

Any Questions ?

We publish below a selection of those questions and answers which seem of general interest. It is regretted that it is not possible to supply answers to all questions submitted.

Corticosteroids and Obstetric Stress

Q.—Should the stress of normal labour be considered an indication for additional corticosteroids (1) in a patient already taking an established dosage for a medical condition; and (2) in a patient who has had such therapy within the last two years? If not, what about a patient who suddenly requires an obstetric operation?

A.—Normal labour subjects the adrenals to a degree of stress which approaches that of an operation. When pregnancy and delivery are complicated by excessive vomiting, infection, haemorrhage, anaesthesia, and operation, the stress increases. The woman who conceives while she is receiving cortisone for impaired adrenal function requires the same treatment during pregnancy. If, however, she is receiving cortisone merely for its anti-inflammatory effect, she is probably best weaned from the treatment slowly during the early months of pregnancy. The withdrawal will in part be compensated for by the increased endogenous production of hydrocortisone during pregnancy.

When a woman who is still taking, or has only recently discontinued taking, steroids enters labour or suffers any incident causing stress during pregnancy, she needs additional supportive therapy equivalent to 200 mg. cortisone acetate, intramuscularly, during each 24 hours. The duration of such treatment must vary with the indication, but, for labour, should not be less than three days. Hydrocortisone-free alcohol, hydrocortisone hemisuccinate, and prednisolone 21-phosphate act immediately when administered intravenously. Diluted in glucose-saline, and given as an intravenous infusion, controlled by blood-pressure readings, they are invaluable in covering emergency operations such as obstetrical manoeuvres and caesarean section. Intramuscular injection is not an alternative route under these urgent circumstances; the rate of absorption from a muscle depot occurs too slowly.

In surgical circles it is generally reckoned that it may take two years for the adrenals to recover fully from the suppressive effect of a course of corticosteroid. The physiological stimulus of pregnancy to the maternal adrenals probably renders this safety margin excessive for normal labour at term. When, however, laparotomy or evacuation of the uterus is required early in the pregnancy of a woman whose adrenal function is at all suspect, she should be treated with cortisone, in the dosage recommended above, for 24 hours before and for 48 hours after operation. Even at term, when there is any doubt, there is much to be said for giving cortisone prophylactically during and after labour, especially if anaesthesia or surgery becomes necessary. It can do no harm and may prevent a catastrophe.

Treating Tapeworms During Pregnancy

Q.—What is the most effective and safest treatment for tapeworm infection in (1) early and (2) late pregnancy?

A.—The first thing is to ascertain the type of tapeworm with which the woman is infected. The vast majority of these infections, both in this country and overseas, are with *Taenia saginata*, which along with almost all other worm infections are best left untreated until pregnancy is over. Such infections have almost always been present for a considerable period and are not likely to give rise to trouble during the pregnancy, whereas to treat them may bring about abortion or other complications.

Taenia solium can easily be identified by counting the lateral uterine branches. Infection with this may give rise

to cysticercosis, so that early treatment is advisable. In the first instance a dose of 5–6 g. dichlorophen ("antiphen") might be tried, and if it fails to eradicate the worm the more effective but more difficult to administer standard treatment with male fern (*filix mas*) should be given. Mepacrine is best avoided in this infection because of its tendency to cause vomiting, which would increase the risk of cysticercosis developing.

Differentiating Megaloblasts

Q.—Is it possible by the microscopic study of a bone-marrow film to differentiate the megaloblasts of true pernicious anaemia from the megaloblasts of the "pernicious anaemia" of pregnancy?

A.—It is not possible microscopically to differentiate between these megaloblasts.

NOTES AND COMMENTS

First-aid Manikin.—Mr. E. R. HARRISON (Smith and Nephew Ltd., Welwyn Garden City, Herts) writes: As distributors in this country and throughout the world, with the exception of Canada and the United States of America, of the "Brook" airway, we were interested to note the question and answer under the heading of "First-aid Manikin" ("Any Questions?" December 17, 1960, p. 1819). . . . Three training aids are available from this Company—the Brook manikin, a wooden cut-out demonstrator head, and a 16-mm. sound and colour film "That They May Live." . . . Whilst we must agree with the view you have expressed in the last paragraph of your reply . . . we would say that, so far as we are aware, there has not been reported a fatality with the Brook airway.

OUR EXPERT replies: I have studied the "Brook" airway and its application to oral resuscitation. From the point of view of mechanics I would say that this airway is satisfactory. The internal portion is not nearly so dangerous as in the original types and the external portion is certainly an improvement. Where it is available the apparatus would normally function efficiently. At the same time it suffers from the great disadvantage of other airways: it is not there at the right time.

Corrections.—Dr. T. J. Thomson has asked us to state that in his article with Dr. T. W. Parsons on "Methaqualone as a Hypnotic" (January 21, p. 171) the words "for tablet A" should be deleted from line 7 under the heading "Results" (p. 172). The completed sentence would then run: "In order to complete this study 28 patients were required, as 17 stated a preference and 11 'no difference' results were obtained."

In the description of the short-term controlled trial in the article by Drs. R. S. Bruce Pearson, J. H. Baylis, and H. C. Smellie on "Treatment of Chronic Asthma with Prednisolone and the Newer Steroids" (February 4, p. 315) the name of one of the bronchodilators used was wrongly given as phenoxymethazone. It should have read methoxyphenamine.

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