such a numerical preponderance of the extensor response in insulin coma as to make the observation of helpful importance. And with something short of completeness we need not be acutely disappointed, for Nature, as exhibited in the field of clinical medicine, does not often provide the sharply defined and unyielding line of separation necessary for the ready and rapid sorting of cases into mutually exclusive pigeon-holes.—I am, etc.,

C. O. HAWTHORNE.

London, W.1, Sept. 7th.

SIR,—In his note on the subject in the *British Medical Journal* of August 24th (p. 345), Dr. J. L. Newman suggests that the occurrence of the extensor type of plantar reflex during an attack of hypoglycaemia "may come to be regarded as a useful clinical sign in the diagnosis of this condition."

The question arises, Is there any evidence that a plantar reflex of extensor type is more frequently present during hypoglycaemic coma than during coma due to various toxic causes—for instance, hyoscine, veronal, uraemia? It even seems probable that in some individuals (adults as well as children) an extensor plantar response may be obtained during very deep normal sleep (cf. C. O. Hawthorne, "On the occurrence of a bilateral extensor response in states of unconsciousness," *Polyclinic*, October, 1914). It has been obtained during a narcoleptic attack (Kinnier Wilson).—I am, etc.,

F. PARKES WEBER.

London, W.1, Aug. 25th.

ANTE-NATAL CLINICS.

SIR,—In common with my colleagues here I was much interested in your leading article on ante-natal clinics on August 17th (p. 315), and in your comment on the Ministry of Health's Memorandum 145/M.C.W.

The reasons for the failure of ante-natal work, if indeed it has failed, to effect any reduction in the maternal mortality rate during the ten years that have elapsed since the passing of the Maternity and Child Welfare Act, are not far to seek. Pre-natal supervision is an adjunct to, and not a substitute for, good obstetrics. "Ante-natal care is successful chiefly where those responsible for it are responsible for the rest of the maternity work, natal and post-natal." The tendency to separate the critical period of pregnancy from labour and the puerperium is bound to have undesirable results. These are commonplaces—as are also the repeated appeals for close co-operation between the various units of a maternity service. Let us have co-operation by all means; but let us first have a midwifery service, and let us build on sound, common-sense lines. In the opinion of all interested in obstetrics the key to the situation is the ante-natal period, which, for this very reason, should be controlled by medical men in the active practice of obstetrics. The Ministry's memorandum rightly suggests "that they [the midwives] should be urged to send their cases to a doctor or a clinic for ante-natal examination at least twice during pregnancy." This, in my opinion, is one of the most salutary expressions in the memorandum, in so far as it indicates the vital importance of the doctor in the ante-natal period.

But surely the time has come for some practical policy to be framed whereby the practitioner shall become a recognized active participant in these ante-natal clinic schemes. Surely the difficulties from an administrative point of view are not insuperable. I have personally organized and supervised many ante-natal clinics, and in consequence would be the last to decry their value and usefulness. At the same time I am the first to perceive their unfortunate tendencies and possibilities. Despite the most punctilious care on the part of the medical officer, patients attend without their doctor's knowledge. Midwives gradually tend to send their patients direct to the clinic, and to short-circuit the practitioner who is likely to be called in to assist in the case of intra- and post-partum complications. It is a matter of the utmost difficulty to avoid overlapping and misunderstandings.

Scattered throughout the country there are now a large number of young practitioners keen and competent to participate in a well-organized maternity service (the word is used in its widest sense and does not imply a State service). These men are trained in the science as well as in the art of obstetrics, and it is quite illogical that their services should not be available to the expectant mother. It is equally illogical that the whole-time official should be in charge of such a critical phase of midwifery—or that the specialist should be dissipating his energies in the routine examination of normal cases. I am quite sure that those consultants who are at present in charge of clinics regard themselves purely as original organizers, and will be glad to hand over their routine work into the only proper hands—those of the general practitioner who is likely to be called in to attend at labour or puerperium. We will then be able to retire into our proper place as consultants in the major obstetrical problems.

I think that the letter from my colleague Dr. E. Farquhar Murray, on September 7th (p. 476), explains very clearly the scheme which we have in view for this area, and which we expect to see in operation in two of our districts in the near future. Other areas would do well to consider some similar scheme.—I am, etc.,

H. HARVEY EVERS,
Honorary Assistant Obstetrician, Princess Mary Maternity Hospital, Newcastle-upon-Tyne.

September 8th.

TREATMENT OF PLACENTA PRAEVIA.

SIR,—With reference to my letter published in the *Journal* of August 10th (p. 278), in which I alluded to the fact that I have been using ovarian extract as a routine in my midwifery cases, I should like to inform inquirers that the solution I employ is "ovarian residue without corpus luteum"; this is supplied in 1 c.cm. ampoules, and is injected deeply into the muscles of the gluteal or the pectoral region. I am indebted to Dr. W. R. Addis of Manchester for his suggesting the use of ovarian extract to me, and I employ it in every case to which I am called early in labour.

The average time taken for complete dilatation of the os in my cases is one and a half to two hours, and one injection is almost invariably sufficient. Uterine contractions increase rapidly in force and in frequency without much, if any, increase in actual pain. The perineum dilates easily, and the last stage is comparatively painless. I always, however, give chloroform and complete the delivery with forceps, because in this way I have control of the delivery and can give the perineum time to dilate. Malpresentations, such as the occipito-posterior, can be corrected with the greatest of ease.

The exhibition of pituitrin or ergot is rarely necessary because of the absence of exhaustion and of the sustained action of the ovarian extract on the musculature of the uterus. The shortness of the labour and the strong tonic effect of the extract give the patient a marked feeling of well-being throughout the puerperium. The milk supply is increased, and, for a day or two, the distension may be troublesome until the adjustment of supply and demand takes place. The physiological action, according to Dr. Addis—and I am convinced that he is right—is a direct one on the uterine muscle, producing tonic contractions of the body and relaxation of the lower uterine segment and of the birth canal.

The application of this remedy to cases of placenta praevia is simple, and no harm can possibly accrue. The blood is already charged with ovarian hormone, and the addition of a supercharge intramuscularly is only assisting nature. Even if one has to resort to the usual procedure of hurrying the case to hospital or nursing home thirty miles away, a single injection of ovarian extract will enhance the patient's chances of reaching the journey's end at least alive.

In the issue of the *Journal* dated August 24th (p. 366) there is a reply to my letter from Dr. Bethel Solomons. The answer to his first question is, that as little attention would have been paid to any remarks made by me, and no full report would have appeared, I elected to bide my time and write a considered article to the *Journal*. The report of the proceedings of the Section and my letter appeared in the same issue, and anyone can count the number of times the words "Caesarean section" occur. I am glad to see

Dr. Solomons has qualified his remarks about the diagnosis, and I thank him for the italics.

I may have been fortunate in my use of ovarian residue, but at least I have not put the blind eye to the telescope. If in Dr. Solomons's practice "results have been absent," there must have been something lacking, either in the material he used or in his powers of observation. The painless contractions of the uterus in an induced case would deceive an observant man, as they frequently deceive the woman herself, and it is difficult to persuade her that she is actually in labour. This is probably due to the small amount of chloretone present in each ampoule.

One of my induced cases was a multipara, aged 42, who had had two previous confinements, both of which, she informed me, were very difficult, and her second child was stillborn. She went over her time with the third, and I decided to induce labour. I gave her six injections during the night at intervals of two hours, and left her at 8 a.m. She was then having strong but absolutely painless contractions. I warned her to remain indoors till I returned. "But, doctor," she said, "I promised to go out to tea to-day!" and in spite of my warning she did so. At 5.30 her hatless husband bounded up my steps, and I followed him to his house. The patient told me she had her first indication that she was in labour while she was having tea, and hurried home. She had had six or eight pains before I arrived; when I examined her the head was on the perineum, and all I had to do was to give her a whiff of chloroform and lift the head over the perineum with forceps. The child was of normal size and there was no laceration, though she had had to be stitched, she informed me, after both her other confinements.

Dr. Solomons's last paragraph is quite uncalled for. If he reads my letter again he will see that I have stated my reason for applying forceps when I did. If I had had more faith in, or experience with, my remedy at that time—nearly three years ago—I should have given further injections of ovarian residue and waited. I have had nearly twenty years of experience of midwifery in general practice, and I was trained in a good school. I may say that I have received complimentary letters from doctors in all parts of the country; many have said they have learned nothing to help them from the report of the Section in the *Journal*.—I am, etc.,

Manchester, Aug. 26th. D. C. MACDONALD, M.B.

CARE OF THE UNMARRIED MOTHER.

SIR,—I missed your issue containing Dr. R. A. Gibbons's plea for the unmarried mother, but was fortunate enough to see the letter on the same subject in your issue of August 24th (p. 367).

It may interest your readers to know that Queen Charlotte's Maternity Hospital was established in 1739 by a few charitable people for the express purpose of succouring unmarried mothers, the neglect of whom, in those days, frequently resulted in attempts at suicide and infanticide. Although the present-day Queen Charlotte's Hospital has enormously outgrown the institution of nearly 200 years ago, it still offers an asylum to unmarried mothers with their first child, and last year 423 such cases were received out of a total number of 2,375 in-patients. Formerly a distinction was made in the wards between the married and the unmarried women, probably due to a prejudice which was inexcusable in view of the original foundation of the charity. I am glad, however, to say that such a distinction is no longer made, and that no one is aware of the status of a patient except those immediately responsible for the reception of the case. Many an unmarried woman has testified to her gratitude for the treatment at Queen Charlotte's Hospital by a letter or an even more concrete token after leaving the institution.

It is, perhaps, a sign of retrogression that the proportion of unmarried women to married women patients has increased in the last two years, although it may be dangerous to deduce this from the bare figures without taking into account circumstances which do not permit themselves to be expressed by statistics.

In view of the plans to build a new Queen Charlotte's Hospital at Hammersmith on a far larger scale, where eventually a total of 358 beds will include accommodation for at least 200 non-paying patients, it will be realized that this very old charity will have additional opportunities for carrying on its sympathetic work for the unmarried mother.—I am, etc.,

DIGBY C. H. D'AVIGDOR,
Assistant Organizer, Queen Charlotte's
London, N.W.1, Aug. 28th. National Mother-Saving Campaign.

THE NEW VACCINATION ORDER.

SIR,—With reference to the above Order, I cordially agree with the letters of Dr. G. Mahomed of Bournemouth and Dr. F. W. Alexander of Teddington in the *British Medical Journal* of September 7th (p. 476). In the days gone by we have had statistics of outbreaks of small-pox showing that four vaccination marks gave the best protection against that disease; and now the new Order says one mark is to be used—surely a very weak-kneed idea. It would be better to abolish vaccination altogether than to play with efficiency.

I consider cross-hatching with a needle must cause a large amount of trauma and a clumsy way of introducing the vaccine. I started as a public vaccinator in the days of arm-to-arm vaccination, and saw the great benefit when the Government lymph was standardized and sterilization came to the front. I would suggest that the blade of the lancet, not the point, should be the only method used, tightening the skin of the arm with thumb and finger, dropping the edge of the lancet lightly on the skin so as to produce four little red lines without drawing blood, and applying the vaccine before releasing the stretched skin.

As to vaccination producing encephalitis lethargica, why does it not produce it in the infant? Surely this is only another instance of an irritant stirring up a latent disease, as, for example, in the case of eczema, which occasionally follows vaccination in a patient who is the offspring of gouty parents.

Vaccination is an art, and needs care and attention to details.—I am, etc.,

A. Z. C. CRESSY,
Wallington, Surrey, Sept. 9th. Public Vaccinator.

RACIAL INCIDENCE IN DISEASE.

SIR,—A remark ascribed to Dr. T. A. Goodfellow, speaking on tonsils and adenoids at the Annual Meeting of the British Medical Association, is that there is a greater frequency of adenoids among Jewish children (see *Journal*, August 17th, p. 302).

It is rather surprising how widespread the tendency is to ascribe all sorts of immunities and predispositions to Jews. This is all the more remarkable since most of such statements are quite incapable of proof, for, barring Holland, vital and mortality statistics are not available for the Jews of Western Europe nor for those of the United States. All statements of such a character are therefore based on clinical impressions, but, unfortunately, clinical impressions are not necessarily satisfactory evidence for such wide-reaching generalization.

On the matter raised by Dr. Goodfellow, my personal experience differs from his. I see large numbers of East End children with tonsils and adenoids, including many Jewish children at the London Jewish Hospital, and non-Jewish children at such large centres as the Plaistow Children's Hospital, and at Guy's Hospital; from my experience, I should not have thought there was any greater frequency of this affection in Jewish children. Granting even that more Jewish children with tonsil and adenoids are brought for treatment it does not follow that the condition is in reality more frequent among them: the generally recognized greater maternal care among Jews may very well account for any apparent greater incidence that Dr. Goodfellow may have observed.

The object of this letter is to draw attention to the fact that all the available evidence seems to point to there being very little of a racial basis for any disease. Many diseases have at one time or another been described as being specially common or specially rare among Jews. In a recent symposium Sir Humphry Rolleston and others