The reference he gave was to a précis of a lecture to the Association of Clinical Pathologists in the *Journal of Clinical Pathology*,[1] but a very much more detailed report, amply illustrated in both colour and black and white, appeared in the *British Journal of Surgery* in 1962.[2]—I am, etc.,

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REFERENCES

1 Shera, A. G., *J. clin. Path.*, 1953, 6, 327.
2 —— *Brit. J. Surg.*, 1962, 50, 68.

Obstetric Forceps or Vacuum Extractor?

SIR,—No doctor would wish to challenge the second sentence of the leading article on obstetric forceps or vacuum extractor (23 September, p. 753): ". . . the obstetrician must not only exercise his skill to deliver the baby from its obstetric dilemma but he must also protect the baby from any damage or delay caused by the operation itself." It therefore follows that, except in the very experienced hands of either a busy registrar or an active consultant, applying a vacuum extractor, either during the first stage of labour or even in the second stage where the position of the foetal skull is difficult to determine, must be considered as potentially hazardous and decidedly risky to the life or subsequent health of the foetus. Similarly there could be no objection to a widely experienced, active, and well-qualified general-practitioner obstetrician undertaking this procedure, but of course only in a specialist obstetric unit where every facility is available for readily treating any complication.

The set of the controversy "obstetric forceps or vacuum extractor" in your correspondence columns clearly takes place in the second stage of labour. Presumably no doctor disputes the vacuum extractor's place in the management of delay late in the first stage of labour, and forceps should always be banned at this time. In the second stage there are two situations where instrumental assistance is needed.

If delay occurs in the *mid-cavity* of the pelvis it is always likely that the foetal skull is in the occipitoposterior or transverse position, such a malposition as is probably the very cause of the delay. Where assistance is needed, either for delay or foetal distress, and before the instrument of choice is applied, the position of the occiput must be accurately determined—that is, if the skull and brain are to be protected from any damage. The delivery is clearly potentially difficult, so in fairness to the child (and mother) only a very experienced obstetrician should be performing. The final decision as to instrument should depend on the obstetrician's experience, enthusiasm, and considered results with its practical use. I can well understand and admire the excellent results obtained by Mr. J. A. Chalmers and others (4 November, p. 292) with the vacuum extractor, but, on the other hand, I firmly suggest that the majority of specialists, at least in this country, would prefer to use the obstetric forceps in order to achieve *their* best results in these obstetric situations.

A vast proportion of instrumental deliveries take place when the foetal skull has advanced beyond the mid-cavity and has now reached the *pelvic floor*; and again the indications for their use are either foetal distress or delay in progress. It is in this group that bony disproportion is no longer a problem, and so instrumental damage to the skull and brain is unlikely, but only provided the requisite care with the application is undertaken—and this applies whatever instrument is used. It is such a case which a general-practitioner obstetrician might easily be coping with in his general-practitioner unit, and in this situation he would naturally opt for the instrument with which he is most familiar, and, perhaps even more important, the overriding consideration he would take in making his choice would be his wish for a delivery with the least possible delay. Surely, therefore, the majority of doctors would choose the obstetric forceps, because most of us would agree with Mr. W. H. Laird (4 November, p. 292) who says: ". . . most obstetricians would agree that forceps delivery is preferable to vacuum extraction in cases where rapid delivery is required in the second stage of labour when foetal distress occurs with the foetal head fully engaged, because there is no doubt that the application of, and delivery with, the vacuum extractor does take longer than forceps delivery." I suggest he should continue his argument to include the potential as well as the recognized foetal distress, and, in mentioning potential foetal distress, I naturally refer to the longer second stage of labour. It is interesting that the well-known advocate of the vacuum extractor, Mr. Chalmers, also finds that forceps delivery is quicker.

I cannot agree that the vacuum extractor should be used without any anaesthetic at all, but would consider that, as with any obstetric forceps delivery, in fairness to the comfort of the patient a local anaesthetic should be administered. Only in exceptional cases would a general anaesthetic be necessary.

Finally, I could never condone the use of the vacuum extractor being applied to a foetal skull above the pelvic brim, even for a second twin.—I am, etc.,

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Alcoholism

SIR,—Thirty years ago three diseases which were little understood, feared, and therefore not talked about were tuberculosis, insanity, and alcoholism. Enormous strides have been made in conquering the first two, but there still remains the same frightened silence about alcoholism, although it is much better understood by experts if not by the general practitioner like myself. I should therefore like to support Dr. A. Spencer Paterson (23 September, p. 798), when he says that the medical attitude is of paramount importance.

The National Council on Alcoholism states that out of 34 million who drink only half a million are alcoholics, and therefore we need only bother about them.[1] These figures are very misleading manifestly, for it implies that the very great numbers of heavy "respectable" drinkers who are inefficient and who cause unhappiness to their relatives are normal. No public health scheme to combat disease has ever neglected prevention—as the National Council appears to be doing. If a man is going to fall over a cliff we grab hold of him rather than send for an ambulance to go to the foot of the cliff.

Prevention must be studied, and this means stopping not only direct advertising, which costs £23m., but also indirect advertising. It also means a fearless education of adolescents on the dangers of drink. Marty Mann's *Primer on Alcoholism*[2] should be compulsory reading, and there should be many more discussions in medical societies and journals.—I am, etc.,

London N.W.1. J. J. MACSORLEY.

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1 National Council on Alcoholism, 1967. London.
2 Mann, M., *Primer on Alcoholism*, 1952. London.

Hypersensitivity Reactions to Phenylbutazone

SIR,—In view of the recent interest in acute leukaemia developing after phenylbutazone therapy, it seems worth while reporting two cases seen during the past 18 months, both of which developed a blood picture with features of glandular fever following phenylbutazone administration. In one of the recent reports Dr. A. Lawrence[1] described a similar case in which "many atypical mononuclears closely resembling glandular-fever cells were seen" in the blood.

A woman aged 53 suffering from rheumatoid arthritis was treated with phenylbutazone, 600 mg. daily for one week, followed by 500 mg. daily for two weeks. A generalized maculopapular rash and a sore throat then developed, and her temperature was 100–101° F. (37.8–38.3° C.). A large soft lymph gland in the left axilla was noted, but no lymphadenopathy elsewhere, and her spleen was not palpable. The results of blood counts are shown below.

Day of Illness	W.B.C. /cu. mm.	Neutrophils /cu. mm.	Eosinophils /cu. mm.	Lymphocytes /cu. mm.
3	1,700	170 (10%)	323 (19%)	1,207 (71%)
4	2,300	40 (2%)	437 (19%)	1,817 (79%)
6	7,000	0	1,120 (16%)	5,880 (84%)
9	8,000	640 (8%)	2,960 (37%)	3,760 (47%)
11	8,000	1,840 (23%)	2,720 (34%)	2,960 (37%)
13	11,000	5,940 (54%)	2,200 (20%)	2,420 (22%)
17	8,000	4,720 (59%)	480 (6%)	2,480 (31%)

On days 3 and 4 a few of the lymphocytes were atypical, and some of these resembled glandular-fever cells. On day 6 about half the lymphocytes were atypical, and about a third of these had the character of glandular-fever cells. These atypical cells decreased in number and had disappeared from the blood by day 13. The haemoglobin level and platelet count were normal throughout the illness. Paul–Bunnell and toxoplasma dye tests were repeatedly negative. A sternal bone-marrow examination on day 7 showed no neutrophil myelocytes or leucocytes but an increase in promyelocytes and in eosinophil myelocytes and leucocytes. The increase in promyelocytes presumably represented a recovery phase rather than a maturation arrest, as neutrophil leucocytes reappeared and increased steadily in the peripheral blood shortly afterwards.

A woman aged 71 suffering from rheumatoid arthritis had been treated with phenylbutazone, 300 mg. daily for three weeks, when a general-