

Period of Gestation

SIR,—Most valuable and accurate information could be given on this subject by married couples where both husband and wife are doctors. We are such a couple, and over the first seventeen years of our married life three births occurred. The first pregnancy was associated with 255 days of amenorrhoea; the second lasted 257 days from the actual day of fertilization, as did the third. At the birth of the first child, we assumed that he was premature in spite of his normal size and normal length of finger-nails. When the second child appeared after 257 days we rejected the idea of prematurity, especially as this child weighed 11 lb. (4.95 kg.).

The maternal menstrual cycle recurs every 24 days with remarkable regularity, and we thought that this shortened intermenstrual time might influence the gestation time to be shorter. On this basis we confidently and correctly predicted the approximate birthday of our third child.

Dr. S. H. Waddy, in his interesting letter (May 24, p. 1132) is thinking along similar lines, and he suggests that a pregnancy lasts ten times the mother's intermenstrual period. In our case, although there is such a tendency, the total gestation time from actual date of conception is more than $10 \times 24 = 240$ days; it is 257 days.

Possibly it is not only maternal factors that influence gestation time; the foetus is born when it is mature, and its rate of attainment of maturity may be inherited from both parents and be a compromise between the two. For example, every poultry farmer who crosses a female Aylesbury duck with a Muscovy drake knows that the resulting egg looks exactly like an Aylesbury egg, but the hybrid emerges at 31 days—a compromise between the respective periods of incubation of 28 days in the case of the Aylesbury duck and 35 days in the case of the Muscovy.

On the basis of our limited observation it would be foolish to dogmatize. We suggest, however, that some future investigation such as the Birmingham series should be analysed along lines to discover whether the gestation time is $10 \times k$, where k is a compromise between the intermenstrual time of the mother and the intermenstrual time of the females on the paternal side.—We are, etc.,

K. JOYCE MULVANY.
BERNARD GOLDSTONE.

East London, South Africa.

Perforation of Small Intestine

SIR,—Reading Mr. Hilary Wade's article (October 25, p. 922) on perforation of the small intestine reminded me of a similar case treated here last year.

A married girl of 26 was admitted with a 24-hour history of abdominal pain, which had moved from epigastrium to right iliac fossa. She complained of nausea but no vomiting. She was also suffering from thyrotoxicosis. A diagnosis of acute appendicitis was made. At operation a Meckel's diverticulum was found to be present, the apex of which had been perforated by a bristle lying partly in the diverticulum and partly in the peritoneal cavity, with an area of surrounding inflammation. The diverticulum was removed. The bristle was the size and shape of those used in the manufacture of tooth brushes.—I am, etc.,

Great Yarmouth.

J. B. BINKS.

An Obstetric Thimble

SIR,—In 1934 I published a very brief article, "A Simple Device for Rupturing Membranes" (*Amer. J. Obstet. Gynec.*, 1934, 27, 273), in which I suggested a spiked thimble for rupturing the foetal membranes. The thimble idea occurred to me while reading, in one of my grandfather's medical books, of the custom of the early accoucheurs to employ a sharpened finger-nail to rupture the membranes. Modern rubber gloves prevent the use of the finger-nail, but it occurred to me that a thimble with a raised pointed sector could be substituted.

This second report is to describe more fully my conception of an obstetric thimble and also to give a technique for using it. Any handyman can, with a jeweller's saw and file, make the device. Two cuts are made in the end of a silver thimble, these intersecting in or near the centre and at slightly more than a right angle. The sector so delineated is then slightly raised and the rough edges are polished off, preserving the point. A small hole is drilled in the base to which a stout nylon cord can be attached for retrieving the instrument in case it should slip off—an accident which rarely happens. Obviously, the foregoing method is by no means the only one of making a point or spike on the end of a thimble. Instrument-makers may suggest improvements which might simplify manufacture. The method I have suggested, however, seems safe and effective.

While some doctors have employed the obstetric thimble for initiating labour, I personally do not now recommend it for this purpose. I advise that the thimble be used only during the second stage of labour, when the cervix is fully dilated and tough membranes seem to be delaying the further progress.

The technique recommended is as follows: The sterilized thimble with cord attached is placed firmly over the tip of the first finger of the examining hand. The point of the thimble is towards the palm. The middle finger of the same hand is placed behind the first finger to protect the point from doing any injury to the soft parts. Previous examination having shown the cervix to be fully dilated, the head rotated and flexed, and no reason for a delay in labour, except tough membranes, the fingers are inserted in the vagina as for examination.

The middle finger being used for palpation, it is slightly flexed on encountering the membranes and a scratching movement is made with the first finger while the thimble is in contact with the membranes (between pains). The membranes are easily ruptured, allowing the escape of amniotic fluid. The technique is very easy and the danger to mother and child minimal. Of course, one should not mistake the buttocks, scalp, or face for unruptured membranes.

A great deal of obstetrics is still, of necessity, done in the home. Therefore an instrument which can be used by touch while the patient is in her bed has advantages. The obstetric thimble can be characterized as one of the less readily of obstetrical instruments. Ease of technique should, however, not lead to unnecessary tinkering with the normal process of labour.—I am, etc.,

Quebec.

ROBERT P. LITTLE.

A Syringe Label

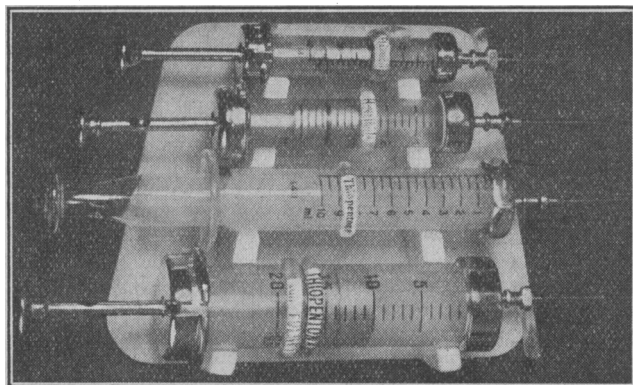
SIR,—Modern anaesthesia is typified by the multiplicity of drugs used. The large number of syringes which litter the anaesthetic trolley is mute evidence of this. The harassed anaesthetist is faced with watching the colour of the patient, his pulse and respiratory rates, blood pressure, general condition, and also four flowmeters, a rebreathing bag, and the contents of two or three syringes. The result of some confusion with the latter difficulty was that a search was made for a simple method of labelling the contents of a syringe.

The illustrated syringe-label clip was designed and made by the Senior Anaesthetic Technician of the Queen Victoria Hospital, East Grinstead, Mr. Cyril Jones. It is simple, cheap, and effective, and takes very little time to make.

The material is "perspex," and strips $\frac{1}{4}$ in. (6 mm.) wide are sawn off a sheet $\frac{1}{4}$ in. thick. These strips are then cut up into varying lengths, the length depending upon the size of syringe it is intended to label. The clip encircles about three-quarters of the circumference of the syringe, and some approximate lengths are 20 ml. syringe, $2\frac{1}{4}$ in. (6.5 cm.); 10 ml. syringe, $1\frac{1}{4}$ in. (4.5 cm.); 5 ml. syringe, $1\frac{1}{4}$ in. (4 cm.); 2 ml. syringe, $1\frac{1}{4}$ in. (3 cm.).

After strips of the appropriate size are cut they are labelled. The label can be typed, but better than this are the printed headings found in the literature sent out by the drug houses.

The back of the perspex strip is moistened with a drop of chloroform, which is a solvent for perspex, and the label, which has previously been cut to size, is pressed into the softened perspex and left to dry. The back of the label is then coated with a varnish to render it waterproof. Mr. Jones uses a varnish



of perspex shavings dissolved in chloroform. Waterproofing the label is essential to prevent its becoming wet and torn, as many syringes are not absolutely dry when used.

The strip is then warmed until it softens, and bent round a syringe or any tube of a size equal to the syringe it is intended to label (test-tubes are very satisfactory). Very little heat is required, the perspex being rapidly flamed back and forth in a small bunsen flame. After bending round the tube it is plunged into cold water and it immediately becomes hard again. The clip can now be polished if required or used right away. Coloured perspex strips might be preferred by some, and are prepared in exactly the same way. The tensile strength of the perspex is considerable, and makes the ring a strong and effective spring clip.

A refinement of these clips may be obtained by chamfering, and then polishing, two edges, thus converting the cross section of the perspex from being square to convex. This has the effect of creating a convex lens in front of the printing and magnifies it considerably. The clips shown in the photograph were treated in this fashion.

These clips were demonstrated on October 4 at a meeting of the Society of Anaesthetists of the South-west Metropolitan Region, where they created much interest and received high praise.—I am, etc.,

East Grinstead, Sussex.

A. A. MASON.

"Et al., ettc."

SIR,—While agreeing with Professor J. W. Howie's conclusion (October 18, p. 883), which is that "*et al.*" is nonsense, I can hardly congratulate him on the analogy he has chosen to prove his point. Surely "*etc.*" stands, as it always stood, for *et cetera*, which was, and remains, plural. There can thus be no need for doubling the c any more than for doubling the l of "*et al.*" which means *et alia* or *et alii*. Incidentally, this is a valid reason for supporting Professor Howie's contention, accepted now by most editors, that "*et al.*" should never be used when there is only a single co-author. On the other hand, the abbreviation "p." stands for a singular word, "page," and the use of "pp." for more than one page is logical as well as traditional, though typographically unpleasant to some people.

The choice would appear to be between, on the one hand, the italics of "*et al.*" with economy of space, and, on the other, the saving in setting of "and others" at some typographical extravagance.—I am, etc.,

London, N.W.3.

A. L. BACHARACH.

Scalpel for Removal of Sutures

SIR,—Patients have a quite morbid apprehension of "having the stitches taken out." There is no doubt that when sutures have begun to cut into a wound the pressure of the blade of a pair of scissors under the suture does cause tension and pain.

Some years ago I was faced with a small nervous child whose eyebrow I had stitched up under an anaesthetic, and the removal of the stitches was approached with considerable caution by both of us. By using a scalpel blade No. 11 I found that I could slide the tip underneath the suture, and before any tension was felt the suture was cut.

Since then I have never used a pair of scissors to remove stitches, and no patient has ever felt one coming out.

Surgery of any kind always involves some pain to the patient, and it is our duty never to become hardened, but where possible we must use forethought to minimize pain. I should like to see scissors entirely replaced by a scalpel in the tray for removing sutures, especially in hospital, where it is so often done by dressers and junior nurses who are gaining experience.—I am, etc.,

Great Dunmow, Essex.

GEOFFREY BARBER.

POINTS FROM LETTERS

Isoniazid Treatment in Advanced Pulmonary Tuberculosis

Dr. T. DONOVAN (Cork) writes: I have been using this drug since late April. The patients were inmates of St. Joseph's Sanatorium, Cork, and were mainly of the advanced incurable or acute moribund types. All the cases treated were pulmonary, 85 in number. The average age was 37. The average duration of the disease was four years. The dosage given was: First week, 100 mg. twice daily; second week, 200 mg. twice daily; third week, 300 mg. twice daily. The dose of 600 mg. per day was continued. In all cases, except six, appetite improved, weight increased, cough and sputum were diminished, temperature, when present, became normal, and there was a remarkable feeling of well-being. In eight cases cough and sputum ceased and have not recurred. In 15 cases the treatment was discontinued after two months, and, of these, eight had a recurrence of cough and sputum. There were four acute and moribund cases for whom the expectation of life was estimated to be about two months. All four revived in a most dramatic fashion and now look and feel well. One patient, aged 70, improved temporarily, then developed tuberculous toxæmia and died. Seven patients, after six weeks, developed peripheral neuritis, starting with numbness and tingling of the hands and feet, progressing, in two cases, to severe burning feelings and pain. No motor paralysis was evident. The average age of these seven cases was 45, and the average duration of illness four and a half years. Treatment was discontinued, and the dose in all other cases was reduced from 600 to 300 mg. per day. No other cases of neuritis have since occurred. After five to six days neuritis has in all cases improved; and two of the cases have resumed treatment without, so far (three weeks), recurrence of neuritic symptoms. All those who discontinued treatment and who had recurrence of symptoms have recommenced, and improvement is evident in most cases. It was noticed that patients improved more rapidly and intensely at the 600 mg. per day level.

Flying Squad Unit for Abortions

Dr. MARY A. FOLEY (London, N.W.6) writes: I would like to see a mobile ambulance unit which would take blood, sterile instruments, and anaesthesia to the home of the patient who is aborting. The general practitioner would then be relieved of the difficulty encountered in trying to get such a patient accepted by a hospital and the valuable beds could be used for waiting-list cases. Of course there are a few cases of abortion which will require hospitalization, but they are very few. I am ignorant of the economics involved, but surely the money saved from the beds would pay for the service. I suggest that the unit should be run on the same lines as a maternity hospital flying squad which could give the patient at home the treatment which she would receive in hospital. The patient needs very little nursing care after a dilatation and curettage and in the majority of cases would be much happier at home. I would be most interested to read the comments of yourself and your readers.

Dupuytren's Contracture

Dr. ERICH GEIRINGER (Edinburgh) writes: That a hereditary disposition plays a part in the aetiology of Dupuytren's contracture is by now well established. The following case concerns female twins, aged 28 years. One of them developed about two years ago a linear thickening and contracture of the palmar aponeurosis opposite the base of the right ring finger. The overlying skin is involved in the characteristic puckered fashion, but there is as yet little interference with the mobility of the finger. She is right-handed. Her left-handed sister has now developed a coarse, nodular thickening of the palmar fascia of the left hand in exactly the same anatomical position. Examination for other mirror phenomena was not possible. In neither case is there a history of prolonged or excessive pressure on the palms. Twinship, mirror phenomenon, early onset, and female sex must be an extremely unusual combination in this disorder.