

women who have a blood-pressure of 140/90 mm. Hg or more, who are more than 10 days past the expected date of delivery, and on primigravidae aged 30 years or over who have reached term undelivered.

A further safeguard—and advance in treatment—in the conduct of labour of women with positive amnioscopic evidence of intrauterine hypoxia is that after the membranes have been ruptured samples of blood can be obtained through an endoscope from the presenting part of the foetus to assess its acid-base status.¹²⁻¹⁴ This more direct and dramatic approach to the assessment of foetal well-being has overshadowed to some extent the possible value of amnioscopy. But amnioscopy does offer a more direct and rational approach to the selection of women for the induction of labour than the arbitrary rules hitherto used by most obstetricians, who would welcome any effectual means of lowering the high rates of induction of labour at present reported by most maternity units.

The success of the procedure depends on the assumption that foetal hypoxia is usually associated with the passage of meconium *in utero*, and that in the absence of this sign the danger to the foetus is minimal. The evidence available on this point is somewhat confusing.^{15 16} Nevertheless, Saling¹¹ has reported that in more than 6,000 pregnancies screened by

amnioscopy there have been only 4 antepartum deaths, and in 2 of them the cause was haemolytic disease. The total perinatal loss in Saling's own series of 1,686 women examined with the amnioscope was 12.4 per thousand births. Amnioscopy at last provides a possibility of treating the individual woman, which is surely an advance over a policy of routine induction of labour, however selective, that is based solely on statistical probability.

- ¹ Butler, N. R., and Bonham, D. G., *Perinatal Mortality*, 1963. E. & S. Livingstone, London.
- ² Gibberd, G. F., *Lancet*, 1958, 1, 64.
- ³ Wrigley, A. J., *ibid.*, 1958, 1, 1167.
- ⁴ Theobald, G. W., *ibid.*, 1959, 1, 59.
- ⁵ Cope, I., and Pearson, M. G., *Brit. med. J.*, 1958, 1, 1211.
- ⁶ Fraser, A. C., and Wood, E. C., *Lancet*, 1961, 1, 454.
- ⁷ Kubli, F., *Geburtsh. u. Frauenheilk.*, 1962, 22, 134.
- ⁸ Parrish, H. M., Rountree, M. E., and Lock, F. R., *Amer. J. Obstet. Gynec.*, 1958, 75, 724.
- ⁹ Fairweather, D. V. I., Murray, S., Parkin, D., and Walker, W., *Lancet*, 1963, 2, 1190.
- ¹⁰ Saling, E., *Geburtsh. u. Frauenheilk.*, 1962, 22, 830.
- ¹¹ ———, *Das Kind im Bereich der Geburtshilfe*, 1966. George Thieme Verlag, Stuttgart.
- ¹² ———, *Arch. Gynäk.*, 1962, 197, 108.
- ¹³ Morris, E. D., and Beard, R. W., *J. Obstet. Gynaec. Brit. Cwlth*, 1965, 72, 489.
- ¹⁴ Beard, R. W., and Morris, E. D., *ibid.*, 1965, 72, 496.
- ¹⁵ Hanon, F., Coquoin-Carnot, M., and Pignard, P., *Le Liquide Amniotique*, 1955. Masson, Paris.
- ¹⁶ Wood, C., and Pinkerton, J. H. M., *J. Obstet. Gynaec. Brit. Cwlth*, 1961, 68, 427.

Sexual Activity after Prostatectomy

The patient inquiring about the possible effects of prostatectomy generally assumes that it will put an end to his sexual life. The assumption is often shared by his medical advisers, for most doctors seem to think that men in their 60's ought to have put such things decently behind them. In fact nothing is further from the truth.

Studies in North America report that more than 90% of married men maintain an active sexual life at the age of 60, and more than 70% are still active from 65 to 70.¹⁻⁵ These findings receive independent corroboration in interviews with elderly women,⁶ and they are virtually identical with results reported in London by M. Caine⁷ in men undergoing prostatectomy. Slight differences due to different definitions only emphasize the basic finding of all these studies that a normal healthy elderly man, if still married, may still lead an active sexual life.

Of course, there is some falling-off with the advance of old age, but the decline is nothing like as marked as tradition and the poets have suggested. Nor is impotence in old age, when it does arrive, easy to explain. It is correlated neither with cardiovascular nor urological disease.¹ Neither previous venereal disease¹ nor excessive sexual activity in early manhood is followed by premature impotence.^{1 4}

The only constant factor which can be found to be related to the decline in the sexual life of the elderly male is the availability of a partner: married men can easily maintain sexual activity; widowers and bachelors cannot,^{1 4 8} and for many elderly couples it is the declining health of the wife which is the limiting factor.^{1 4} It is certainly not possible to single out any one factor responsible for impotence in the elderly.

Set against this background, what effect does prostatectomy have? Perhaps four out of every five married men who need prostatectomy will still be leading an active sexual life and

were it not for the operation might reasonably expect to continue for several years to come. Must prostatectomy end it?

In Caine's retrospective series⁷ of those who claimed that they had been sexually active before operation half thought they had not been affected by prostatectomy—a proportion which was bigger in those who were under 60 at the time of prostatectomy. Postoperative deterioration in sexual performance was unrelated to the technique of prostatectomy, though this series included too few cases for a separate assessment of Millin's retropubic procedure, and there were no perineal prostatectomies. Very similar findings were reported after perineal prostatectomy by A. L. Finkle and T. G. Moyers⁹ who tentatively suggested that there was least impotence after transurethral resection. These preliminary conclusions have now been supported by a more complete prospective study.⁸ Finkle and D. V. Prian found that 88% of the married men who were potent before operation retained potency afterwards; and that 71% retained potency after perineal prostatectomy, 87% after an open suprapubic operation, and 95% after transurethral resection. Unfortunately their series is small, and it is difficult to assess the different methods of prostatectomy used in the study without data for the average weight of tissue removed by each approach. Nevertheless, the results should dispel some of the folk-lore in this field.

Patients with cancer of the prostate who have been treated by orchidectomy and stilboestrol therapy may retain the

- ¹ Bowers, L. M., Cross, R. R., and Lloyd, F. A., *J. Amer. Geriat. Soc.*, 1963, 11, 647.
- ² Finkle, A. L., Moyers, T. G., Tobenkin, M. I., and Karg, S. J., *J. Amer. med. Ass.*, 1959, 170, 1391.
- ³ Freeman, J. T., *Geriatrics*, 1961, 16, 37.
- ⁴ Kinsey, A. C., Pomeroy, W. B., and Martin, C. E., *Sexual Behaviour in the Human Male*, 1948. Philadelphia and London.
- ⁵ Newman, G., and Nichols, C. R., *J. Amer. med. Ass.*, 1960, 173, 33.
- ⁶ Christenson, C. V., and Gagnon, J. H., *J. Geront.*, 1965, 20, 351.
- ⁷ Caine, M., *Brit. J. Urol.*, 1954, 26, 205.
- ⁸ Finkle, A. L., and Prian, D. V., *J. Amer. med. Ass.*, 1966, 196, 139.
- ⁹ ———, and Moyers, T. G., *J. Urol. (Baltimore)*, 1960, 84, 152.
- ¹⁰ Jewett, H. J., *J. Amer. med. Ass.*, 1963, 183, 373.

ability to maintain an erection and achieve intercourse.⁴ Even total radical perineal prostatectomy, an operation seldom done outside a few centres in North America, does not inevitably entail impotence.¹⁰

What is it about prostatectomy which gives rise to impotence in some patients but not in others? No simple answer can be given. The ability to maintain erection and achieve orgasm is independent of ejaculation: but even ejaculation may persist after prostatectomy in spite of destruction of the bladder neck.⁷ Sexual ability is unrelated to infertility, though most surgeons routinely divide the vas on each side to prevent epididymitis, believing that patients in this age group are infertile in any case.

The problem is common, and the numbers are increasing. A large, careful prospective series, taking into account some of the social and psychological factors in these cases, would be valuable. These elderly patients deserve to know the answer to this question.

N.H.S. Statistics

The National Health Service costs more than £1,000m. a year, and no industry of comparative size could function efficiently or develop healthily without a statistical service. Large numbers of facts must be collected and analysed to monitor performance and to guide future action. In its early years the Ministry of Health improvised, as it had done before 1948, and did not bring its statistical services under unified and professionally qualified direction until the mid-1950s. In the latter part of the decade, however, more use is being made of these tools of good management.

The Imperial Calendar for 1966 shows the Statistical Division to be devoted to "the collection, analysis and interpretation of statistics of all branches of the N.H.S. as an aid to administrative decisions; provision of advice to aid the recognition and solution of new management problems of a statistical character; statistical forecasting for planning purposes; statistical checks on the efficiency of the N.H.S. and the application of statistical techniques to problems of improving efficiency." All this is under a director supported by a chief statistician, six professional statisticians, and two assistant statisticians. More recently, it is known that the Statistics Division was being strengthened to enable the director to give more attention to the analysis of health authority statistics, to provide a statistical foundation for hospital planning, and to develop operational research. There have been other developments outside the Division which are nevertheless of a statistical character. A central unit is concerned, for instance, with the application of computers to hospitals. A section within the Hospitals Division tries to identify and gain acceptance for new ideas of good practice; it also administers the sanctioning of grants for research and maintains a follow-up of results. Finally there is a central research section to enable the Ministry to conduct its own programme of research.

Dr. Bernard Benjamin was until recently the director of the Statistical Division. He has now moved to the Greater London Council and is succeeded this month by Mr. W.

¹ *Report on Hospital In-patient Inquiry for the Year 1961*, Pt. 2, 1964. H.M.S.O.

² *Health and Welfare. The Development of Community Care*, Cmnd. 3022, 1966. H.M.S.O.

³ *Brit. med. J.*, 1966, 1, 1557.

Rudoe. At the same time the logical step has been taken of bringing these allied functions together. The new form of organization should increase the Division's effectiveness for the development of health services must be predicted on a proper assessment of needs and of the likely imbalance between the demand for and supply of manpower and physical resources.

On the planning of medical manpower a useful contribution is already being made by the Ministry's statisticians. Through their registers and the central medical recruitment committee index, which they collaborate with the B.M.A. in maintaining, they are now in a better position to follow trends in recruitment, emigration, and changes in the career pattern. Forecasts in this field are expected to become more firmly based, and statistics on nurses are likely to improve. But more attention to physical resources will be needed. For example, in the Hospital Programme, with its heavy dependence on crude bed ratios, there is little evidence that the implications of population changes in the regions have been sufficiently taken into account, or that information available on the changing use of hospitals—for example, from the Hospital In-patient Inquiry¹—has been adequately exploited.

Examination of the recently published revision of the plan for development of community care^{2,3} shows considerable variation among local authorities in their approach, and this may be because better indices of the level of provision of health and welfare services are needed. Objective examination of the actual needs of the welfare services would be helpful, as some of these seem now redundant. Money has always been short: it is specially so at present. All the more need, therefore, to gather accurate information on which to assess priorities in the health and welfare services.

Jumping for Joy

Although Leonardo da Vinci designed a parachute in the fifteenth century, the first actual descent was made by Sebastian Lenormand from the tower of Montpellier Observatory on 26 December 1783, using a canvas device 14 ft (4 m.) in diameter. The first collapsible parachute was used by an American balloonist, Captain Baldwin, in 1885, and by 1908 the familiar packed parachute opened by a ripcord was already in use. Thereafter, research was undertaken in many countries to perfect the technique of jumping and improve the design of the canopy to minimize landing injuries. The public imagination was caught, and parachute jumping became an entertainment with the aerial circuses of the 1920s. The demands of military parachuting in the 1939–45 war resulted in the organization of parachute training schools in many countries, and serious study was made of factors such as wind speed, type of landing zone, rate of descent, body build of the parachutist, and hazards in the air and on the ground that may affect a successful landing.

The desire to fly unrestricted through the air touches a deep cord in many people, and the inherent danger makes its appeal as a sport understandable. Moreover, there is a great sense of exhilaration and release after a successful jump that can prompt a man to continue the sport for years. The first few jumps in sport parachuting are normally made with a static line fixed in the aircraft so that the parachute automatically opens at a predetermined time after the man has jumped. Later he learns to "free-fall," when he opens the parachute

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