

This is an even more "simple and expeditious" procedure than "the microscopical examination of a small quantity of epithelial debris taken from the lesion."—I am, etc.,

Belfast.

MARY N. M. PAULIN.

Portable Stand in Domiciliary Midwifery

SIR,—Good lighting is essential for the efficient practice of domiciliary midwifery, particularly for the repair of a torn perineum. By using a stand the light can be placed in the most advantageous position independent of the fittings and furnishings in the patient's house. I have designed the stand described below to fit into any midwifery bag, and it has proved entirely satisfactory under all conditions.

The stand consists of a 7-in. (18-cm.) length of hollow brass tubing to which a 3/16-in. (5-mm.) nut has been welded on to one end. The tubing can then be screwed on to any standard photographic tripod. A clip-on light is attached to the tubing and, by a bayonet plug, connected to the electric light point in the patient's room. This obviates the necessity of numerous three-point plug adaptors to fit the power points. A 150-watt pearl bulb provides sufficient light for any operation likely to be performed at home. Seven yards of flex allows complete mobility for the lamp under all conditions. The tripod I use has a universal joint so that the light can be directed at any angle I require. The advantage of hollow brass tubular rod is that a 4-in. (10-cm.) S-type hook of the type used by butchers, and covered by adhesive plaster, can be fitted into the upper end of the tube. This provides an ever-ready stand for giving intravenous blood or plasma in an emergency. The weight of the brass tube and S-hook is 4½ oz. (130 g.) and that of the tripod 12 oz. (340 g.). Fully extended the stand measures 54 in. (137 cm.) from the ground. This is usually adequate for transfusions, as the average height of a patient's bed at home is 20–24 in. (50–60 cm.) from the ground (in hospital it is about 34 in. (80 cm.)). If added height is required, the stand can be placed on a chair or a table. The tripod can be telescoped down to 9 in. (23 cm.) with brass tube detached.

Used in conjunction with a portable lithotomy frame, the stand allows the midwife attending the patient to become a useful assistant to the doctor during any operative procedure. In cases of haemorrhage valuable time is not wasted in looking for a stand from which the bottle of plasma can be suspended.—I am, etc.,

Liverpool, 18.

MERVYN GOODMAN.

Weight in Relation to Pregnancy Toxaemia

SIR,—The use of a standard weight for height estimation as employed by Dr. Cicely D. Williams (*Journal*, December 7, p. 1338) still seems unproven. First, the association of a high standard weight for height in the majority of pre-eclamptics does not necessarily mean that there is a causal relationship between the two or that the finding is of value in prophylaxis. This has yet to be shown. Secondly, apart from purely aesthetic reasons, one cannot standardize a woman's weight to her height. Thirdly, the standard itself could be criticized, as it is 45 years old, American, and based on the non-pregnant condition.

The significance of initial weight and weight gain in pregnancy is still in some doubt. In some clinics the incidence of pre-eclampsia is higher in patients with obesity. Again there may be no causal relationship, as both clinical states may result from an endocrinal, nutritional, or psychosomatic disorder. Certain authors have reported a reduction in the incidence of pre-eclampsia following careful calorie calculations in the obese and overweight. More frequent visits, greater mental care, increased rest, and salt restriction are often coincident with the calorie reduction, and an adequately controlled series has yet to prove that weight restriction is the specific prophylactic.

Finally, the advice given by Dr. Williams, "If she is already hypertensive or oedematous she should, of course, be admitted; or she should be advised to restrict salt and calorie intake," is a little confusing. In the presence of an adequate bed state, hospital admission is imperative when hypertension or oedema occur.—I am, etc.,

Sidcup, Kent.

CARL WOOD.

Preparation of Skin for Electrocardiography

SIR,—I was interested in a letter in your correspondence columns by Dr. James Maxwell (*Journal*, October 19, p. 942) on the preparation of skin for electrocardiography. I fully agree with the view expressed by Dr. Maxwell that special jelly application is not essential in the preparation of the skin before applying electrodes during electrocardiography. I have found in my experience that moistening the skin at the place of contact with the electrode by means of a small piece of flannel, soaked in water or 3% solution of sodium carbonate, gives satisfactory results. To obtain better results, however, the spot where the electrode will make contact must be rubbed until the skin shows slight reddening, so that the surface resistance of the body to the electrode is decreased.—I am, etc.,

Karachi.

MOHAMMED KAMAL.

Abuse of E.C.T.

SIR,—It would appear that over the past decade or more there has been an increase in the application of electro-shock in all forms of psychiatric disturbance, even including some cases of cerebro-degenerative disease and cerebro-vascular disease, and it is not unknown for this type of treatment to have been given in cases of cerebral tumour and disseminated sclerosis. In this respect it would be interesting to consider the agreement, reached at the Psychiatric International Congress in Paris in 1950, to the effect that E.C.T. is a treatment of choice in cases of depression, but is every mood of sadness to be diagnosed as depression and thereby treated by E.C.T., or can we be more precise in diagnosis? I would suggest we can.

The following factors appear to be operative in this increased abuse: (1) misguided zeal to treat the patients where no adequate treatment is available; (2) a substitute for old-fashioned seclusion; (3) too great an emphasis on statistical assessment, in which many fallacies can occur, without sufficient consideration of the ultimate effect on the patient; (4) the open door policy; (5) the inadequacy of the number of beds for the appropriate catchment area, and the increasing number of psychiatric patients being referred to a mental hospital. There are also many other reasons.

This policy would indicate a lack of concern for the future of psychiatry as a science, and complicates the work of those descriptive psychiatrists and other investigators in the psychiatric field who meet these cases following a "trial" of E.C.T. What appears to be required is a firmer adherence to both contraindications and indications for electro-shock. In this respect I would suggest that the time is ripe for re-assessment and restatement of this subject by some authority, particularly for the guidance of those now embarking on a career in psychiatry.—I am, etc.,

St. Albans.

H. RASSEKH.

Nova et Vetera

HEBERDEN AND HARVEY

Professor Robert Platt, P.R.C.P., has presented the Heberden Society with the original of an autographical note by William Heberden (1710–1801) on the habits of Harvey communicated to him by Harvey's great-niece, as follows (spelling unchanged):

"1761, May 29. Mrs Harvey (great niece to Dr Harvey) told me that the Dr liv'd at his brother's at Roehampton, the later part of his life. That he used to walk out in a morning combing his head in the fields.

"That he was humoursome, & would sit down exactly at the same time he had appointed for dinner, whether the company were come or not.

"That his saltseller was always fill'd with sugar, which he used to eat instead of salt.

"That if the gout was very painful to him in the night, he would rise & put his feet into cold water."