

plications, and, therefore, any method of artificial respiration taught them should be simple and fool-proof and should have stood the test of time.—I am, etc.,

London, W.1.

CECIL P. G. WAKELEY.

Sulphonamides in Measles

SIR,—The writers of the letters extolling the use of sulphonamides in measles appear to ignore the importance of controls in assessing the value of a drug. The score or so of cases I have seen in children in the recent epidemic were all treated by cutting off all food and drink except water, sugar, and fruit juice until the temperature was nearly normal. Some of them had expectorant cough mixtures, others sedative cough mixtures, and the rest no drugs at all, but this slight variation in treatment seemed to make no difference to the course of the disease. All the cases were as mild as those described by Dr. Frankland West (April 21, p. 567).

It may be that if sulphadiazine had been withheld from some of the cases described the course of the illness would have been more severe, but proof of such a theory is completely lacking.—I am, etc.,

Binfield, Berks.

L. G. JACOB.

Oxaluria

SIR,—I was much interested in the article by Lieut.-Col. J. M. Black (April 28, p. 590) on the cases of oxaluria treated by him in India in 1943. He has rightly emphasized the importance of adequate fluid intake, and the avoidance of oxalate-containing foods in order to prevent oxaluria. There is one possible factor in oxaluria production which he has not mentioned, and which indeed seems seldom referred to in British medical literature, but which I have reason to think is very important. Prof. Herter in his *Lectures on Chemical Pathology* (1902) tells how his assistant, Dr. Helen Baldwin, produced oxaluria experimentally in dogs by giving them large quantities of cane sugar or glucose until a state of excessive fermentation accompanied by gastritis was produced, and gives it as his own opinion that "human oxaluria may arise during carbohydrate decompositions in the digestive tract under conditions at present imperfectly understood"—one of which may be "permanent diminution or absence of free hydrochloric acid in the stomach contents." My own experience in examining urines in the laboratory of this hospital leads me to think that this enterogenous formation of oxalic acid from excessive use of sugar, and perhaps even from excessive use of other carbohydrates, is far more common than is generally appreciated. Patients who are guiltless of partaking of such exogenous sources as rhubarb, spinach, etc., may show considerable oxaluria.

A case which came under my notice in May, 1944, may be of interest in this connexion. H. B., aged 48, a plumber in the employment of this hospital, noticed in March, 1944, that every evening after about 4 p.m. his urine became very red. His morning urine was normal in colour. This state of affairs continued for about three months, during which time he began to feel listless and lacking in energy, so that he became alarmed, and finally on May 4 presented himself at the accident dispensary of the hospital. He was cystoscoped, but no calculi were seen. Cystoscopy was again done on May 13, and a pyelogram taken, with negative findings. On account of his occupation he was sent to me for count of R.B.C., W.B.C., etc. There was no evidence of plumbism, but on examination of his urine I found oxalate crystals, as well as blood, present. I questioned him as to his diet, and found he was taking what seemed to me to be excessive quantities of sugar and other carbohydrates, as well as a good deal of strong tea. I advised him to modify his diet regarding these particulars, and gave him a little potassium citrate for a short period, asking him also to include a fair amount of ordinary vegetables (free from oxalic acid) and vegetable broths in his daily menu. After about four days haematuria ceased and has never since returned, and examination of urine on several occasions subsequently showed absence of oxalates, while his general health has returned to normal. It is true that his use of strong tea laid him open somewhat to exogenous oxaluria, but I think his excessive carbohydrates contributed largely to his condition. In the same way I would consider that the sugar content, no less than the cocoa content, of the chocolates used by Lieut.-Col. Black's patients is to be looked on with suspicion; oxalic acid might be formed from excessive sugar through sheer inability from any cause to oxidize glucose—to go no further with explanations. It is well known that diabetic patients frequently exhibit oxaluria. Neville's findings of oxaluria in cases of vitamin B deficiency are intelligible on this basis—oxidation of carbohydrates being neces-

sarily slowed down under such a condition. Bacterial action is also a possibility in formation of oxalic acid from sugar.

I agree with Lieut.-Col. Black that it is useless to try to control oxaluria by reducing the calcium intake. Indeed, if sources of oxalic acid—exogenous and endogenous—are not avoided, reduction of the calcium intake may be a serious mistake, as in that case calcium may be abstracted from the bony framework in order to neutralize the oxalic acid. Oxalic acid, not calcium, is the primary sinner. But if oxalic acid for any reason tends to be introduced in excess, I would think it good therapy, in order to avoid formation of the insoluble calcium oxalate, to provide the system with a rational amount of sodium and potassium salts, which will tend to sweep away the oxalic acid in soluble form. A reasonable proportion of non-oxalic-acid-containing vegetables in the diet should help materially in this direction. Quite possibly the non-appearance of blood in H. B.'s urine in the morning hours was due to the well-known tendency of the system to be more alkaline after sleep and warmth. There may be, perhaps, some risk of running into the opposite danger of formation of phosphate crystals if excessive vegetables are taken, but all virtue, we are told, is a mean between two vices.—I am, etc.,

Royal City of Dublin Hospital.

E. HARVEY.

Intravenous Pentothal in Placenta Praevia

SIR,—If Dr. J. Campbell (May 5, p. 642) reads the article by Majors S. O. Aylett and A. F. Alsop in the *Journal* of April 21 (p. 547) he will find that these surgeons describe pentothal as being "an ideal anaesthetic for abdominal operations in shocked patients." On the other hand, Crooke, Morris, and Bowler (*Journal*, Nov. 25, 1944, p. 683) prefer cyclopropane and oxygen, an anaesthetic which I also recommended in my letter. Evidently these latter observers are not favourably impressed with pentothal in cases where shock exists, which shows that experiences differ. Perhaps our favourable impression of pentothal in these exsanguinated cases can be accounted for to some extent by the glucose-saline which is given intravenously throughout the operation at the same time as the pentothal. Although the fluid administered in this way is probably beneficial, yet in those cases of retained placenta where shock is often present and manual removal is necessary pentothal is given without the saline; and so far we have seen no evidence in this institution that this form of treatment has been associated with increased shock.—I am, etc.,

County Maternity Hospital, Bellshill.

S. J. CAMERON.

Barotrauma

SIR,—The correspondence on barotrauma has been followed with close interest. Some interesting discussions and important observations have been made. Whether one uses the term "otitic barotrauma," "tubo-tympanic pressure syndrome," "aural barotrauma," "anisobaric otitis," or, to keep in the fashion of mutilating the King's English, merely O.B., the fact remains that the condition is of great importance in aviation, both Service and civil.

I cannot agree that the condition is an inflammation, seeing that an acute inflammatory process is one which may proceed to pus formation. Such a sequel has not been reported, except when the area has been secondarily infected. Passive hyperaemia or congestion, yes; but inflammation, no.

It is interesting to note the percentages of visible auto-inflation mentioned by McGibbon. A recent survey of 2,500 cadets, who had been fully instructed in Valsalva's manoeuvre and who had practised auto-inflation by this method before ascending to altitude in a decompression chamber, showed that only 32 (1.28%) had any subjective or objective symptoms of barotrauma. Those affected showed all the clinical stages of the syndrome: (1) Hyperaemia of the tympanic membrane with slight retraction relieved by auto-inflation at ground level (3=0.12%). (2) Moderate retraction of the membrane, hyperaemia of the malleal region with occasional small bullous formation in the posterior quadrant (21=0.84%). (3) Gross tympanic retraction, congestion of the membrane, serous or haemorrhagic bullae or exudate into the middle ear with residual deafness at ground level (8=0.52%). No case of rupture of the tympanic membrane was observed.

It will be seen from these figures that auto-inflation by Valsalva's method, if correctly performed, is a reasonable prophylactic against barotrauma. The use of a Politzer bag while flying is excellent in theory but not in practice. Not only would it be an additional item of equipment, but it is not always successful, as may be seen when endeavouring to inflate the middle ear by politzerization in severe cases of barotrauma.

The answer to the problem is to avoid, so far as possible, the onset of the condition. This may be done by teaching aircrew (and passengers) the simplest effective method of auto-inflation and to "ground" anyone unable to ventilate the middle ear satisfactorily, whether due to barotrauma or to upper respiratory infection. If the condition should then arise and be diagnosed, the term "otitic barotrauma," although it may not be terminologically exact, does describe the syndrome and rolls off the tongue as easily as "tubo-tympanic pressure syndrome" or any other such designation.—I am, etc.,

M. E. GORDON, Fl. Lieut.

Newer Concepts of Breast-feeding

SIR,—I have read Dr. M. Witkin's article (March 31, p. 441) and the varying, though in most respects diametrically opposed, views of Dr. R. O. Barber (April 21, p. 566), Mr. Eric Coldrey, and Miss Isabel Wilde (April 14, p. 530) with interest. I consider satisfactory breast-feeding and any constructive aid thereto to be of paramount importance, and would like to put forward the following observations.

Taking only mothers who are keen to feed their babies, I would say that breast-feeding fails (*a*) because of "trouble" with one or both breasts, and (*b*) only in a minority of cases because there is insufficient milk. By "trouble" I mean primarily engorgement and the cracked nipple, the latter often being due to the baby being presented with an engorged breast which it cannot possibly "get on to" in the proper manner, this resulting in a chagrined chewing of the nipple which is sooner or later bound to produce a crack. I view engorgement as a complication which is unfortunately common, which is avoidable, and which ought to be avoided at all costs; I am certain the following regime does this and provides a sound approach to satisfactory breast-feeding.

The expectant mother should be shown by some competent person how to express her breasts, and she should do this twice a day for at least the last fortnight of her pregnancy. This prevents the ducts getting blocked by inspissated secretion, and, if an emollient such as arachis oil be used, keeps the areola and nipple pliable. I am assuming that the days of the nail-brush, however soft, and the bottle of methylated spirit are dead and gone for ever. I would like to insert here my abhorrence of such "hardening" agents as the much-used tr. benz. co. in the treatment of cracked nipples; I have found ung. hydrarg. ox. flav. excellent for this purpose, it being both an emollient and a mild, bland antiseptic.

Next, I am quite certain that both breasts should be used at each nursing. Five minutes at one breast, ten minutes at the other, then finishing with a further five at the original breast I consider to be the ideal arrangement. Dr. Barber states that "it is not until the babe has been to the breast for two minutes that the milk begins to flow": this just is not true. I can state as a fact that, if questioned, three out of every five nursing mothers with breast-feeding established experience what is termed (at least by the ladies of Lambeth) the "draught"—that is, the feeling of the breast filling up and in many cases the passive secretion of quite copious quantities of milk at times when the babe is due to come to the breast. In view of this I firmly believe it wrong to empty one breast and leave the other.

One problem I have often encountered is when the babe for some reason (e.g., after a difficult forceps delivery) is not considered fit to be taken to the breast for forty-eight hours or so after delivery. How often are the wretched mother's breasts left unattended for these forty-eight hours, with resulting engorgement and the sequelae depicted above? In such cases both breasts should be expressed at such times as the babe will be coming down, so that when it arrives it finds soft, pliable breasts with milk secretion, partially at least, already established, instead of a pair of hard, hot, painful balloons.

I disagree with Dr. Coldrey if by his concluding paragraph he infers that he says to his mothers: "Here's your babe, now feed it." Breast-feeding is, I know, a natural biological and physiological function, but the ignorance of most primiparae is immense, and I think it is a matter which, if we are to increase our most unsatisfactorily low percentages of fully breast fed babies, needs a very great deal of skill, patience, and experience.—I am, etc.,

St. Thomas's Hospital.

MICHAEL PALLOT, D.R.C.O.G.

Women in Labour

SIR,—I feel that a sense of proportion must be reached in endeavouring to make labour painless. There is a danger, partly due to the publicity campaign for analgesia and partly due to labour being made to appear more pathological by insisting on hospitalization, that labour will become more painful, and therefore will require more analgesia. I am, personally, very insistent upon analgesia being given where necessary, but I feel that there is less required where the patient has been prepared by a calm conduct of the antenatal period. The power of the mind on sensitivity to pain is very strong, and, incidentally, too much "fussing" antenatally can make a patient apprehensive and therefore more sensitive to pain. It would be an advantage if, in the hearing of the mothers, the term "contraction" were used instead of the word "pain," the usual reference to "good pains" being calculated to upset a certain number of patients.

I fully endorse Dr. Florence McClelland's view (April 28, p. 607) that there is no universal analgesia for every case, and agree that a resident anaesthetist should be included on the staff of maternity hospitals. If hospitalization is to become the routine—and in view of the lack of home helps I feel that it is a necessary evil—the accommodation in hospitals must be radically altered. Every maternity hospital should have one or more "first-stage" rooms, so furnished that there is an atmosphere of a home and not the stern barrenness of hospital. By this I mean no tiled walls, many comfortable chairs, and recreational interests. There is no more distressing case than the patient who comes into hospital too early in labour and who has a prolonged labour solely due to the psychological inhibitions of hospital atmosphere on the uterine contractions.—I am, etc.,

Liverpool.

JOHN HAMILTON.

Institutional Maternity Service

SIR,—Dr. Laura Hutton (May 5, p. 639) has made a useful contribution. There can be no question that "hygiene and asepsis have been allowed to outweigh all else in the modern development of maternity technique." She has done well to raise the issue of neonatal psychology. I venture to make the following observations.

1. The more we get away from the natural and the obvious, the more do we encourage an artificial attitude towards motherhood. Our changing social life may make institutional maternity frequently, or even generally, desirable, but let us refrain from pretending that this is a progressive step for which no price has been paid. We are converting an experience of rich emotional possibilities into a cold-blooded surgical episode, and we have no right to do so unless the change can be justified by convincing statistical proof rather than mere scientific theory. So far such proof seems to be lacking.

2. Breast-feeding is favoured and indiscriminate artificial feeding discouraged by all the highest authorities. Their grounds for doing so are chiefly physiological. But the psychological benefit to both mother and child is no less important.

3. The vogue of "rolling new-born babies into tight little mummies" is neither confined to institutions nor is it new. Swaddling clothes have been used for thousands of years and are still used in many countries. Dr. Hutton is no doubt correct in her psychological interpretation of the effect. But it seems to me that this also is a question of discrimination. The baby with an aggressive temperament will endure much environmental stimulation without damage to character development. He should be free from the beginning. But the infant of sensitive and apprehensive temperament needs security first of all. The mother's arms are the natural agents of this security. Failing them, I am prepared to believe that such infants benefit from habitual constriction—of course within