Fetal Damage from Breech Birth

SIR,—Your leading article "Fetal Damage from Breech Birth" (26 April, p. 158) is a timely reminder of the hazards of this type of delivery. As you point out, more frequent recourse to caesarean section in recent years has improved results, and most obstetricians will subscribe to the formula "breech + anything else = caesarean section." However, I feel that your article was incomplete in its failure to point out that caesarean section carries a 10-fold increase in maternal mortality over vaginal delivery. If this fact is not borne in mind, then too frequent use of caesarean section in breech presentation may result in an unwelcome rise in maternal mortality figures.

I had not previously associated breech presentation of a normal fetus with premature labour, except in so far as the frequency of breech presentation decreases towards term as a result of spontaneous version. No doubt admission to hospital, as you suggest, would reduce the incidence of premature labour in breech presentation, but so would it in cephalic presentation. You advise admission "(as in cases of twin pregnancy)... some six weeks before term." In a recent study of 200 consecutive twin pregnancies from this unit premature delivery was defined as delivery before 36 weeks gestation. However, on reviewing the figures it was found that only one normal infant died as a result of premature delivery after 34 weeks, and in this case labour was induced at 36 weeks because of severe pre-eclampsia. May I, therefore, point out that any measure taken to prevent premature labour in multiple pregnancy must be instituted much earlier than you suggest, the most dangerous time being between 28 and 34 weeks? This presupposes an early diagnosis, and any suspicion of multiple pregnancy should be investigated at the earliest opportunity. The availability of ultrasonic diagnostic facilities in most centres means that most such pregnancies should be detected at an early stage and not, as so often happens, when the patient is admitted already in premature labour.—I am, etc.,

W. D. GRIFFITHS

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SIR,—I must take issue with the ridiculous suggestion made in your leading article (26 April, p. 158) that "in an attempt to lower the incidence of premature labour it would be reasonable (as in cases of twin pregnancy) to admit the mother to the antenatal ward for complete rest some six weeks before term."

Unfortunately you have confused cause with effect. The association of breech delivery with prematurity is due to the fact that the incidence of breech presentation decreases naturally as term approaches unless there are other complicating factors. Hence a premature labour is more likely to produce a breech birth than is a labour at or near term. Breech presentation (unlike twins) is not in itself a factor in the initiation of premature labour.

I do hope that your suggestion is seen to be illogical by all who give antenatal care. Otherwise many mothers-to-be may be cruelly and needlessly incarcerated in our

antenatal wards for several weeks before the penny drops (tails or heads!).—I am, etc.,

PETER PEDLOW

Queen Elizabeth II Hospital,
Welwyn Garden City.
Herts

** Our suggestion that the risk of premature labour in breech presentation might be reduced by admitting those cases which continue beyond the 34th week was a compromise. Earlier admission would indeed lead to large numbers of patients being admitted, but by 34 weeks the numbers should be much smaller and it would be interesting to establish whether, in these high-risk cases, rest and closer observation in an antenatal ward led to a more favourable outcome. Apart from the possibility that this might reduce the risk of premature onset of labour (which is not known at the moment) there could be other bonuses. It is likely that cord presentation or prolapse would be diagnosed earlier and there is the advantage that the obstetrician, away from the pressures of the antenatal clinic, would be better placed to make a more balanced judgement on the management of the case. We had in mind that these mothers might spend one or two weeks in the antenatal ward, but where the presentation converted to a vertex the patient would go home at once.—ED., *B.M.J.*

Warfarin Poisoning in Domestic Animals

SIR,—May we comment on your leading article "Rats Today" (19 April, p. 105) on the basis of our clinical experience of warfarin poisoning in domestic animals?

An animal may be poisoned by warfarin as a result of eating affected rodents or warfarin bait. The warfarin bait is usually prepared by making a 1:20 mixture of a 0.5% or 0.1% commercial warfarin preparation with oatmeal or other suitable food to give a 0.025% or 0.005% warfarin bait. Papworth¹ quotes the weights of 0.005% bait to give different animals the estimated LD₅₀ dose if consumed daily for five days as follows:

Animal	Weight of Bait		LD ₅₀ (mg/kg)
	oz	g	
Rat ..	0.8	22.7	1
Dog ..	2.4	68	3
Dog ..	2.4	68	3
Pig ..	0.1	2.8	0.4
Poultry ..	8.0	227	10
Cattle ..	40.0	1134	200

The inherent danger of warfarin compounds rests with their cumulative effect, whereby a large single ingestion of warfarin is less likely to be harmful than small quantities consumed over a period.

Pigs may be poisoned by eating warfarin bait or affected rodents, whereas dogs are usually poisoned by eating warfarin bait and cats by eating affected rodents. Clinical cases of warfarin poisoning are most commonly seen in dogs, cats, and pigs in that order of frequency, and this is to be expected when both the susceptibility of the animal and the availability of the poison are taken into account.

At the Cambridge Veterinary School we deal only with the more complicated cases

of warfarin poisoning which are referred to us by veterinary surgeons in practice. Our cases are thus but a small proportion of the number actually occurring, but even so we average one or two cases of warfarin poisoning in dogs each week during the time of year that warfarin bait is laid. Not only the amount of blood lost but the site of haemorrhage (intrapleural, intrapericardial, or intrapulmonary) demands that immediate and vigorous steps be taken if the animal's life is to be saved.

To say with regard to warfarin that "ordinary domestic animals... are not particularly sensitive to it" is to perpetuate the myth that warfarin is a safe poison to all but the rat.—We are, etc.,

S. M. CRISPIN
S. W. DOUGLAS
L. W. HALL
J. F. R. HIRD

R. B. LAVELLE
M. C. G. LITTLEWORTH
E. T. REES EVANS
R. G. WALKER

University Department of Veterinary Clinical Studies,
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¹ Papworth, D. S., *Journal of the Royal Society of Health*, 1958, 78, 52.

Diffuse Pulmonary Disorder Caused by Oxyphenbutazone

SIR,—Lung disorders caused by pyrazolones, of which phenylbutazone is one, are uncommon. Pulmonary oedema has been reported¹ and also two cases in which a syndrome resembling systemic lupus erythematosus developed.² I wish to report a case of reversible diffuse pulmonary disorder which I saw five years ago in a patient who had been taking oxyphenbutazone over a long period.

The patient, a 66-year-old woman, suffered from stiffness of the hands and painful ankles and had radiographic evidence of osteoarthritis. She had been taking oxyphenbutazone for nearly three years when she suddenly developed breathlessness. On examination fine crepitations were heard at the base of both lungs. The erythrocyte sedimentation rate was raised and antinuclear factor was present transiently in the serum. Neither rheumatoid factor nor L.E. cells were found. Oxyphenbutazone therapy was stopped. Diuretics were given initially but no diuresis or loss of weight resulted. During the eight weeks after stopping the oxyphenbutazone the patient's breathing returned to normal. When given a further challenging course of oxyphenbutazone breathlessness and crepitations rapidly returned, despite concomitant diuretic therapy.

A drug-induced lupus diathesis seemed the most probable diagnosis in this case and was supported by the finding of antinuclear factor.^{3,4} The failure of diuretics to produce a diuresis or loss of weight excluded the complication of excessive tubular sodium reabsorption. Fibrosing alveolitis, though associated with rheumatoid arthritis, was unlikely in the absence of rheumatoid factor and also the symptoms were reversible. Systemic lupus erythematosus, unmasked by the drug, was also unlikely since antinuclear factor was present only transiently and no L.E. cells were found. Now, five years later, there is no clinical evidence of the disease.

Drug-induced diatheses are rarely complete or dose-dependent and, apart from those due to hydralazine, they cannot be induced in animals.⁵ They are due either to a delayed immunological response to the drug or a metabolite and possibly a type 3 hypersensitivity reaction or to hyper-

sensitivity invoked by the drug acting as a hapten and becoming conjugated with body proteins.

I thank Dr. N. W. Horne for permission to report this case.

—I am, etc.,

D. C. CAMERON

Royal Infirmary,
Edinburgh

- 1 Nevins, M., *et al.*, *Lancet*, 1969, 2, 1358.
- 2 Ogryzlo, M. A., *Canadian Services Medical Journal*, 1956, 11, 66.
- 3 Alarcón-Segovia, D., *et al.*, *New England Journal of Medicine*, 1965, 272, 462.
- 4 Alarcón-Segovia, D., *et al.*, *Medicine*, 1967, 46, 1.
- 5 Siegel, M., Lee, S. L., and Peress, N. S., *Arthritis and Rheumatism*, 1967, 10, 407.

Complications of Laparoscopy

SIR,—A few years ago, because of reported complications of laparoscopy, I introduced at St. Thomas's Hospital what came to be known as a Cusco laparoscopy. In this a 1-in (2.5 cm) incision is made in the pubic hairline and then a small Pfannenstiel approach to the pelvis is developed. Access is made easy by sliding the skin from side to side. The edges of the out peritoneum are stitched to skin. A large Cusco speculum is passed down into the pouch of Douglas and the blades are opened across the pelvis. One or two fingers passed through the speculum allow the gut to be displaced above the sacral promontory, where it can be held out of the way by a gauze pack.

By moving the speculum to and fro and opening and closing the blades the whole pelvis may be visualized. A long Babcock forceps can pick up the ovary and draw it to the surface, withdrawing the speculum at the same time. So that the ovary may not slip back it may be seized again by a forceps introduced between the blades. If the ovary cannot be seen easily the Babcock forceps grasps the round ligament of the uterus and pulls that to the surface. A finger passed behind it will easily deliver tube and ovary into the incision.

Any variety of sterilization operation can be carried out on the tube. The ovary can be handled, inspected, and a specimen taken for biopsy. Everything is under the same sort of control as at laparotomy. If difficulty is encountered the incision can quickly be enlarged. Closure is routine. The peritoneum can be bunched up into a very small hole. The skin requires one or two clips or stitches. Stay in hospital need be only overnight, mainly to get over the effects of anaesthesia.

Anyone who can perform a gynaecological laparotomy safely can do this operation too. It does not require the special expertise of laparoscopy. It might be considered a serious rival to the technically more difficult laparoscopy, for it can be used in all situations where laparoscopy is considered and it has wider scope with fewer of the disadvantages.—I am, etc.,

PHILIP RHODES

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Side Effects of Methyl-dopa

SIR,—We were interested in your leading article on the side effects of methyl-dopa (22 March, p. 646). The list is a fairly formidable and not only of academic interest,

since many of the side effects lead to considerable incapacity which in many cases requires alteration of a previously accepted way of life.

We are currently comparing the side effects volunteered by recipients of methyl-dopa with those mentioned by the same patients when given a simple questionnaire with specific questions. We were particularly looking for the incidence of loss of sexual prowess, a symptom seldom volunteered spontaneously through embarrassment and hence probably underestimated. We were also interested in the incidence of postural hypotension. We have currently only 30 patients, all men aged less than 60 years. Methyl-dopa dosage has varied from 1.0 to 2.5 g daily and the duration of therapy from six months to three years. Blood pressure readings were taken with a sphygmomanometer lying, standing, and after running on the spot (30 steps).

Despite the small numbers we felt the preliminary results (see table) were of interest. The table compares the incidence of volunteered symptoms with those that subsequently came to light when patients filled in the questionnaire. The differences are obvious and we think that all patients should be asked directly about sexual function and the significance to them of any change, as much domestic and psychological trauma can ensue from loss of sexual function. Five of the patients admitted to feeling much better generally since starting the drug, and this was usually manifest as a lessening of tension. Postural hypotension, though rarely symptomatic, was detected after exercise in 26 patients: 14 had a drop of systolic blood pressure greater than 20 mm Hg (range 20 to 70 mm) and 12 a drop between 10 and 15 mm. Post-exercise blood pressure readings should be made routinely in all hypertensives taking methyl-dopa, as clearly there may be a significant

Incidence of Side Effects in 30 Patients Taking Methyl-dopa

Symptom	Questionnaire		Volunteered	
	No.	(%)	No.	(%)
Erection failure	16	(53)	2	(7)
Impotence	0	(0)	0	(0)
Drowsiness	18	(60)	14	(47)
Postural hypotension	2	(7)	2	(7)
Asymptomatic	3	(10)	10	(33)
Improvement	5	(17)	5	(17)

postural drop in many patients which is detectable only after exercise.

Patient compliance is a big problem with long-term therapy and intolerable side effects can only aggravate it, particularly since hypertension is essentially an asymptomatic disease. We think that with the introduction of beta-blocking agents with, as yet, relatively few troublesome side effects methyl-dopa should no longer be a first-line choice in the treatment of hypertension.—We are, etc.,

WILLIAM D. ALEXANDER
JOHN I. EVANS

University Hospital of Wales,
Cardiff

Hospital Pharmacy Committees

SIR,—I would like to comment on the membership of hospital pharmacy committees (8 February, p. 323), and on the importance

of including in the membership a number of staff involved directly in patient care. These comments are based on the activity of our own very active district therapeutics committee. When suitably constituted, such groups have an important role in making certain that recommended changes in policy are realistic. Policies decided centrally do not always appear to be influenced by such considerations, nor do those who make these policies appear to be interested in utilizing information on the impact of their policies on patient care.

The membership of our committee has always included a member of the ward nursing staff (as well as of the nursing administration) and members of the non-consultant medical staff (as well as of the consultant medical staff). I consider that the contribution from these representatives has been quite outstanding, and their absence from many similar committees may well have made them less effective. Another addition to our committee, an indirect result of N.H.S. reorganization, is our general practitioner member. There is no reference to the possible contribution of a general practitioner in the recent article, but the interface between hospital and general practice should not be ignored. We have already discussed several important problems on this interface, and have taken active steps to create general interest in one of these (5 October 1974, p. 41).

The membership of our committee has made it an appropriate forum for discussion of a variety of directives issued by the Department of Health and Social Security, who have often been advised by committees whose members may not always be able to claim such a close daily involvement in clinical work. Our views have at times been at variance with the recommendations of the D.H.S.S. On three occasions the committee, supported by the district hospitals medical committee, have reported their views to the appropriate department at the D.H.S.S. It has concerned me that these carefully considered comments have on only one occasion produced a reply from the Department.

The contributions of pharmacy and therapeutics committees should, perhaps, include a role in providing "feed-back" to the D.H.S.S., to region, and to area. These administrative bodies might then be more aware of the views of those responsible for patient care. There are other important contributions that these committees can make in encouraging the efficient use of scarce financial and manpower resources. It is an appropriate time for the B.M.J. to encourage increased interest in their activities.—I am, etc.,

MARTIN S. KNAPP

Chairman,
Therapeutics Committee, North Nottingham District

City Hospital,
Nottingham

Social Work in General Practice

SIR,—At a recent meeting of social workers and general practitioners in Manchester it was decided that there is a need for a group whose special function is to foster co-operation between social work and general practice. It was thought that professional organizations involved in promoting co-operation were too remote to be able to