Analgesia in Midwifery

SIR,—I read with interest the recent article on anaesthesia and analgesia in childbirth (*Journal*, February 8th, p. 273). My own experience was in the clinics of Doederlein (Munich) and Opitz (Freiburg). Later on for cases of abortion I used an intravenous injection of about 5 c.cm. of evipan, at the same time injecting into each of the lateral fornices 10 c.cm. of a 2 per cent. solution of novocain-suprarenin. This prevented any appreciable blood loss, made the operation possible after the administration of only a small initial dose of evipan, and therefore did not affect the contraction of the uterus. I was so impressed with the results of this type of intravenous anaesthesia that I was led to try the same technique for the relief of pain in childbirth. The technique which was finally elaborated was as follows, using in these cases pernocton rather than evipan, although this latter is the more modern and at least equivalent drug.

As soon as the cervix was dilated to admit one finger, and the pains were regular, 2 or 3 c.cm. of pernocton were injected intravenously, very slowly, taking some two minutes or perhaps longer over the actual injection. The effect is dramatic, and represents all that is needed in the way of intravenous injection. Further injections of 2 or 3 c.cm. were given, as necessary, intramuscularly, and maintained the relief from pain though apparently not affecting the uterine contractions. With regard to the successive intramuscular doses, no hard-and-fast rules can be laid down, but up to 6 to 8 c.cm. of pernocton may be given intramuscularly without any fear of toxic reactions.

I have never seen the child affected by the use of this drug, and this fact, with the other advantages I enumerate, makes this an almost ideal type of analgesia for midwifery. The only point where danger may arise is in the actual intravenous injection of the drug. The injection must be made slowly, and should always take one minute for every cubic centimetre.—I am, etc.,

ROBERT KUHN,
Formerly of Baden-Baden.

London, W.2, Feb. 9th.

Prostatectomy

SIR,—I should like to take this early opportunity of thanking Mr. B. G. S. Belas for his helpful commentary on my article "Prostatic Resection." Mr. Belas raises three points of criticism: (1) possible damage to urethra and sphincter by heat conducted down the speculum; (2) danger of haemorrhage when the final coagulum separates; (3) the question of sepsis.

In reply to the above points I should like to state that the question of danger from conducted heat caused me a lot of anxiety during the first few operations, so much so that I considered getting an ivory speculum made (as stated in my article). So far I have not had any trouble from this source, and have come to regard the risk as only "theoretical." Any contact of electrode and speculum would only be momentary, and the moisture of the surrounding tissues evidently acts as an efficient "water-cooling system."

The risk of secondary haemorrhage is inseparable from all diathermy operations, and like many other surgical risks it just has to be taken. However, I think the method of constant irrigation with sodium citrate during the post-operation period does a great deal to reduce this risk.

Sepsis is again a factor inseparable from diathermic procedures in infected tissues; but the amount of sepsis in the small smooth area resulting from a diathermic resection must be less than that in the cavity left after any operation of total prostatectomy, with the possible exception of the Harris operation, which latter should certainly be performed in preference to any partial resection in all cases considered capable of surviving the major operation. I have not had any experience with special resectoscopes, but am grateful for the information that such instruments can be used for the "retrograde method."—I am, etc.,

C. DUNDAS MAITLAND.

Guildford, Feb. 16th.

Nutritional Needs

SIR,—In his helpful letter in your issue of February 15th (p. 335) Dr. Harry Campbell says that man's "system has become organized for digesting, assimilating, and metabolizing animal food." Will he please favour your readers with exact anatomical and physiological facts to support the above statement.—I am, etc.,

SYDNEY M. WHITAKER.

Wythenshawe, Manchester, Feb. 16th.

Cancer in the Far East

SIR,—Dr. I. Lloyd Johnstone, in a letter published in the *British Medical Journal* of February 8th (p. 283), says that it is difficult to estimate the prevalence of cancer in the Far East. Having spent nearly twenty years in Tungkun, a large town in the province of Canton, I was able to compile statistics which might help to elucidate the problem. From my book on *Tropical Hygiene*[1] I quote the following:

During a period of six years:
34,197 Chinese were examined. We noted
187 cases of malignant growths—that is, 0.5 per cent.;
299 cases of benign growths—that is, 0.9 per cent.

During the same period at the Royal Infirmary, Edinburgh:
68,639 patients were examined. They included
3,890 cases of malignant growths—that is, 5.6 per cent;
1,183 cases of benign growths—that is, 1.7 per cent.

Three reasons are given to explain this difference:

1. The frugality of the Chinese diet, which consists mainly of rice, vegetables, fruits, and small quantities of salt fish.
2. The almost total abstinence from alcohol.
3. Free evacuations of the bowel.

This seems to support the opinion of those who deny the bacillary origin of cancer. Professor Askanasz of Geneva speaks of a "carcinogenic factor" of a chemical nature. This factor, elaborated in our bodies, may be responsible for the production and quasi-immortality of the cancer cell.—I am, etc.,

JOHN E. KUHNE.

London, N.W.1, Feb. 14th.

Treatment of Erysipelas, Acute Cholecystitis, and Acute Pyelitis

SIR,—Some months ago there were letters in the *British Medical Journal* about the treatment of erysipelas with serum and the desirability of operative as opposed to the expectant treatment of acute cholecystitis.

Erysipelas.—A few years ago an Egyptian doctor, whose name I have unfortunately forgotten, wrote from Cairo recommending the intramuscular injection of milk in cases of erysipelas, and claiming results which sounded too good to be true. I determined to try the treatment, and found that his claims were in no way exaggerated. Since reading his letter I have had the opportunity of treating only some half-dozen cases. In each patient I injected intramuscularly 10 c.cm. of boiled cow's milk, filtered through gauze, with the result that

[1] *Manuel d'Hygiène et de Médecine Tropicales*, p. 84. Editions Labor, Rue de l'Athénée 4, Genève. H. K. Lewis and Co., Gower Street, London.

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