what can be done before more extensive specialist services can be provided. In this respect the role of general practitioners and private practice doctors has recently been canvassed. There has been much criticism both of the liberality of prescribing by independent doctors on the one hand and of the reluctance to prescribe by special clinics. This debate has been reflected in journals and the media and needs to be examined very carefully. The combined experience of the special drug dependence clinics as put forward here requires serious consideration. Overprescribing is widely accepted as harmful. The singlehanded doctor, whether general practitioner or consultant in the NHS or private practice, who has little or no experience of addicts is a vulnerable target for the drug seeker. So have been consultants and juniors in special treatment clinics where a team approach is not used.

The substance of this communication has been agreed by those working in London drug dependence clinics. They consider that their experience will be helpful to those ad-

ministrators (medical and otherwise) who are faced with responding urgently to the rapid increase in the addict population—and who are required to implement the recommendations of expert bodies such as the Advisory Council on the Misuse of Drugs—and the increasing political and public pressures surrounding this problem.

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Personal Paper

Kiellands forceps delivery

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The recent reviews and correspondence on the use of Kielland's forceps prompt me to write an account of my own experience of the procedure as a patient. I make a token apology for inflicting my views on others, but on the whole I think that there is advantage to obstetricians in feedback from a patient.

In June 1982 I presented to the labour ward of the maternity hospital for the delivery of my fourth child, the first three having been uneventful vaginal deliveries. The membranes had ruptured spontaneously and full dilatation had been achieved. The baby's head was in an occipitoposterior position, and I felt continuous back pain. Because of the severity of this pain I was unaware of any contractions or impulse to bear down but continued for over an hour to push when urged to do so. The head seemed to me too high to push out.

At the end of this time the fetal heart rate was normal, but I was becoming somewhat distressed. The position of the head was between left occipitoposterior and transverse, mid-cavity and poorly flexed. A pudendal block was performed, the Kielland's forceps were applied, and attempts were made to rotate the head. This resulted in very severe pain in the left buttock and down the back of the left thigh. Attempts to rotate the head were then abandoned, an episiotomy was performed, and the baby was delivered face to pubes with Kielland's forceps. This was also extremely painful because of a pelvic tearing sensation.

The baby, a 3700 g boy, had Apgar scores of 8, 9, and 10 at

one, five, and 10 minutes and his development to date (15 months) has been normal.

In the weeks after delivery I developed numerous symptoms including incontinence of faeces, numbness in the left posterior perineum, difficulty in sitting for any length of time because of a tender and painful coccyx, a feeling of heaviness in the perineum especially with any jarring movement, and occasional pain in the left buttock and back of the thigh. The pain in the buttock and thigh became worse when I returned to work 12 weeks after delivery. Examination at 15 weeks after delivery showed an indurated tender area in the left perineum with maximum tenderness in the left ischioanal fossa. The perineal numbness had been replaced by paraesthesiae and a stabbing rectal pain, presumably caused by inferior rectal nerve damage.

Six months after delivery I noticed a positive Trendelenburg sign on the left, indicating some weakness of the left gluteus medius. It also seemed to me that I limped when tired or when carrying a heavy weight. The neurological damage was presumed to be intrapelvic. Adequate pain relief was obtained for the first time in March 1983 when I was fitted with a transcutaneous stimulator. I took up jogging to improve the strength of the left leg, but in July the pain became worse and the limp more pronounced, and the left ankle jerk was absent. A myelogram showed herniation of the disc between L5 and S1, and at operation a complete prolapse of the disc was found. There has been considerable pain relief since laminectomy.

Obstetric textbooks affirm that injury to pelvic nerves in labour is comparatively rare and that nerve injuries may occur after spontaneous delivery but are more often the result of a difficult forceps delivery. The classic obstetric paralysis—that is, painless foot drop—was previously thought to be caused by damage to the lumbosacral cord, but now it has been suggested that the injury is the result of sudden prolapse of an intervertebral disc.

As a result of my experience and a search of the published

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papers I should like to make some points about the management of a persistent occipitoposterior position. Firstly, it is important to provide adequate analgesia. A full epidural service is not available in all consultant obstetric units, and in my case a pudendal block provided totally inadequate analgesia for Kielland's forceps rotation. I am surprised that in view of the evidence of the inadequacy of the pudendal block obstetricians still "make do" with it.¹⁻⁴ There is a tendency for some obstetricians to think that "a really good pudendal block" can anaesthetise areas not served by the pudendal nerve. The psychological effects of enduring such pain both in the short term—possible rejection of the baby and depression—and in the long term—bitterness and souring of family relationships because of the painful and humiliating memory—seem to be very often ignored. Perhaps this is because obstetricians do not normally deal with these sequelae.

Secondly, it has been suggested that a senior obstetrician should examine the patient⁵ and conduct the delivery.⁶ If this is to be the case, the use of the forceps must become even more a declining art.

Thirdly, delivery face to pubes with Kielland's forceps seems to carry a high perinatal mortality—6.3% is the only figure I can find.⁷ It is also traumatic for the mother. I therefore feel, as it must sometimes be difficult to predict in advance whether the head will rotate easily or not, that all attempted rotations should be carried out in an operating theatre with an anaesthetist standing by in case caesarean section is required. This method of management would require an on the spot anaesthetic service that is not universally available.

Fourthly, I cannot find any up to date information about

maternal morbidity after Kielland's forceps delivery. It should be possible to obtain some retrospective information both on immediate damage such as lacerations and haematomas and on the incidence of subsequent stress incontinence and the need for repair of prolapse.

Finally, the need for rotational forceps might be reduced by earlier use of an oxytocin drip.

A multicentre trial in multigravidas of Kielland's forceps versus caesarean section for midcavity arrest should pose little ethical problem. Results of such a study would provide much needed information on perinatal mortality and maternal morbidity on which future trials in primigravidas could be based.

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Lesson of the Week

Leprosy masked by steroids

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Leprosy is often assumed to be rare in the Middle East. In 1975 the prevalence in Saudi Arabia, based on 460 registered cases, was 0.1 per thousand population,¹ a prevalence similar to that in Spain and considerably lower than that in Burma, where it is 8.6 per thousand population. We wish to alert physicians to the hazards when the diagnosis of leprosy is overlooked and steroids are administered indiscriminately. We report on a patient with leprosy receiving oral steroids in whom

Injudicious use of systemic steroids in an undiagnosed illness may obscure the diagnosis of any infectious disease, including leprosy

the disease downgraded to lepromatous leprosy before it was diagnosed. The patient presented with an atypical clinical picture.

Case report

A 24 year old Saudi Arabian man had developed a rash and fever 18 months before admission to Charing Cross Hospital. He had been examined in Jeddah and Cairo, where skin biopsy specimens had been taken but no definite diagnosis made. Shortly after the onset of his illness he had developed generalised mild weakness, and eventually treatment with oral corticosteroids was started, which relieved his symptoms. When he presented in London he had been receiving steroids for eight months and was currently taking fluocortolone

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