Intravenous Ergometrine for Retained Placenta

SIR,—Prof. J. Chassar Moir in his letter (Aug. 23, p. 309) states that "it is a matter of opinion whether severe third-stage haemorrhage is best dealt with by injection of an oxytocic drug, or by prompt manual removal of the placenta when simpler manipulative measures have failed." He then goes on to say that his own preference, if the uterus is relaxed, is for an oxytocic drug.

I feel that the treatment of all severe third-stage haemorrhages should not be along any such line of routine therapy. There are the well-known physical predisposing causes of third-stage haemorrhage, such as multiple pregnancy, exhaustion after a long labour, encroachment of the placenta on the lower uterine segment, etc., in which the giving of an oxytocic drug may be the most convenient and best treatment, but there is a group of cases in which third-stage disordered action of the uterus is due to psychogenic causes. These cases may follow a primary uterine inertia, or other evidence of functional uterine disorder, in the previous stages of labour. There may have been openly expressed morbid fears, or, more often, these may have been suppressed. These cases exhibit a degree of collapse out of all proportion to the amount of blood lost. In my opinion they are best treated by giving an anaesthetic (I prefer open ether) and manual removal of the placenta, followed by an oxytocic drug and morphine. It is a feature of these cases that the condition of the patient improves rapidly during induction of anaesthesia, and their condition tends to deteriorate with the return of consciousness unless morphine has been given.

With the remainder of Prof. Chassar Moir's letter I am in complete agreement, and he has done a valuable service in pointing out the certainty of undesirable side-effects being produced if a dose of ergometrine 0.5 mg. is given intravenously, as advised in "Any Questions?" (Aug. 2, p. 195).

Finally he criticizes, by inference, the routine administration of ergometrine in the third stage. This practice appears to be an attempt to improve on normality, and will be looked upon by future generations in the same light as we view to-day the routine (ritualistic?) purging of children every Friday night.—I am, etc.,

South Shields.

TERENCE ROBINSON.

Oxygen Poisoning in Man

SIR,—Prof. J. B. S. Haldane is wrong in stating (Aug. 9, p. 226) that I attribute oxygen poisoning to carbon dioxide accumulation. I take the same view as he does that it enhances oxygen poisoning, and that is why Dr. Donald observed oxygen poisoning with exceptionally low pressures, particularly in the case of a diver tested under water in a dock basin. In this case anxiety may have caused rapid shallow breathing and consequent accumulation of the dead-space carbon dioxide. I think that "nitrogen" poisoning may really be due to accumulation of carbon dioxide.—I am, etc.,

Chalfont St. Peter, Bucks.

LEONARD HILL.

The Extent of Neurosis

SIR,—The leading article entitled "Neurosis and Industry" (Aug. 16, p. 257) has tempted me to inform you of the result of a survey I undertook in June in an endeavour to estimate the proportion of 'psychic disturbances in a general practice. I did this for my own interest, but the result was surprising even to myself.

The survey was undertaken at a time when the surgeries were not heavy, when there was time to discuss complaints, conduct examinations, and assess the situation more fully than usual. It occupied 17 days and concerned 100 consecutive new patients coming to the surgery between the age of 5 and decrepitude; 46% were frequent attenders whose general physical and emotional backgrounds were well known. Each patient was given ten units of illness, and these ten units were apportioned to psychopathic or rationally physical disorders as best I could judge. A middle-aged woman stating that her nerves were out of order, complaining of irritability, ready fear, and insomnia, and demanding a tonic would be given a bromide mixture and rated as ten units of emotional anxiety, *nil* physical.

A man exhibiting a follicular tonsillitis, with a temperature of 100° F. (37.8° C.), wanting a gargle, and stating he would like to continue at work would be sent home to bed, given appropriate treatment, and assessed as ten units of rationally physical disorder. Many cases were intermediate, with anxiety enlarging a normal ailment. Of the total 1,000 units 453 were attributable to psychic causation and 547 to adequately physical disorder—a proportion which indicated that of every twenty patients coming to the surgery nine were more emotionally ill than actually so.

While the assessment must be regarded as subjective on my part it was not undertaken lightly, and almost four years of completely psychological work has given me fair ground for carrying out such an investigation with accuracy. There must be many experienced general practitioners who could carry out such an estimation, and their figures would be most interesting to know and of value in calculating the neurotic element in illness—I am, etc.,

Stockton-on-Tees.

L. F. DONNAN.

A Giant Naevus

SIR,—Miss X, aged 21, consulted me in June, 1940. Her history was that she was born with a small port-wine stain on the margin of her lower jaw, that it had grown steadily, and that she wanted to be rid of it as it precluded her admission into a convent. She said it had not caused her any trouble, that her general health had always been good, and her complaint was more of a nuisance and disfigurement than anything else.

On examination I found a tumour, port-wine in colour, with large veins coursing over a coarse and roughened surface, hanging over her left breast and completely occluding it. Its boundaries were as follows:—From the mid-point on the chin it extended along the border of the lower jaw, skirting the lobe of the ear to the middle of the nape of the neck, just below the occipital protuberance; medially down along the midline of the neck, and half-way down the sternum; laterally, from the occipital protuberance obliquely across the back of the neck to the top of the shoulder, and curving inwards to meet the opposite side at the mid-sternal level.

The excision of the tumour appeared a formidable task owing to its vascularity. A dose of 16,000 mg.-hours was given superficially with radium needles distributed over Columbia paste plaque, screened by lead sheeting 1 mm. thick. Three weeks later, with circumferential local analgesia, the whole of the tumour was excised. It consisted of the thickened skin and platysma. The bleeding was not troublesome. The weight of the tumour had dragged upon and loosened the surrounding skin, and it was quite easy to close the gap left by the base of the tumour. The wound did quite well, except for a small area the size of a florin, which healed by granulation. I heard from the patient a few weeks ago that she was quite pleased with the result of the operation.—I am, etc.,

Newtown, Waterford.

A. J. D'ABREU.

Poliomyelitis

SIR,—According to your report¹ of a recent meeting at the Central Public Health Laboratory, Colindale, there is no evidence that flies are helping to spread infection in the present outbreak of poliomyelitis. This is so opposed to American experience that I was not surprised to learn from the Ministry of Health that it is essentially an assumption. The statement is not based on specific investigations, for none has been attempted.

American research² has shown that the virus can be recovered from house-flies and blow-flies trapped in urban and rural areas during poliomyelitis outbreaks. Food contaminated by such flies was found to produce the disease when fed to chimpanzees.³ The flies almost certainly acquire the virus from the stools of poliomyelitis patients or carriers. The virus has been recovered from the stools of a child 123 days after an abortive attack,⁴ though three weeks appears to be the average time of persistence.⁵ Such an experienced researcher as Sabin⁶ inclines to the view that flies are a more important vector than droplets during poliomyelitis epidemics.

One objection to applying the fly-carrier theory to the present epidemic is the apparent lack of opportunity for flies to settle on infected stools. Though the virus has been detected in