

especially when local conditions are such that expert help and adequate facilities for breech delivery are not always available. Probably most obstetricians to-day use general anaesthesia for external version only in special cases, such as when there is a question of possible disproportion which could be much more easily assessed if the head were presenting.

Sceptics have suggested that the incidence of breech presentation in labour is the same whether or not routine external version is practised antenatally, but this has been disproved.<sup>5</sup>

## REFERENCES

- <sup>1</sup> White, A. J., *J. Obstet. Gynaec. Brit. Emp.*, 1956, 63, 706.
- <sup>2</sup> Hay, D., *ibid.*, 1959, 66, 529.
- <sup>3</sup> Macafee, C. H. G., *Med. Press*, 1956, 236, 268.
- <sup>4</sup> Neely, M. R., *J. Obstet. Gynaec. Brit. Cwlth.*, 1961, 68, 490.
- <sup>5</sup> Beischer, N. A., and Townsend, L., *ibid.*, 1960, 67, 668.

## Ovulation After Childbirth

**Q.**—How soon after normal childbirth is ovulation normally resumed? Is the resumption of menstruation any guide, and does inhibition of menstruation by lactation also imply inhibition of ovulation?

**A.**—Thirty-three per cent. of lactating primiparae experience a return of menstruation within three months of delivery, and the figure rises to 45% for multiparae. If lactation is suppressed menstruation returns within three months in 90% of both categories. When the baby is partly breast-fed and partly bottle-fed the figures are 75% for primiparae and 85% for multiparae. Although the first period can be anovular, it is preceded by ovulation in approximately 60% of cases. This means that ovulation often occurs while the woman is still amenorrhoeic. Indeed, ovulation commonly takes place within six weeks of delivery in non-lactating women, and is delayed only a few weeks longer in women who are breast-feeding their babies. It follows that a woman can conceive before the menstrual cycle is resumed. Information on this subject has been given by McKeown and Gibson<sup>1</sup> and Sharman.<sup>2,3</sup>

## REFERENCES

- <sup>1</sup> McKeown, T., and Gibson, J. R., *J. Obstet. Gynaec. Brit. Emp.*, 1954, 61, 824.
- <sup>2</sup> Sharman, A., *ibid.*, 1951, 58, 440.
- <sup>3</sup> — in *Modern Trends in Obstetrics and Gynaecology*, 2nd series, edited by K. Bowes, 1955. Butterworth, London.

## Apert's Syndrome

**Q.**—I have under my care a girl aged 2, an only child, who presents the syndrome of mental retardation, oxycephaly, and syndactyly. There is no relevant familial history. The parents wish to know what the possibilities are of further children being affected.

**A.**—The commoner "typical" acrocephalosyndactyly (Apert's syndrome) nearly always occurs sporadically. There are some indications that a dominant mutation is concerned.<sup>1</sup> The parents may be told that the chances of further children being affected are small. Atypical acrocephalosyndactyly without the characteristic interdigital bony union has been reported more than once in a sibship, and here there is a higher risk.

## REFERENCE

- <sup>1</sup> Blank, C. E., *Ann. hum. Genet.*, 1960, 24, 151.

## Vitreous Opacities

**Q.**—What causes vitreous opacities and can they be congenital? Do they increase with age? Is there any treatment?

**A.**—There are many different causes of vitreous opacities and they can be congenital. Some kinds increase with age, others do not. Some respond to treatment, others do not. Most of the congenital opacities are remnants of the hyaloid vascular system which in foetal life extends from the optic disk through the whole antero-posterior length of the vitreous.

Small floating opacities, consisting of granules shed from the iris pigment or small protein flakes representing irregular

vitreous consistency, are for the most part harmless and often come to light during a routine examination of healthy eyes. These floaters are commoner in myopes than in non-myopic people and commoner in the old than in the young. They cannot be dispersed by treatment.

Inflammatory particles beset the vitreous when the uveal tract (the iris, the ciliary body, and the choroid) becomes inflamed. Such opacities diminish if the causative uveitis can be successfully combated, but a few residual opacities may be evident long after the acute stage is over.

Various types of retinopathy, as well as trauma, may give rise to vitreous haemorrhage. Crystalline opacities are occasionally found after injury.

## Lupus Erythematosus

**Q.**—A boy aged 18 has had local lupus erythematosus on the typical site on the face for about four months. The rash is controlled by chloroquine. The blood-pressure is not raised. Blood examination shows nothing abnormal. There is a trace of albumin in the urine. What is the prognosis, and in particular what are the chances of disseminated lupus erythematosus developing?

**A.**—A small proportion of patients with chronic discoid lupus erythematosus ultimately develop systemic lupus erythematosus. A considerable proportion, 50% or more, on exhaustive investigation show one or more signs suggestive of systemic disease, and it is probable that such patients are more likely to pass into the systemic phase clinically than others. The presence of albuminuria here is suspicious. A complete overhaul of cardiovascular, renal, respiratory, and haemopoietic systems is necessary. The E.S.R., serum protein characters, the blood picture, assessment of renal function, and especially examination for red blood cells in the urine, and perhaps renal biopsy, etc., will help determine whether there is systemic disease, and that will determine prognosis. The renal state is perhaps the most important in prognosis.

## Blowing the Nose

**Q.**—How should children be taught to blow their nose?

**A.**—The important thing about blowing the nose is that it should be effective in clearing the mucus without giving rise to any untoward pressure effects or direct dissemination of infection from the nose to the sinuses or middle ear cleft. To achieve this object it is important that only one nostril should be closed at a time—the nasal secretions being expelled through the free side. Not every child finds it easy to do this, but it may be facilitated by taking in a deep breath at first and holding it for a few seconds before blowing out.

**Correction.**—We much regret that in our Parliamentary Report (December 30, p. 1790) we wrongly described Mr. MAURICE EDELMAN as a Conservative Member of Parliament. He is of course a Labour Member.

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