Post-operatively, haemoglobin was 63%, and the patient was transfused with 2 pints (1.1 litres) of blood. Investigation showed bleeding- and clotting-time to be normal.

The drainage tube was removed after 48 hours. There was a little oozing for the next few days and the patient was discharged well three weeks after admission.

The second patient, whom we saw in October, 1962, was a young married woman aged 31, para 2, who had also had a nasty cough for two weeks. She had abdominal pain on coughing for a few days, and this became much worse one evening, when we were called to see her. She complained of sudden severe pain in the right iliac fossa, and felt nauseated. She did not vomit, but in the next hour had two bouts of diarrhoea. Straining at stool and rising from a lying position caused extreme pain. Pulse was 94/min., temperature 99.2° F. (37.3° C.). Micturition was normal. Her last menstrual period was two weeks before. She was not shocked. B.P. 120/80. There was a tender mass to the right of the midline, ovoid in shape, with the long axis in the line of the rectus measuring about 4 in. by 3 in. (10.2 by 7.6 cm.). It was extremely tender, not movable, and felt relatively superficial. With the memory of the previous case fresh in our minds, a diagnosis of ruptured rectus abdominis was made and she was admitted to the surgical wards of the Gloucester Royal Infirmary.

At operation on the following day a lower midline incision revealed a haematoma behind the right rectus muscle and the posterior wall of the rectus sheath. Blood clot amounted to 5 oz. (142 ml.). There was no evidence of torn muscle fibres or bleeding points. The abdomen was explored: the ovaries and uterus were normal. Routine appendicectomy was performed. The post-operative period was uneventful, the patient being discharged well after 11 days.

Although this condition is said to be most common in middle-aged and elderly women with chronic bronchitis, it is of interest that our second case occurred in a well-nourished healthy woman of 31 during an isolated episode of mild bronchitis.

We should like to thank Mr. E. M. Edwards and Mr. W. J. Wilkin, of the Gloucester United Hospitals, for permission to publish details of their operation notes.

—We are, etc.,

City Health Centre,
Gloucester.

D. MCCARTHY.
T. E. DURKIN.

"Ancoloxin" and Foetal Abnormalities

SIR,—The facts so hastily published by the College of General Practitioners about "ancoloxin" (meclozine and pyridoxine), far from constituting mounting evidence against it, do not add up to any evidence at all. They neither incriminate nor absolve it.

In the matter of the 784 cases, the College must have discovered, in addition to the published facts, the answers to the following questions: (a) How many abnormalities were there in the 660 cases where no anti-emetic was taken; (b) how many of the 124 took ancoloxin; and (c) what was the nature of the three malformations?

If there were only three mothers who took ancoloxin, and these three gave birth to grossly deformed babies, and if there were no abnormalities among the 660, then obviously ancoloxin should be at least temporarily withdrawn. On the other hand if the three deformities were trivial, if nearly all the 124 took ancoloxin, and if there were some severe deformities among the 660, then ancoloxin would be virtually cleared.

Of the 29 other cases of congenital abnormality culled from an unknown number of pregnancies, all that can be said is that ancoloxin and certain other unnamed anti-emetics do not absolutely prevent the occurrence of

foetal abnormalities. One could doubtless find a similar mixed bag of abnormalities ranging like these from the trivial to the severe among mothers who, for example, smoke, had influenza during pregnancy, themselves suffered from congenital abnormalities, or conceived when there was no "r" in the month.

I cannot believe that this preliminary, one might say premature, report is putting the information sent into the College to its best use.—I am, etc.,

Southsea, Hants.

J. R. JAMES.

Chlorpropamide and Foetal Damage

SIR,—Earlier this year Dr. W. P. U. Jackson and I uttered a preliminary warning in the correspondence columns of the *South African Medical Journal*¹ about the unusual findings in a paper of ours² where the perinatal mortality in a series of insulin-independent young diabetics treated throughout pregnancy with the sulphonylureas was described. Briefly it was found that the perinatal foetal mortality of 50 control pregnant diabetics treated with insulin and/or diet was 20%. A series of 40 patients (plus two in an addendum) were treated throughout pregnancy with the sulphonylureas: in 20 cases treated with tolbutamide the perinatal mortality was 23%, but in those 22 treated with chlorpropamide (including the two added cases) the perinatal foetal mortality was 65%: these differences appeared statistically significant ($P < 0.01$). Previously we had described³ multiple congenital abnormalities in the foetus of a patient well controlled throughout pregnancy with tolbutamide, but we found it impossible in this case to incriminate the drug; more recently² we said that "the danger to human pregnancy does not appear to lie in the production of multiple congenital abnormalities."

The chlorpropamide cases can be tabulated as follows:

Drug dosage (daily)	Number of pregnancies	Foetal mortality (No. of cases)
500 mg.	19	14
250 mg.	3	—

Thus of the 19 pregnancies which were controlled with 500 mg. of chlorpropamide daily, only five foetuses survived.

As might be expected, the survivors have been followed carefully. One mother defaulted between the third and the tenth months after delivery, which had been terminated by caesarean section at the thirty-seventh week, after good diabetic control during the course of the pregnancy. She returned again because of the apparent failure of the child to thrive. On examination, it was apparent that the child was suffering from an advanced degree of microcephaly, and that it had a spastic quadriplegia. We had noted previously that death in the perinatal mortality cases following chlorpropamide was of a respiratory nature: in this case the paediatrician reported that "the child nearly died twice because of apnoeic attacks in the immediate post-natal period." Unfortunately skull circumference at birth was not noted.

In view of our experiences and the immediate post-natal history in this patient we feel that there is a stronger case for regarding these abnormalities as the result of chlorpropamide therapy than was so in the tolbutamide-treated case,³ as this latter case had a very bad obstetric history and in the 14 months since details of the case were noted she has had three miscarriages. The more recent case has made us even more certain

that we are correct in withholding chlorpropamide from pregnant insulin-independent diabetics in favour of tolbutamide. As treatment of pregnancy glycosuria, not shown to be due to lowered renal threshold, especially in tropical diabetes, commonly includes a sulphonylurea we believe that tolbutamide (or perhaps even the newer acetohexamide) to be the drug of choice.—I am, etc.,

Diabetic Clinic,
King Edward VIII Hospital,
Durban, Natal.

G. D. CAMPBELL.

REFERENCES

- ¹ Jackson, W. P. U., and Campbell, G. D., *S. Afr. med. J.*, 1962, **36**, 427.
- ² ———, Notelowitz, M., and Blumsohn, L., *Diabetes*, in press.
- ³ Campbell, G. D., *Lancet*, 1961, **1**, 891.

Aetiology of Schizophrenia

SIR,—We feel that Dr. Clifford Allen's observations on the aetiology of schizophrenia (December 1, p. 1475) may be supported by the following:

Our patient, an apparently happy adolescent of some 17 years of age, became acutely schizophrenic. The episode was precipitated by a chance personal remark about the hairiness of her upper lip. She was dark-haired with a moderate degree of general hirsuties, presumably due to an excess of steroids.

The obsession about her hairiness continued throughout her illness and as a result she refused to go out and meet people and had to be admitted to a mental hospital for E.C.T. and drug treatment. Several admissions in fact took place totalling a period of well over 12 months and extending over a period of five years.

Each discharge from hospital was accompanied by a guarded prognosis, and the almost inevitable relapse occurred, during which time, although she was unable to verbalize her anxieties, she felt depressed and "different" from other girls. She could foresee no married future for herself with the possibility of children of her own. Such feelings of "difference" had in fact afflicted her since early adolescence.

It is of interest that she had a suitor who remained loyal to her throughout her illness, and who, in spite of everything, still wished to marry her. During the last illness he took matters into his own hands, for she became pregnant and they have married.

From the moment that pregnancy was diagnosed she improved rapidly. Throughout the pregnancy and puerperium she remained well. She even insisted on breast-feeding the baby and showed every sign of normal affection towards it.

It is possible that the changes in endocrine balance during pregnancy may have lessened the effects of the masculinizing hormones, or perhaps the achievement of motherhood, settling finally all her doubts about her femininity, may have been responsible for the remarkable change in her psychological orientation. Incidentally, her weight has increased almost by 2 stones (12.7 kg.) since her recovery.

Whether this improvement in her mental condition will be maintained remains to be seen, but so far, eight months after parturition, she remains completely normal.

It might be of interest to obtain the ketosteroid level in this patient; so far it has not been done.—We are, etc.,

LEONARD JONES MORGAN.
KATHLEEN B. MORGAN.

Llangefni, Anglesey.

Family Influence on Schizophrenia

SIR,—In the final paragraph of your annotation (December 15, p. 1595) "Family Influence on Schizophrenia" it was suggested that the study by Dr. G. W. Brown and his colleagues¹ seems to contradict some of the current views on providing a therapeutic community. Surely the "high emotional involvement" homes, particularly those in which contact with the "key" relative was frequent and prolonged, are the very antithesis of a truly therapeutic community such as may be found in progressive mental hospitals. It is the pathological interpersonal relationship with the key relative which is so antitherapeutic. Some of the psychopathological factors involved, such as strongly expressed emotion, hostility, or domineering behaviour were mentioned in the annotation, and these should be contrasted with the relatively nondirective, accepting, less emotionally charged attitudes and behaviour in a therapeutic community—whether hospital, social club, or other mental health centre.—I am, etc.,

Hellingly Hospital,
Hailsham, Sussex.

RICHARD NEVILLE.

REFERENCE

- ¹ Brown, G. W., Monck, E. M., Carstairs, G. M., and Wing, J. K., *Brit. J. prev. soc. Med.*, 1962, **16**, 55.

Health and Social Class

SIR,—It is not surprising that "less-well-off people seem to experience illness not so much with greater frequency as with greater severity" (your annotation, December 15, p. 1596).

Several factors may play a part in this, including education, intelligence, and the spending of both money and leisure. The age at which children of the lower social grades start work may play a part. There is obviously more physical stress involved in a boy of 15 (until recently 14) doing manual work for eight hours a day than there is in attending school and playing games. There are possibly many other factors such as insufficient sleep in early childhood.—I am, etc.,

Hatfield, Herts.

K. C. HUTCHIN.

Protein Loss in Pregnancy

SIR,—We have seen a patient similar to that reported by Dr. R. J. McGill and Dr. J. E. Middleton (December 15, p. 1615). An otherwise healthy white woman, aged 21 years, developed extensive oedema of the legs during the 28th week of her first pregnancy. There was no other clinical abnormality. Her blood-pressure was 100/70 mm. Hg; chemical and microscopic examination of the urine and a full blood count were normal. The total serum proteins were 4.5 g./100 ml. (albumin 1.7 g., globulins normal on electrophoresis); blood urea, cholesterol, CO₂-combining power, sodium, potassium, and chlorides normal.

The patient remained very oedematous despite bed-rest and a high-protein, salt-free diet, the highest serum albumin during the rest of this pregnancy being 2.2 g./100 ml. A normal child was born, and the oedema disappeared within five days of delivery; the serum proteins then were 6.9 g./100 ml. (albumin 3.3 g.).

The patient was investigated two months later, when she was physically well and had no oedema. Serum albumin 3.4 g./100 ml., globulin 2.6 g.; screening test for excess faecal fat negative; serum carotenoids 88 µg./100 ml.; xylose tolerance test normal. Barium meal: rugal hypertrophy similar to that in the patient reported by Drs. McGill and Middleton; normal small-bowel pattern. We concluded