reactions, or long-standing personality disorders, or dementing illnesses is possible. It is useful in allowing us to concentrate our limited facilities for active treatment on the patients most likely to benefit. But classifying our patients with a view to "disposal" does not mean that we subscribe to a watertight system of disease entities, or assume that affective illness precludes insidious organic dementia. The fact that active treatment was advised in 17 patients belonging to groups thought to be therapeutically unrewarding indicates that we have not been using our three types rigidly, but merely as points of orientation. To an increasing extent we are attempting to treat elderly patients as out-patients whenever possible. Apart from the obvious advantages, this furnishes us in doubtful cases with a period of observation during which to assess the relative importance in the individual patient of irreversible dementia, lifelong or long-standing personality disorder, or of affective, and thus mostly reversible, reaction.

Summary

Of 192 patients over 60 attending consecutively for psychiatric consultation at an out-patient clinic, 188 were allocated to one of three clinical groups: (a) organic psychoses of old age; (b) long-standing neurotic, psychotic, or character disorders; and (c) affective illnesses of recent onset. Corresponding recommendations for their treatment were made.

The status of the patients 12-18 months later demonstrated that these categories had been useful pointers towards making prognostic assessments and recommendations for treatment.

The assumption was supported that affective illnesses in aged patients show a favourable immediate response to active treatment.

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PREMATURE DELIVERY IN HAEMOLYTIC DISEASE OF THE NEWBORN

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Premature delivery of the baby with haemolytic disease of the newborn has been widely condemned (Allen, Diamond, and Vaughan, 1950; Mollison and Walker, 1952; Bourne and Williams, 1953) because the premature baby with haemolytic disease is less likely to survive and more likely to develop kernicterus than is the full-term baby. However, in our experience, individual cases do arise in which there are definite clinical indications for premature delivery of the baby. This is exemplified in the following case.

Case Report

A married woman aged 33 attended Solihull Hospital in August, 1951, and gave the following obstetric history. Her first pregnancy, in 1939, ended in a stillbirth at 28 weeks

gestation; her second pregnancy, in 1941, ended in an abortion at 24 weeks; her third pregnancy, in 1943, ended in a stillbirth at 38 weeks gestation (at this time she had a blood transfusion, but the full details are not available, and, of course, this was before the days of routine rhesus grouping); her fourth pregnancy, in 1945, ended in a stillbirth (spina bifida) at 36 weeks; and her fifth pregnancy, in 1950, ended in a stillbirth at 36 weeks; there was an associated mild toxæmia, and antirhesus antibodies were found early in this pregnancy. Her last menstrual period was April 3, 1951. She was blood group A Rh-negative (cde/cde), and blocking antirhesus antibodies were present in the serum. The husband belonged to blood group O Rh-positive; the most likely genotype being CDE/cDE.

The pregnancy continued normally, and serological examination showed virtually no change in the antibody titre. At the thirty-third week of pregnancy she described a reduction in the frequency and strength of the foetal movements. She stated: "The baby moves as if it is tired." When questioned further she said that the other babies had behaved similarly prior to the intrauterine death of the foetus. It was therefore thought that unless the baby was delivered within a short time it would die *in utero* like its predecessors, and that nothing more would have been achieved than in the previous pregnancies. The spur to action was the symptom of diminishing foetal movements.

Accordingly, on November 27, lower segment caesarean section was performed, and a living male child weighing 4 lb. 6 oz. (2 kg.) was delivered. It was noticeably pale at birth, and the findings on examination of the cord blood were: Group O Rh-positive; genotype cDE/cde; haemoglobin, 4.8 g.%; direct Coombs test positive.

A replacement transfusion was given three hours after birth and 430 ml. was exchanged (100 ml. per lb.—220 ml. per kg.). Next day the jaundice had deepened, but an attempt at a second replacement transfusion failed. At this stage the haemoglobin was 18.2 g.%. During the following month it was necessary to give three small "topping-up" blood transfusions. At 21 months the baby was normal in every respect.

In September, 1952, the mother returned to the antenatal clinic when 12 weeks pregnant. Serological examination confirmed the presence of blocking antirhesus antibodies of approximately the same titre as in the previous pregnancy, and it remained so throughout this pregnancy. At the thirty-fourth week of this pregnancy the foetal movements again diminished, and the patient was immediately admitted to hospital and caesarean section again performed. A living male child weighing 3 lb. 10 oz. (1.6 kg.) was delivered. The spleen was just palpable and the liver edge was 2 cm. below the costal margin. There was slight oedema of the legs, and jaundice developed within one hour of birth. The findings on examination of the cord blood were: Group O Rh-positive; genotype cDE/cde; haemoglobin, 6.5 g.%; direct Coombs test positive. A replacement transfusion of 600 ml. (166 ml. per lb.—365 ml. per kg.) was given four hours after delivery. Jaundice became more severe on the following day and lasted 24 days. "Topping-up" blood transfusions were given on the eighteenth and the sixtieth days. At seven months the baby was completely normal.

Discussion

It is obvious from the mother's history that she belongs to the group of women who in each pregnancy have infants severely affected by haemolytic disease of the newborn, and it seems that if a mother's first affected infant is stillborn or hydropic, subsequent infants delivered at term are unlikely to be viable (Davies, Gerrard, and Waterhouse, 1953). Our patient had had five successive stillbirths or abortions, and the outlook for further pregnancies seemed even more hopeless. We considered that the only chance of having a viable infant was by premature delivery. The serological findings, the diminishing foetal movements, and the condition of these two babies at birth indicated that premature delivery was a life-saving procedure. The indication for premature delivery

was diminishing foetal movements, and caesarean section was thought to be the ideal method for this patient. Mollison and Walker concluded that premature delivery was contraindicated from the consideration of the mortality rates in a series of cases, "the choice of treatment being determined by random numbers" (Mollison, Mourant, and Race, 1952). We feel that each case should be treated individually according to its clinical merits.

In view of this case, it would seem that there is still a place for premature delivery of the infant in cases of haemolytic disease of the newborn. The indication for such treatment would be a patient with a history of two or more stillbirths, whose husband is homozygous, Rh-positive. We suggest that diminution of foetal movements is a symptom of importance, that it requires the case to be treated as an emergency, and that premature delivery should be carried out in a hospital equipped both for replacement transfusion and for the care of premature babies. It also demands the daily supervision of the patient in the last weeks of pregnancy, especially in cases that show by the pattern of their history that they are liable to produce severely affected infants. Mollison and Walker showed that "the total death rate in the 'induced' group is higher than in the group allowed to go to spontaneous delivery." However, in our experience premature delivery can produce a live birth instead of a stillbirth; and, even though the baby is premature, kernicterus can usually be prevented by one or more adequate replacement transfusions. In the group of severely affected cases of haemolytic disease of the newborn there is the opportunity of rearing a normal living child by premature delivery, and to achieve this the complete co-operation of the obstetrician and paediatrician is essential.

Summary

A case of rhesus iso-immunization of severe type is described.

After several stillbirths, two living babies were delivered prematurely by caesarean section.

The symptom of diminution of foetal movements in two severely affected babies is described.

This symptom is an indication for premature delivery of the foetus in order to prevent another stillbirth and in order to give a possibility of survival.

With the close co-operation of the obstetrician and paediatrician this can be achieved.

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Last July the Standing Conference of Societies Registered for Adoption held a conference at Roehampton, a report of which is now available. Papers were read and discussed on co-operation between adoption societies and local authorities, co-operation in case work, the point of view of the natural mother, heredity as it concerns adoption, and difficult placement. Discussion centred on legislation that is required to prevent the private placing of children for adoption (even by the children's own mothers), the complex factors entering into any estimate of heredity, the placing of older and handicapped children, and a plea for greater confidence in placing children in good adoptive homes even though their social background is poor. The report is obtainable from the honorary secretary, Gort Lodge, Petersham, Surrey, price 5s.

INCARCERATED AND STRANGULATED INGUINAL HERNIA IN THE FIRST YEAR OF LIFE

REPORT ON 45 CASES

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The incidence of strangulated hernia in the first year of life is variously reported by different authors, perhaps owing to the lack of uniformity in the definition of "strangulation." It is usually considered that an incarcerated hernia is an irreducible hernia in which there is obstruction to the passage of intestinal contents, and that a strangulated hernia is an irreducible hernia in which there is interference with the blood supply of the bowel, irrespective of whether or not the gut is viable. If, therefore, in any series, only those cases are recorded in which the gut is strangulated, the incidence is obviously lower than if incarcerated hernias are also included. But, clinically, incarceration can prove as dangerous as strangulation, and, in fact, in three out of five fatal cases in the present series no strangulation was present.

Incidence

The incidence of strangulation in inguinal hernia in infancy varies from the statement by Stammers (1951) that "in a long experience of children's surgery I have never seen a strangulated irreducible inguinal hernia" to those of Potts *et al.* (1950), who say that 19% of their series were incarcerated. Thorndike and Ferguson (1938), in a series of 1,740 herniorrhaphies in children, found "strangulation" in 106, of which 45 occurred in the first year of life—"true strangulation," however, was present in only five cases.

According to Potts *et al.* 70% of all congenital inguinal hernias occur on the right side. Strangulated inguinal hernia is also much more common on the right side, Thorndike and Ferguson reporting an incidence of 80% in children up to 12 years of age.

The sex incidence is even more striking. Uncomplicated inguinal hernia is nine times more common in male than in female infants (Herzfeld, 1938), while strangulation was reported by Thorndike and Ferguson to occur in 25 males to every one female. When strangulation does occur in the female, the Fallopian tube and ovary are often found in the sac.

The age incidence of strangulation is remarkably constant, the greatest number of cases up to the age of 12 years being found in the first year of life, and most of these occur in the first three months; about 50% of Thorndike and Ferguson's 45 cases were under 3 months of age.

Presentation of Cases

The present series comprises 45 infants under 1 year of age: 43 were treated in the United Cardiff Hospitals during the past six years, one was seen at St. David's Hospital, Cardiff, and one at the East Glamorgan Hospital, Church Village. Fifteen of the children were seen personally by one or other of us.

The sex ratio was similar to previous series; only once did the condition occur in a girl; in this case the hernial