

These figures show that regular chemoprophylaxis is not widespread in Gambian women during pregnancy. This view is further supported by the fact that precipitating malaria antibodies were found in maternal sera from 74% of the Bathurst group and from 98% of the group resident elsewhere. Evidence of passive transfer of antibodies from mother to child was also observed. Malaria precipitins were present in 75% of sera from infants born of the Bathurst women and in 97% of sera from infants of the non-Bathurst residents.

Our findings support earlier observations that in areas where malaria is highly endemic and where the inhabitants by adult life have acquired substantial protective immunity congenital malaria is rare.¹⁻³ Congenital infections, however, occur not uncommonly as a sequel to untreated or inadequately treated malaria during pregnancy in poorly immune women.⁴

The factors which lead to congenital infection are not clearly understood. Damage to the placenta which permits access of maternal erythrocytes and parasites to the fetal circulation is probably the mechanism by which parasites enter the fetus. Such damage may originate from many different causes and may be most likely to occur during birth. However, this mechanism alone does not satisfactorily explain the apparent difference in incidence of congenital malaria between infants born of relatively immune mothers and those born of mothers with poor immunity. It therefore seems likely that parasite multiplication within the newborn is affected by the concentration of transplacentally-acquired protective antibodies in the blood of the infant. When these are present in adequate concentration (as may be the case in infants born of relatively immune mothers) parasite multiplication may be prevented. When they are not (as in the case of infants born of poorly immune mothers) parasite multiplication may be uninhibited and clinical malaria supervene.

Dr. Okeke's observations indicate that malarial infection is frequent in pregnant women attending the Enugu Medical Centre. Yet the immune state of these women and of their newborn children seems low. It would be of interest to know whether this situation has emerged through the widespread but inadequate use of antimalarials unassociated with measures intended to reduce the incidence of malaria transmission in the area.—We are, etc.,

DOROTHY E. LOGIE,
IAN A. MCGREGOR.

M.R.C. Laboratories,
The Gambia.

REFERENCES

- Blacklock, B., and Gordon, R. M., *Annals of Tropical Medicine and Parasitology*, 1925, **19**, 37.
Covell, G., *Tropical Diseases Bulletin*, 1950, **47**, 1147.
Bruce-Chwatt, L. J., *Annals of Tropical Medicine and Parasitology*, 1952, **46**, 173.
Bruce-Chwatt, L. J., *British Medical Journal*, 1957, **2**, 764.

Eyes and Cosmic Rays

SIR,—The astronauts of Apollo 13 repeatedly reported seeing flashes of light. These were seen at infrequent intervals but still observed when the astronauts closed

their eyes. It is now known that this effect is due to the impact of cosmic rays (high energy particles) on the retinal cells causing ionization, chemical effects, and finally, neurotransmission in the optic nerve fibre.¹

Cosmic rays may penetrate the atmosphere and cause a "cascade" effect. Many of these high energy particles penetrate the atmosphere and reach ground level without losing their energy, and following sun spots there is an enormous rise in the incidence of cosmic rays at ground level. It therefore follows that any individual at ground level might experience similar flashes of light especially following the appearance of a sun spot.

With this in mind, inquiries were made among healthy patients with normal blood pressures, normal renal function, and normal retinas whether they had experienced "light flashes." It was found that in many cases normal healthy people experience this phenomenon. Another interesting finding was that the people who volunteered the information of positive findings also reported the presence of vitreous floaters. As the vitreous is a colloidal gel it therefore appears that it may be behaving as a bubble-chamber and that the floaters are due to the paths of the high-energy particles through the vitreous causing chemical changes along these paths. With the arrival of sun spot activity the incidence of these light flashes and associated floaters should be increased.—I am, etc.,

B. E. FINCH.

London N.W.11.

REFERENCE

- ¹ *New Scientist*, 4 June, p. 462.

Induction of Labour

SIR,—The obstetric data in our maternity unit are being recorded as part of the pilot study of a data retrieval system devised by the Royal College of Obstetricians and Gynaecologists. Because these data are readily available for analysis by computer I have been able to compare the results for induction of labour in this unit with those reported by Dr. M. E. Pawson and Mr. S. G. Simmons (25 July, p. 191).

During 1969 there were 2,288 deliveries, and of these labour was induced in 472 using simultaneous intravenous Syntocinon and amniotomy. The results are summarized below, showing induction-delivery interval and the cumulative percentage of patients delivered.

Induction-Delivery Interval		
0-6 hrs.	255	(54%)
7-12 hrs.	151	(85%)
13-18 hrs.	44	(95%)
19-24 hrs.	17	(99%)
Over 24 hours	5	(100%)

Twenty-four (5.1%) of these patients required to be delivered by caesarean section, compared with the overall hospital rate of 7.4%. There were four neonatal deaths, but two of these were associated with severe erythroblastosis fetalis, and one infant had multiple congenital malformations. There were no neonatal deaths which were directly attributable to induction of labour. As in other reported series^{1,2} the maternal morbidity was low.

Routine use of amniotomy followed shortly afterwards by an intravenous Syntocinon infusion has been the practice in this unit for at least four years. The safety of the method has led to much more ready use of induction of labour in late pregnancy, rather more than 20% of the total number of patients having had labour induced in 1969. Eighty-five per cent. of the patients had delivered within 12 hours of induction. It could be argued that this high figure could be the result of careful selection, and there was certainly a large proportion of multigravidae; only 180 of the patients were having their first baby. However, no patient was undelivered after 48 hours and the longest induction-delivery interval was 37 hours.

Increasing knowledge of the limitations of the technique and careful assessment of patients prior to induction can produce extremely satisfactory results. Where care is taken over the timing of induction and the selection of patients (and this must be done by experienced obstetricians), then most of them can be given a guarantee of delivery on the same day as induction of labour.—I am, etc.,

EVAN G. ROBERTSON.

Department of Obstetrics
and Gynaecology,
University of Newcastle upon Tyne.

REFERENCES

- ¹ Bradford, W. P., and Gordon, G., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1968, **75**, 698.
² Garud, M. A., May, D. P. L., and Simmons, S. C., *British Medical Journal*, 1969, **1**, 346.

Profession, Press, and Television

SIR,—While it is desirable that there should be more trust between doctors and journalists (18 and 25 July, pp.161 and 226), pleas for better co-operation cannot succeed while so many doctors refuse to recognize some of the main functions of the press.

The Press does not exist primarily to satisfy the public's vicarious pleasure nor, as some doctors appear to think, to be useful in publicizing research fund appeals. The valuable contributions made by the Press in the medical sphere over the past year or so have included the exposure of several black sheep doctors, particularly those concerned with over-prescribing for drug addicts, the stimulation of public discussion on controversial topics like transplants, which will probably lead eventually to a change in the law to make organs more easily available, and the exposure of abortion racketeers, not to mention the backing given by the majority of the Press to doctors in their fight for better pay.

Like it or not, doctors have no special claim to be a privileged minority who should not be exposed to the inquiries of journalists. All a journalist wants when he asks a straightforward question is a truthful and straightforward answer. Many of the articles which have generated concern among the medical profession have been caused because a reporter has had his suspicions raised when his questions have been evaded.

As a case in point I recently received two different answers when I telephoned a hospital and put the same question first to a senior doctor and then to the hospital administrator. The doctor, whom I knew