

### Intact Membranes at Full Dilatation

SIR,—I suggested that allowing a patient to linger or push with unruptured membranes at full dilatation of the cervix is a cause of amniotic fluid embolism (28 February 1970, p. 545). I should like to put on record that this is also a cause of accidental haemorrhage, fetal distress, and stillbirth.

Last year I saw a patient who had been transferred from a district hospital to Benin General Hospital, Nigeria, because of antepartum haemorrhage and suspected placenta praevia. On examination there were no fetal heart sounds, the cervix was fully dilated, and the forewaters were intact. When these were ruptured a fresh stillborn infant was immediately delivered. Marginal retroplacental clot was noted. Last week a patient, nearing the end of an uneventful first stage, suddenly began bleeding and fetal distress ensued. The blood loss was about 200 ml and the fetal heart rate was 90. On examination the cervix was fully dilated and the membranes were intact. These were ruptured and a healthy baby was immediately delivered. There was a 4 oz (114 ml) retroplacental clot and the membranes around the placenta were ragged. I have seen two other cases in which small accidental haemorrhages resulted from allowing patients to push at full dilatation of the cervix with intact membranes. In both cases healthy babies were delivered immediately the membranes were ruptured.

When the cervix is fully dilated and the membranes or forewaters are intact, the uterus will try to expel the entire sac with its contents because it cannot expel the baby from the intact sac. The sac is fixed to the uterine wall by the placenta. If the forewaters do not rupture the placenta will peel off the uterine wall resulting in accidental haemorrhage and fetal anoxia, or the membranes will tear at the placental margin exposing the patient to the risk of amniotic fluid embolism.

It is worth drawing attention to this because the situation is so easily avoidable and, to my knowledge, this has not previously been reported.—I am, etc.,

LOUIS D. COURTNEY

Department of Obstetrics and Gynaecology,  
Cavan County Hospital,  
Lisarn, County Cavan

### A Blinding "Trip"

SIR,—In view of the increase in drug-addiction this report of a young addict, both of whose eyes were perforated with a needle, may be of interest.

A woman aged 24 years was admitted to the Westminster Hospital on 23 January 1972 because of a hyphaema in the left eye. She was well known as an addict, having taken methadone for four years and barbiturates for the past two years. She was withdrawn and it was initially impossible to elicit the circumstances of her injury.

The left eye had its vision reduced to hand-movements. There was an extensive hyphaema and three perforating corneal scars; a recent corneal perforation was associated with a tear in the iris. To our surprise, the right eye had two perforating corneal scars and the lens had been absorbed. Happily, with an aphakic correction, the vision was 6/6.

Intensive treatment with local and systemic antibiotics was instituted. The left hyphaema cleared revealing a needle-track passing through the lens and vitreous to a rent in the retina just medial to the optic disc. The surrounding retina was detached and, in spite of two operations, it remained so. The eye is now essentially blind.

Subsequently, the story emerged that she found her vision to be defective on recovering from a "trip" with fellow-addicts. She had a vague recollection of someone pushing a needle into her eye and she thought the same thing had happened to her right eye some time before.

Because there were no other signs of an assault and, bearing in mind how difficult it is to see the eye of a resisting subject, let alone impale it with a needle, and since there were in all six perforations, it is likely that these wounds could have been caused only with the patient's active connivance. There are many reports of malingerers causing trivial, if dramatic, ocular injuries to further their aims, but serious damage to the eye is characteristically avoided. Trauma to the eyes, sufficient to cause blindness, often by auto-enucleation (Oedepism), is confined to either the psychopath or to those harbouring extreme feelings of guilt. Cocaine addicts have assaulted their eyes to rid themselves of terrifying visual hallucinations and perhaps this patient was attempting a similar solution.

Incidentally, the results of the "needling" on the right are a salutary reminder that the need for absolute sterility may be over-emphasized, for doubtless the needle was filthy and the circumstances squalid yet an admirable aphakic eye has resulted.—We are, etc.,

ANDREW ELKINGTON  
M. G. GLASSPOOL  
J. R. O. COLLIN

Ophthalmic Department,  
Westminster Hospital,  
London S W 1

### Sleep and a Bedtime Beverage

SIR,—The validity of the conclusions which one may draw from any clinical drug trial is directly related to the amount of care taken to exclude the influence of placebo reactions and preconception of response on the part of either patient or physician.

The studies reported by Mr. P. R. Southwell and others and by Drs. Vlasta Brezinová and Ian Oswald (20 May, pp. 429 and 431) unfortunately do not succeed in avoiding these pitfalls. In the case of the former study four subjects were observed during sleep after having received either no drink, 350 ml of water, or 350 ml of Horlicks in milk. In the second study electroencephalographic records were made during sleep after the administration of either a yellow capsule or 250 ml of Horlicks in milk.

It is unlikely that any of the subjects in either study were unaware of the alleged hypnotic powers of this commercial concoction, and thus the studies have an in-built preconception of the probable outcome on the part of the patients. This difficulty could only be avoided by the use of an adequate placebo and the administration of test compound and placebo in a double blind design. It is obviously difficult in this case to design an adequate placebo but some attempt might have been made. The comparison of water with Horlicks in milk by

Mr. Southwell and others seemed particularly inappropriate, as pointed out by Drs. Brezinová and Oswald, in view of the obvious diuretic effects of water. One possible procedure might have been to administer an equivalent dose of Horlicks disguised in tablet form and to compare this with an inert placebo tablet.

Subjective bias makes all clinical research difficult but this is especially true of neuropharmacological and psychopharmacological studies. We are forced to conclude that these studies fail to establish any psychopharmacological properties of the preparation in question.—We are, etc.,

L. L. IVERSEN  
A. V. P. MACKAY

M.R.C. Neurochemical Pharmacology Unit,  
Department of Pharmacology, Cambridge

### Febrile Convulsions in Early Childhood

SIR,—May I comment on your leading article "Febrile Convulsions in Early Childhood" (10 June, p. 608)? It was stated that every child with a febrile convulsion should be admitted to hospital immediately. If this advice were to be followed by family doctors the paediatric departments of our hospitals could not possibly cope with the vast number of febrile children that would be referred to their care.

As a country general practitioner situated 30 miles (48 km) from the nearest paediatric hospital, may I suggest the following guide lines for admission to hospital when confronted by a child with a febrile convulsion, diagnosed on the criteria in your leading article. I would admit to hospital:

The very young child, because the classical signs of meningitis are often absent or difficult to detect in a child under 2 years old;

Those children who have had a severe convulsion or series of convulsions;

Those in whom no definite cause for their pyrexia can be detected clinically;

Those who have signs of meningeal irritation;

Those whose mothers are unable to manage emotionally or intellectually with a child who had a convulsion.

And, lastly, of significance in a country practice, those children living in inaccessible places.

The children that are treated at home should then be reviewed within two to three hours, and again over the next day. If the child's clinical state were to deteriorate then admission to hospital would be indicated. The child having his first convulsion would be referred for electroencephalography after a few weeks to exclude an epileptic focus.

In my view each case must be judged according to its clinical and social merits, remembering that a small percentage of these children will have a virus encephalitis, and that an even smaller number will have meningitis. Such a sweeping statement that all children should be admitted if they have a febrile convulsion may be theoretically correct and justifiable in a health service with unlimited paediatric beds, but in the present state of the Health Service such a statement can only add to the chronic shortage of hospital beds and qualified staff.—I am, etc.,

K. C. HARVEY

Talgarth, Brecon