Ergometrine and the Undiagnosed Twin

SIR,—I wonder if I might comment on that part of Mr. P. G. Seed's letter (1 October, p. 828) which reads: " . . . the comparatively innocuous and unprecipitate effect on the uterus of an intravenous injection of 0.5 mg. ergometrine administered carelessly before the birth of an unrecognized second twin."

In my experience this obstetric mishap is by no means rare in hospitals where intravenous ergometrine is administered at, or immediately prior to, delivery as a routine. This is hardly surprising when it is recollected that above 10% of multiple pregnancies[1] (more than 35% in some series) remain undiagnosed until after the birth of the first twin. Unfortunately, accidents such as this tend to receive little publicity even within the hospital in which they occur and, in addition, are often poorly documented. For this reason it is difficult to obtain good statistics on this subject. However, the following information may be of interest.

Since 1960 approximately 500 sets of twins have been delivered in one or another of the five English obstetric units at which I have worked. During that time the iatrogenic error described above was held to be primarily responsible for the death of a second twin on no less than three occasions. In each case the infant was immature, was born precipitously, and weighed significantly more than its co-twin. The three firstborn infants survived. Post-mortem examination demonstrated the presence of a ruptured liver in one case and of an intracranial haemorrhage in another; the third death was attributed to " asphyxia."

This unhappy experience emphasizes the importance of palpating the uterus before injecting oxytocic drugs at delivery. It also adds weight to the arguments advanced by Mr. J. H. Patterson (15 October, p. 952) in favour of greater discrimination in the use of " Active Management of the Third Stage of Labour."—I am, etc.,

San Francisco, California. PETER M. DUNN.

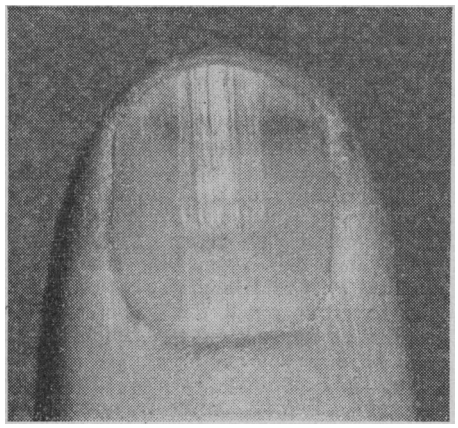
REFERENCE

1 Spurway, J. H., *Amer. J. Obstet. Gynec.*, 1962, 83, 1377.

Disorders of the Nails

SIR,—I read Dr. W. I. Carter's letter (12 November, p. 1198) with interest. Reports of photosensitivity due to demethylchlortetracycline have been appearing since 1960. Orentreich *et al.*[1] observed onycholysis in seven patients in their series of 108 patients who received demethylchlortetracycline. In all of these seven an abnormal erythematous skin response to sunlight had been noted previously. The nail changes appeared as a loosening of the nail plate from the nail bed. The distal third of the nail was involved, sparing the lateral margins. One of the patients complained of onychodynia one week before noticing visible nail changes. The time between the onset of photo-onycholysis and previously exaggerated sunburn reaction varied from three to six weeks. In all seven patients improvement of the photo-onycholysis was noted in two to three months.

I should like to report a case of nail discoloration occurring in a patient who has received demethylchlortetracycline therapy. Mrs. A., aged 40 years, was started on a seven-day course of demethylchlortetracycline (300 mg. twice daily) on 14 July for vasomotor rhinitis. Two days later she went away on her summer holiday and on the same day developed an erythematous eruption over her hands and legs with some associated swelling. The eruption improved soon after she discontinued the drug. About five weeks after commencing demethylchlortetracycline her left thumb nail became painful and showed yellow discoloration. Other finger nails then became tender and discoloured. She said that the discoloration started on the proximal third of the nails distal to the lunula. When first seen on 22 October in the Skin De-



partment (that is, about nine weeks after her nail symptoms started) the distal third of her finger nails, with the exception of the left ring and little finger, showing a blackish discoloration not involving the lateral portions of the nail and unassociated with any nail thickening or evidence of inflammation. On 19 November there was improvement but still discoloration of the distal portion of the nails, which were growing normally (see Figure).

Although the sunburn reaction and onycholysis are well known with demethylchlortetracycline actual nail discoloration appears to be uncommon.—I am, etc.,

Guy's Hospital, London S.E.1. JULIAN L. VERBOV.

REFERENCE

1 Orentreich, N., Harber, L. C., and Tromovitch, T. A., *Arch. Derm.*, 1961, 83, 730.

Haemolytic Disease of the Newborn

SIR,—The outstanding paper on the " Prevention of Rh-Haemolytic Disease " (15 October, p. 907) obviously marks a major step in the prevention of this type of haemolytic disease of the newborn. There is, however, a risk that the opinion may become widely held that once the technique described in the paper is generally available haemolytic disease in newborn infants will cease to be a major problem. This view has indeed been expressed to us recently by a group of final-year medical students, who claimed to have had it from one of their teachers. The implication was that exchange transfusion would soon be a thing of the past. We have checked on the reasons for the last 32 exchange transfusions in this hospital, and the results are:

Anti-D antibodies in maternal blood	...	19
Anti-D plus Anti-C	,, ...	4
Anti-c	,, ...	1
Anti-A (Immune)	,, ...	5
Anti-A plus Anti-B (Immune)	,, ...	1
Antibodies not identified but ABO incompatibility present	... ...	2

In the case of the " c " group incompatibility an intrauterine transfusion was carried out because the previous pregnancy had resulted in the birth of a severely affected infant who had died in spite of repeated exchange transfusions.

In view of these figures it seems to us that paediatricians would be well advised to maintain their expertise in the technique of exchange transfusion. In our experience ABO incompatibility was the cause of one-quarter of the cases of haemolytic disease severe enough to require exchange transfusion. Antigens of the Rh group other than D cannot be ignored, and are unlikely to be detected until after the birth of an affected child.—We are, etc.,

DUNCAN MACAULAY.
Z. A. QURESHI.

Withington Hospital, Manchester.

" Family Doctor "

SIR,—I can assure your correspondent Dr. G. W. Roberts (26 November, p. 1329) that the B.M.A. is not indifferent to health education, and I would join with him in emphasizing that the need for significant activity in this field is now very great.

Through the generosity of the British Life Offices the B.M.A. has been enabled to set up the British Life Assurance Trust for Health Education, whose objects are, briefly, to facilitate the continuing education of doctors in both the preventive and curative aspects of medicine, and to educate the public in health matters generally. The leading article " Audio-visual Aids to Learning " (29 October, p. 1023) provides details of the Trust's proposed activities in the future.—I am, etc.,

T. A. QUILLIAM,
Chairman, B.M.A. Film Committee, Trustee, British Life Assurance Trust for Health Education.

University College, London W.C.1.

Jenner Trust

SIR,—Further to Dr. A. G. Marshall's kind letter (19 November, p. 1266), as you know the above trust has been set up under the chairmanship of Professor Bruce Perry, of Bristol.

I have been asked to be chairman of a small Berkeley subcommittee, whose duty it will be to see to the condition of the Jenner Hut at Berkeley, and also to establish a museum in a cottage near-by, where lived a man named Phipps, whom Jenner first vaccinated.

All the moneys we collected in 1959 and a little more were used to replace the thatch of the hut. The remaining fabric is in dire need of repair if it is to be saved. For this we appeal for funds. Furthermore, we wish to collect any Jenner relics we can hear about. If any of your readers possess any we should be glad to have them on loan or as a gift to the museum. If funds permit, we should be glad to purchase such relics. Either Dr. A. M. G. Campbell, of Bristol, or I would be pleased to hear from any such reader interested.—I am, etc.,

Painswick, Glos. E. N. DAVEY.