We hope that those made in this paper will be better connected, as Dr. Farrant's observations deserve.—We are, etc.,

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Phenothiazine Derivatives

SIR,—The article by Dr. Linford Rees on the uses of chlorpromazine and allied phenothiazine derivatives (August 13, p. 522) has prompted me to write concerning our experience with intramuscular "sparine" (promazine hydrochloride) as an adjunct to analgesia in obstetrics. During the past two years I have tried various combinations of pethidine, scopolamine, plus phenothiazine derivative. By using the latter, it was hoped to reduce the dosage of other drugs whilst maintaining or boosting their effect.

We have found the following dosages most suitable: A primigravida at two-fingers dilatation is given pethidine mg. 100, scopolamine gr. 1/150 (0.43 mg.), and promazine mg. 50, intramuscularly. Depending on the progress of labour, she may need a half "round of the cocktail" in four hours, or perhaps only "pethilorfan," mg. 100. A second full round is rarely needed. A multigravida in early labour will usually require only one full dose, or perhaps pethidine plus promazine only. Except in those cases specified below, analgesia plus amnesia has been "very good" or "excellent," the patients being very relaxed, with only a hazy memory of the labour ward. This statement is based on a combination of nursing sisters' impressions and the patients' remarks at post-natal visit.

Taking 75 consecutive cases, and excluding those who had very short hospital labours or caesarean sections, we can report on 30 multigravidae and 25 primigravidae who had planned analgesia. No undue delay was found in the establishing of respiration in the babies. Mucus-extraction or no treatment is reported for all except three. These cases were in white asphyxia; one was premature and subsequently proved to have an intracranial haemorrhage. The surviving two had foetal distress in the second stage of labour, presumably due to placental insufficiency.

Blood-pressure recordings in labour showed no significant fall, and no untoward reactions were noted—e.g., urticaria. Three low-forceps deliveries were blamed on the analgesia, the patients being too sleepy to bear down. We found it quite safe to allow the second stage to progress a little longer than usual before interfering. No changes in foetal pulse rates were observed which could be attributed to the drug. Four patients were very restless following the first dose of the mixture, but would probably have settled following a second injection. Three patients declared that the relief afforded was poor—one of these, a primipara, was 26 hours in a colicky type of labour, and had two full doses of mixtures plus 100 mg. of pethilorfan. The average duration of labour was 16 hours in the primigravidae and 8½ hours in the multigravidae. There was one post-partum haemorrhage following forceps delivery for persistent occipito-posterior.

The overall impression gained is of a quiet labour ward, with good relief of distress and no apparent increase in risk. I hope this formula may help in those practices where facilities for intravenous therapy are not easily available.—I am, etc.,

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Central Steri!e Supply Departments

SIR,—After reading Dr. V. D. Allison's detailed analysis of his splendid organization (September 10, p. 772), I have thought it appropriate to comment upon his sixth paragraph. Central supply of sterile ward packs for minor operations, etc., was routine procedure at the London Hospital long before I served as a surgical dresser, which was in 1933, and very excellent was the system, which was also improved every year. It would be interesting to know if perhaps there has been a complete C.S.S.D. at the London Hospital during the post-war years. This would then have priority over the perfected organization in Belfast.—I am, etc.,

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Our Hospitals

SIR,—Lord Taylor in his article on "Hospitals of the Future" (September 10, p. 752) suggested that the building materials and methods which were good enough for Wren are good enough for us. Would it be any less reasonable for an architect to claim that the methods prevailing in medicine at the time of Wren should be good enough for Lord Taylor? Progress in architecture, as in medicine, comes only from research and experiment. That failures occur in both fields as a result of such experiments does not invalidate the principle.—We are, etc.,

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Caravans as Homes

SIR,—The paper by Dr. G. K. H. Hodgkin (September 17, p. 854) serves a useful purpose in illustrating a technique of assessing the health of a small community such as the occupants of a caravan site, but there is a real danger that the conclusions drawn from this survey of 31 children of 18 families living on a single poor site, with a turnover of families much more rapid than usual, may be used for highly misleading generalizations.

Apart from the very small size of the sample, we do not know if the site is a typical one. Even if it is, which from the description seems doubtful, the survey would not condemn caravan life, that should be judged on what it can and should be like, and not on what, in the stress of acute housing shortage and a great excess of demand over site supply, it very often is like. One might as well survey the health of families in one rather slummy block of flats and use that to condemn living in houses. However, I welcome Dr. Hodgkin's pointing out a gap which Sir Arton Wilson had to leave in his report, and would welcome further sample surveys of the same kind from other sites.

Future surveys should include some information on the size and quality of the caravans occupied. In some areas there are many shoddy medium-size holiday vans in use as permanent homes, and these are obviously very undesirable. The properly made 22-ft. (6.7-m.) residential models are a very different proposition, but even these have never been defended by this magazine as satisfactory for more than two people. They are vastly