Contemporary Themes

A programme for shared maternity and child care

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One of the problems in running a practice is that of communication between the various participants—the patients, the doctor, and the ancillary staff. With shared obstetric care the problem becomes more complicated as the patient sees at least two doctors, two sets of nurses, and two secretarial departments. The use of the obstetric co-operation card has been a real breakthrough, as information is recorded and kept by the patient to be shown at her next attendance.

There still, however, remains the problem about how adequate information is to be given to the patients. Many women do not seem to know when they are due to attend relaxation classes or receive maternity benefits. This may increase their anxiety, particularly during a first pregnancy. The co-operation card records what has already occurred but does not tell the patient what to expect during her pregnancy.

We decided to draw up a timetable of expected events, which could be duplicated and given to each expectant mother at her first visit confirming the pregnancy.

It was devised by the general practitioner in charge of antenatal care in the practice, the obstetrician at the local district general hospital, and the health visitors and midwives. Copies were circulated for inspection and criticism to the local community physician and the other midwives and gynaecologist. Finally, copies were distributed to each mother at her first attendance.

They have proved popular with the patients and very useful to the practice staff and as a teaching aid to trainees. A copy of the timetable is shown below. Individual details differ in various areas and practices, but the general lay-out remains similar.

We would welcome comments and suggestions, particularly as to whether the programme should be written in a more popular style.

MATERNITY SERVICES AND CHILD WELFARE

Telephone numbers: Hospital
Surgery
Health visitor
Midwife (1)
(2)

2 months First booking visit (general practitioner).
Confirmation of pregnancy and maturity.
Patient signs maternity book.
Doctor arranges hospital referral and hospital appointment will be received by post.
Brown form for free prescriptions for vitamins and free dental treatment.

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10-12 weeks	Hospital checks blood pressure, weight, maturity and arranges for blood tests—that is, blood count, rubella antibodies, rhesus grouping, ? antibodies, WR: scan routine, 13 to 15 weeks.
16 weeks	Alpha-fetoprotein blood test at hospital (for all patients who wish spina bifida to be excluded). If positive, scan and test is repeated. If repeat positive, amniocentesis carried out. If any doubt about dates, a scan is performed as test must be done at 16 weeks.
16-17 weeks	Visit to general practitioner and midwife at surgery. Telephone surgery to make an appointment. Weight, blood pressure, urine examination. Prescription for iron tablets. (Wednesday afternoons 2 pm.)
20 weeks	Visit to general practitioner and midwife at surgery (as above).
24 weeks	Visit to general practitioner and midwife at surgery (as above).
26 weeks	Maternity benefit payable from now to 3/12 postnatal. BM4 form signed by midwife or doctor. Must have sufficient stamps on own or husband's card. Maternity allowance is claimed at 26 weeks, but is only paid from 29 weeks to seven weeks postnatal, on mother's contributions.
28-30 weeks	Hospital visit. Blood test—rhesus, antibodies, blood count. Scan is performed to check placental site, 30 to 32 weeks.
28 weeks	Relaxation and mothercraft classes at Bollington Clinic (health visitor). Eight talks include film, visit to West Park Labour Unit, and talk on breast and bottle feeding. Also classes at West Park. Antenatal classes: Monday 10 am to 12 noon. Notified by letter.
28-36 weeks	Fortnightly visits to general practitioner and midwife.
36 weeks	Hospital check and pelvic assessment. Weekly checks up to term. Hospital may do these in primipara or high-risk pregnancies, otherwise general practitioner.
40 weeks	Hospital.
AFTER BIRTH	Anti-D immunisation if rhesus negative and baby is rhesus positive. Rubella vaccine for non-immune women and contraception advice. Baby has check at hospital.
48 hrs-5 days	Return home. Doctor visits that day or next. Discusses contraception briefly. Midwife visits daily up to 10 days and does phenylketonuria test. Midwife checks weekly for four weeks.
10 days	Health visitor visits weekly for six weeks.
6 weeks	Postnatal check at general practitioner's surgery. Family planning advice. Cervical smear test. Repeat smear every three years.

6 weeks	Baby's first developmental check at clinic (health visitor).
3 months	Polio and first triple immunisation (diphtheria, tetanus, and whooping cough).
5 months	Polio and second immunisation.
6 months	Baby's developmental screening check at clinic (doctor).
9 months	Baby's developmental screening check at clinic (health visitor).
11 months	Polio and third triple immunisation.
14 months	Measles immunisation.
2 years	Child's developmental screening check at clinic (doctor).

4 years	(Pre-school) diphtheria and tetanus and polio immunisation.
12 years	BCG immunisation against tuberculosis if Mantoux skin test is negative.
11-13 years	Rubella (girls only) even if they have had "German measles."

If you wish to have anything explained please ask the doctors, midwife, or health visitor.

We are grateful for help and advice from the following: W. R. Plews, district community physician, Macclesfield; R. Butler Manuel, consultant obstetrician, Macclesfield West Park Hospital; Helen Weighill, health visitor; and Mary Wolstenholme, district midwife.

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What investigation is advised for a woman in her 60s with idiopathic fluid retention and no indication of kidney disease?

Any patient with oedema must be investigated for a systemic underlying cause such as renal disease, heart failure, liver disease, and myxoedema or for a local cause of oedema such as lymphatic obstruction and, occasionally, severe varicose veins. Most of these causes may be excluded by careful physical examination but it is wise to check renal function and plasma albumin and thyroid hormone concentrations and to test the urine for protein. If these underlying causes have been eliminated such patients are often labelled as suffering from "idiopathic" oedema. It has been shown, however, that the intermittent swelling in many of these patients may be caused by the intermittent use of diuretics compounded by fluctuations in sodium and carbohydrate intake due to dieting.¹ Such patients are often very concerned about their weight and subject themselves to intermittent starvation followed by a binge, which in itself can cause retention of sodium and oedema. Diuretics initially cause loss of sodium and water with temporary improvement, but they then stimulate compensatory mechanisms to retain sodium. When the diuretic is stopped these compensatory mechanisms, which are longer lasting than the effect of the diuretic, cause retention of sodium and oedema. In this type of patient, therefore, it is important to ensure a regular intake of food and at the same time moderately to restrict the intake of sodium. This may be done by instructing the patient not to add salt to the food both at the table and in cooking and to avoid sodium-loaded foods. We have found that many of these patients with so-called "idiopathic" oedema are relieved of their symptoms on this regimen and many, after some months, can go back to a normal intake of sodium.—G. MACGREGOR, honorary consultant physician, London.

¹ MacGregor GA, Markandu ND, Roulston JE, Jones JC, de Wardener HE. Is idiopathic oedema idiopathic? *Lancet* 1979;ii:397-400.

What action should the doctor take if a patient is found to be Australia antigen positive?

If a patient is found to be positive for the "Australia antigen"—that is, the surface antigen, HBsAg—serum should be sent for testing for the "e" antigen, HBeAg, and its antibody, anti-HBe, to assess infectivity. If HBeAg is positive the patient's blood must be regarded as infectious, and the doctor should wear gloves when drawing blood, take special care to avoid contamination of skin or eyes, and, if accidentally inoculated, he should receive 500 mg of hepatitis B specific immune globulin (HBIG) intramuscularly immediately and again after one month. As semen may also be infective the patient with an acute infection should be advised to abstain from sexual intercourse until the HBeAg becomes negative or, in the case of a chronic infection, he should be advised of the risk to his sexual partners (except those with anti-HBs in the serum, who are immune) and that the risk can be reduced by using a contraceptive sheath. Women of any nationality who have HBeAg in the serum are likely to transmit the virus to their children unless the babies are given HBIG at birth and monthly for six months.¹ Since only blood and semen have high infectivity HBeAg-positive patients who are admitted to hospital need not be isolated or barrier nursed.

If an HBsAg-positive patient is negative for HBeAg and has anti-HBe in the serum he may be considered non-infectious for most practical purposes, though transfusion of a unit of his blood could transmit infection. Any patient found to be HBsAg positive, whether HBeAg is positive or not, should be examined clinically for evidence of liver disease and have serum tests of liver function carried out. If any abnormality is found he should be referred for further investigation, which would include liver biopsy to diagnose chronic active hepatitis requiring treatment.—M. E. CALLENDER, senior registrar in medicine, Belfast.

¹ Reesink HW, Reerink-Brongers EE, Lafeber-Schut BJTh, Kalshoven-Benschop J, Brummelhuis HGJ. Prevention of chronic HBsAg carrier state in infants of HBsAg-positive mothers by hepatitis B immunoglobulin. *Lancet* 1979;ii:436-8.

What is the legal position of a child rejected by its parents because of a severe congenital handicap?

The question recalls the Hammersmith case last summer,¹ but as a description of the parents' conduct in that case it is simplistic. It was hardly a matter of rejection: the parents decided that it would be kinder to allow their newborn daughter, who had Down's syndrome, to die rather than to consent to an operation, whereupon the local authority made the child a ward of court and obtained the High Court's authority for surgery. If, as in that case, a child needs an operation it is the parents who must give their consent, and it is open to them to refuse it. The general rule, surgical cases aside, is that any parent—in fact anyone who has custody, charge, or care of a child under 16—commits an offence by neglecting or abandoning it in a manner likely to cause it unnecessary suffering or injury to health.² There are many cases, however, where the parents are incapable, whether physically or emotionally, of looking after a handicapped child themselves. When this happens, and intervention is necessary in the interests of the child's welfare, the local authority is under a duty to take the child into care.³—RICHARD PARKES, barrister.

¹ In re B (A minor) 1981 1 WLR 1421.

² Children and Young Persons Act 1933 s1. London: HMSO, 1973.

³ Children Act 1948 s1. London: HMSO, 1948.

What is textile purpura?

Several types of textile purpura have been described.¹ The simplest to explain is the petechial rash caused by pressure from "string" vests. An unknown toxic chemical impregnating woollen fabric was postulated as the explanation of the purpuric eruption experienced by hundreds of British soldiers from their khaki shirts in the second world war. One summer in London a transient purpura occurred on the legs of female traffic wardens: the pressure of a coarse regulation stocking on mildly oedematous legs may have been the cause. Purpuric eczema has also been reported in Bulgaria as caused by allergic contact sensitivity to the rubber antioxidant isopropylaminodiphenylamine in underclothes elastic and, in Britain, from the same chemical in rubber boots.—R. J. G. RYCROFT, consultant dermatologist, London.

¹ Cronin E. *Contact dermatitis*. Edinburgh, London, and New York: Churchill Livingstone, 1980:87-90.