Correspondence

Jaundice of Pregnancy

Sir,—Your leading article "Jaundice of Pregnancy" (2 December 1967, p. 499) should stimulate further interest in this important subject, and especially in the fascinating condition of recurrent jaundice. You stress that the prognosis in recurrent jaundice is excellent, and Dr. J. E. A. Oni-Orisan writes subsequently (6 December 1967, p. 683) to re-emphasize the benign nature of this condition for mother and child. I write now to question this.

I recall one of my former patients who was jaundiced towards the end of five successive pregnancies. In the second and fourth pregnancies the child died in utero near to term, and a day or two before labour began spontaneously; in the first and third pregnancies the child was born alive at about 38 weeks; and in the fifth pregnancy labour was induced at about 37 weeks and a live child resulted. I have come across another report, by Moore, in which he refers to one patient who had stillbirths in association with jaundice in her first and third pregnancies; the second and fourth babies were born alive and well, although the mother was again jaundiced. Your correspondence columns often bring to light interesting information, and it could be that others of your readers have known of cases of recurrent jaundice in which the disease was less benign than has been believed. Incidentally, from my own experience I would agree with your leading article that pruritus disappears quickly when considering the jaundice more slowly, and not in the reverse order as Dr. Oni-Orisan suggests.—I am, etc.,

C. J. DEWURST.
Institute of Obstetrics and Gynaecology, (University of London), Queen Charlotte's Maternity Hospital, London W.6.

Reference


Personal Viewpoint on Anaesthesia

Sir,—In reviewing my book Studies in Anaesthetics, I have noticed Intravenous Analgesia. Anaesthesia, Dr. P. W. Thompson (13 January, p. 106) criticizes my dosage of methohexitone as being somewhat high and takes me to task for not suggesting how long the resulting respiratory depression or brief period of apnoea should be allowed to last before needing treatment. May I say that I have 3 years' experience of more than 2,500 patients, and in not a single case has respi- ratory depression or apnoea been other than momentary or needed any treatment what- soever?

Haematemesis

Sir,—I have read with interest the series of articles on diseases of the digestive system. Concerning the treatment of bleeding from the upper gastrointestinal tract (22 December, p. 723), mention is made of the fact that usually gastrointestinal bleeding stops within 12 to 24 hours of admission and that blood may be given over this time, a reason- able criterion for transfusion being a systolic blood pressure of 110 mm. Hg or less and pulse rate of 110 or more.

On two occasions I have seen patients who on admission to hospital have had blood pressure and pulse rates within normal limits who subsequently "collapsed" and in whom the putting up of a drip even by a cut-down proved exceedingly difficult. Is there not a case for setting up a slow-running infusion of Hartmann's solution on all patients admitted with a history of upper gastro-intestinal tract bleeding to cover this early danger period and allow an easy rapid trans- fusion of blood if required?—I am, etc.,

Salisbury, Wilts.
J. G. BOURNE.

Localisation of Intracranial Tumours

Sir,—I was interested to read Mr. C. A. Gladhill's letter (6 January, p. 53). Unfortunately lumbar punctures are done in some hospitals in cases of suspected brain tumours, and, what is even more disturbing, Queckenstedt's test may be performed into the bargain, the dangers of which are all too well known in the risk of disaster. Of course Queckenstedt's test should never be performed as a routine, but only when it is indicated—that is to say, when a spinal block is suspected—and it should be done carefully, with the neck flexed and extended if necessary.—I am, etc.,

Newcastle Regional Hospital Board, Newcastle upon Tyne 6.
W. REX MORRIS.

Carcinogeneity of Tobacco and Tobacco Smoke

Sir,—I regret that I missed Dr. M. Glass's letter on carcinogeneity of tobacco and tobacco smoke (5 August, 1967, p. 373) and the reply from Dr. F. J. C. Roe and Mr. A. L. Levene (2 September, 1967, p. 615). Dr. Glass pointed out that the majority of tobacco- stained fingers have been continually con- taminated with tobacco condensates and tar, but that not a single instance of papilloma or carcinoma caused by this has ever been seen or reported. He wrote: "Does not this argue for some other essential factor, besides cigarette smoke, for the evolution of malignant disease in any particular heavy cigarette smoker?" Dr. Roe and Mr. Levene explain the discrepancy by saying that the keratin layer of human skin is thicker than that of mouse skin, and therefore human skin does not develop skin cancer as readily as mouse skin.

In fact Dr. Glass's observation proves one thing only: that the tobacco tar which con- taminates the fingers of smokers is not carcinogenic to the skin of the human finger. It follows that the substance in tobacco smoke which causes or helps to cause lung cancer is probably not the same as the sub- stance in coal tar which produces skin cancer in man. Incidentally neither of these substances can be identified by chemical means; ethical reasons is not likely to be identified. The statement by Dr. Roe and Mr. Levene that human keratin is thicker than mouse keratin is probably irrelevant, since it has been shown (particularly by Ghadially's brilliant work*) that molluscum sebaceum (or keratoacanthoma), much the commonest form

* Personal viewpoint on anaesthesia

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