after antirabic vaccine, concludes that "antirabic treatment should be given only when the correct indications are present. A healthy dog should be kept under observation for the usual ten days before treatment is begun, except possibly in cases of severe bites on the face."

As far as I am aware, it is still the practice in most centres responsible for treating persons bitten by dogs and other animals not to wait until the disease declares itself in the dog before commencing treatment; for the reason that, although the virus is believed to reach the brain via the nerves, the time it takes to do so varies over wide limits (days, weeks, or months). Consequently it seems to me that as this rate of travel of the virus can only be guessed at in the majority of cases the withholding of treatment for some days may amount to jeopardizing the life of the patient, who has no chance of surviving once the disease does develop.

Since the incidence of neuromuscular accidents following antirabic vaccine is one in many thousands and the mortality from all types about 25%, I cannot help feeling that Dr. Ansell's conclusion is likely to be misleading, and almost comparable to advising a patient not to undergo what might prove to be a life-saving operation merely because one person in many thousands dies unexpectedly during the induction of the anaesthetic.

I would welcome your opinion on this point, which I feel is important, because so few practitioners have a clear idea of what should best be done in bites from animals. Rabies is a disease in which one cannot afford to take a chance.—I am, etc.,

Hong Kong.

E. F. DUCK.

Thiosemicarbazone

SIR,—The letter from Dr. L. Fish (June 4, p. 1005), together with your note following it, is timely. Perhaps the readers would be interested to hear that a whole day was devoted to the chemotherapy of tuberculosis at the recent Congress of Internal Medicine at Wiesbaden, which I attended. The treatment of pulmonary disease by thiosemicarbazone held an extremely prominent place in the papers and discussions, which were initiated by Professor Domagk from the pharmacological aspect and Professor Heilmeyer from the pathological aspect.

Apart from the general work on this group of substances (which are directly derived from sulphonamides), the only reference I know to its use has been in a lecture given in New York in June, 1948, by Dr. D'Arcy Hart.

The Germans place these drugs—mainly one which they call "T.B.1"—midway between streptomycin and para-aminosalicylic acid in their chemotherapeutic efficiency, and it would seem that very much work is needed to be done in this country on the subject if our armamentarium in the treatment of tuberculosis is to be completed. It is proposed shortly to do a small clinical trial with thiosemicarbazone if arrangements for its supply can be adequately made, and this will be the subject of a future communication.—I am, etc.,

London, S.E.12.

M. M. NAGLEY.

Routine Medical Examinations

SIR,—With reference to Dr. R. Frank Guymer's letter on routine medical examinations (June 4, p. 1007) and the application of Pulheems to industry, I am sure Dr. Guymer would be interested to know that we have been applying this system at Messrs. Taylor Woods, Ltd., Hosiery Factory, Enniskillen, for two years. In conjunction with the personnel department a series of profiles for the various jobs have been made.

We find that the system is almost an essential, as some of the jobs are very highly skilled and long periods of training necessary. We believe it has helped to avoid labour turnover and absenteeism. Three hundred and fifty potential employees have been examined up to the present. This number we consider insufficient, but when the 500 is reached we hope to have some figures to substantiate our belief in this system as applied to industry.—I am, etc.,

Enniskillen, Co. Fermanagh.

HAROLD K. ARMSTRONG.