

## Reports of Societies

### OESTROGENS IN UTERINE INERTIA

The fifth meeting of the North of England Obstetrical and Gynaecological Society was held at the Royal Victoria Infirmary, Newcastle, on June 4, with the president, Mr. J. E. STACEY, in the chair.

Mr. LINTON SNAITH, of Newcastle, briefly reviewed the literature on the use of oestrogens in uterine inertia and discussed the theoretical basis for this treatment. He then went on to give a preliminary account of a clinical trial of an intravenous preparation of oestradiol in propylene glycol. This had been used in an attempt to induce labour in 9 cases and to improve uterine action in 10 cases of inertia. A total dose of 125 mg. was normally given, either in a single or in repeated injections. No ill effects were noted, but the results, so far as increasing the sensitivity and the contractions of the uterus were concerned, were extremely variable and could not be regarded as significant. Prof. T. N. A. JEFFCOATE said that one of the difficulties was to justify the treatment on theoretical grounds, and he agreed that, although oestrogens might appear to help in some cases, their value was doubtful. He had tried giving oestradiol intravenously in repeated doses of 125 mg. and had once given 500 mg. in a single injection without ill effect. If the injection was given when the abdomen was open and the uterus was directly observed, there was no immediate obvious effect on uterine contractions or vascularity.

### Infarction of the Uterus

Mr. STANLEY WAY, of Newcastle, read a short paper on infarction of the uterus, by which he meant necrosis of part or all of the uterus as a result of thrombosis or embolism occurring in its main vessels. This was a rare condition because of the very free blood supply and anastomosis within the uterus. He described four cases in which infarction had been produced by thrombosis resulting from (i) vasoconstriction, associated with ergot poisoning; (ii) torsion of the whole uterus; (iii) atheroma of the ovarian vessels; and (iv) anaerobic infection following a woman's attempt to cut off her own prolapsed cervix. In the last case the diagnosis of infarction of the uterine cornu was made before operation.

Mr. Stanley Way also described a rare case—a variant of Meig's syndrome. This was a woman of 61 who had ascites and bilateral hydrothorax as a result of a mixed tumour lying in the right side of the pelvis. The tumour was partly an ovarian cyst and partly a solid growth arising from the round ligament and extending retroperitoneally. Although sections of the solid tumour showed areas of carcinoma in a fibrous tissue stroma, the operation was successful and the patient was alive and well five years later. Mr. Way suggested that the case was unique in that it appeared to be the first recorded in which a retroperitoneal tumour had been associated with Meig's syndrome.

### Full-time Abdominal Pregnancy

Mr. T. G. ROBINSON, of Newcastle, said that both of these cases gave rise to difficulty in diagnosis, and in both the foetus died shortly before laparotomy. At operation the foetus was removed but the placenta and membranes were left undisturbed, the abdomen being closed without drainage. In spite of taking great care not to disturb the placenta, severe bleeding occurred from the placental site in the second case as soon as the foetus was delivered through the abdominal wall. This was ultimately controlled by pressure. Both patients were shown at the meeting, and in each the placenta was still palpable although the operations had taken place six and twenty-four months previously. The general opinion during discussion was that as a rule the placenta should be left in the abdomen in these cases, and that there was no need for drainage or marsupialization of the sac. Some members pointed out, however, that occasionally the placenta is pedunculated and can be removed easily and safely.

During the recent war, the Board of Trade reports, the *British Medical Journal* brought news of British medicine to the mountainous South American republic of El Salvador.

## Preparations and Appliances

### A SPLINT FOR OBSTETRIC PARALYSIS

Mr. J. D. CRONIN, assistant orthopaedic surgeon, Prince of Wales's General Hospital, London, writes: It is well known that in the upper arm (Erb-Duchenne) type, comprising about four-fifths of all cases of obstetric paralysis, a large degree of neurological recovery takes place spontaneously. In the whole-arm type, which includes most of the remaining fifth, a fair degree of recovery also occurs. In these patients, unless adequate splintage is instituted early, the neurological recovery is invariably marred by the early onset of severe contractures—adduction and internal rotation at the shoulder-joint and, to a less extent, wrist and finger flexion and forearm pronation. To avoid these contractures it is necessary, as soon as the diagnosis is made, to put the infant in a splint, supporting the shoulder in 90° abduction and full external rotation, with the elbow in right-angled flexion, the forearm in full supination, and the wrist and fingers extended.

With the invaluable technical help of Mr. U. Williams, a splint has been designed to maintain the correct position and been given a thorough clinical trial. It has the following advantages: (1) It is extremely light, although durable, being made of acrylic resin; (2) it can be removed so that the child can be bathed, be dressed, and receive massage, with passive and active movements; (3) it is so simple that the mother herself can easily remove and reapply it after adequate instruction; (4) it is easily adjusted to fit the child as it grows; (5) it is comfortable and hygienic.

The splint (here illustrated) consists of a corset moulded to the form of the trunk, and is padded with surgical felt when applied. It has slots at its edges for the passage of tapes or bandages, which keep it in position. The upper arm is supported by a platform joined to the side at right angles. The forearm is held in supination and right-angled flexion at the elbow by an extension which can be adjusted vertically and horizontally. The forearm support is bent so that the wrist is kept in extension; by adjustment the fingers may also be kept in extension. Adjustment for growth in length of the limb is made by unscrewing, moving, and rescrewing the forearm and wrist pieces in their slots. Adjustment for growth in the width of the trunk is made simply by heating the side of the corset opposite the arm-piece until malleable (about 80° C.) and remoulding as required. The hot air above the flame of a Bunsen burner is convenient for this. The patient illustrated, at the age of 7 months, has had the splint applied by his mother and has worn the same splint, appropriately adjusted, since the age of 4 weeks.

The splint is made by Hygiene (London), Ltd., 134, Orchard Way, Shirley, Surrey.

