Any Questions?

We publish below a selection of those questions and answers which seem of general interest. It is regretted that it is not possible to supply answers to all questions submitted.

Abortion and Bicornuate Uterus

Q.—Is hormonal treatment indicated during pregnancy in a woman who has a bicornuate uterus and a history of repeated miscarriages?

A.—The incidence of abortion, and of premature labour, is raised when the uterus is malformed, probably either because the abnormal organ cannot grow and stretch normally, or because of inadequate placenta (especially if sited on the spur or septum between the horns), or both. Theoretically hormone therapy with oestrogen and progesterone might counter these factors to some degree, for the progosis for a viable baby seems to improve with successive pregnancies, but in practice such therapy has not yet been shown to be effective. In general the prognosis is better the greater the degree of imperfect fusion (e.g., better in uterus didelphys than bicornis). Nevertheless, gross degrees of bicornutity are sometimes corrected between pregnancies by the reconstructive operation of utriculoplasty, but in minor degrees the operation is difficult and of doubtful value.

Risk of Meningocoele

Q.—What are the risks of malformation in further children of a young couple who have already had two children born with a meningocoele?

A.—The risks for a further child after a mother has had two children with meningocoele are not yet accurately known. The risk after one such child is of the order of 1 in 255,1 and the risk is probably further increased when two such children have been born. A small personal series indicates a risk of about 1 in 10. The risk is probably somewhat modified by the part of the country in which the parents live, and by the parents' social class.

Reference

Oral Contraceptives

Q.—What is the latest information about oral contraceptives?

A.—Data of a kind which can be appraised critically are available on two oral contraceptive agents. In a trial in Puerto Rico, directed by Dr. Gregory Pincus, and referred to in an annotation in the Journal,1 the steroid known as "enovid" administered in a dose of 10 mg. daily for 20 days, beginning on the 5th day of each menstrual cycle, proved 100% effective in preventing conception in those volunteers who omitted no tablets while under treatment. The mechanism involved is inhibition of ovulation, which some might regard as potentially dangerous if long continued, and particularly if children were desired at a later date. Further drawbacks to this method are its costliness, the need for regular daily treatment in 20-day courses, and the intolerance to the drug which a proportion of women show. None of the patients in the trial had any untoward effects from the treatment.

The second agent is m-xylohydroquinone, which Sanyal1-4 considers to be the antifertility factor of pea oil, acting by virtue of its anti-progesterone and anti-vitamin E effects. This has been tested fairly extensively in India, the patients taking a capsule of 300-350 mg. on the 16th and 21st days of the cycle—that is, twice a month only. A significant reduction in fertility rates has been observed—but to the extent only of reducing them by about half, so that this agent would appear to be far less effective than enovid.

It is encouraging that a good deal of high-quality research into the problem of devising the ideal contraceptive is now being undertaken by first-class investigators, and, though "the pill," in its ideal form, is probably still a long way off, optimism would appear to be not unwarranted.

References
3 Banerjee, S. C, and Sen, J., ibid., suppl. 28, 81.
4 Banerjee, S. C, and Sen, J., ibid., suppl. 28, 93.

High-fat Reducing Diet

Q.—In view of recent work showing the efficacy of high-fat reducing diet, what percentage of fat, carbohydrate, and protein should the average reducing diet contain?

A.—Some of the recent work in relation to high-fat reducing diets has related only to diets suitable for experimental purposes.1-2 Others, notably Pennington,4 have used similar diets to reduce obese patients, apparently with success. There is at the moment no fixed agreement as to the relevant portions of fat, carbohydrate, and protein, but the usual practice in reducing diets is to diminish the carbohydrate intake and thus to increase the relative proportions of fat and protein. This latter can be increased if the resulting diet is unsatisfactory.

References
3 Metabolism, 1957, 6, 447.
4 Pennington, A. W., Delaware St. med. J., 1951, 23, 79.

NOTES AND COMMENTS

Intestinal Hurry.—Dr. Ian Stewart (Keighley) writes: In the advice on intestinal hurry ("Any Questions?", October 4, p. 668) there is the sentence: "In severe dysentery morphine by injection may greatly help the patient, but it can only be used once or twice. In infections with Shiga's bacillus and the presence of a powerful exotoxin, I would have thought that morphine by injection was extremely dangerous. During the 12 years I was working with this group of diseases no form of opium was used until the diagnosis was established.

Our Expert replies: Opium has been used for over 200 years with benefit in the treatment of dysentery. Manson-Bahr4 says nothing against its use, and morphine is strongly recommended by Strong. In extensive experience with cases of dysentery I have used morphine as described in patients whose diarrhoea and pain were severe. No ill effects occurred and the patients were always greatly relieved.

References

Correction.—In the article on "Sedatives and Tranquilizers" by W. Sargant (Journal, October 25, p. 1031) the dose of bromide in the paragraph headed "Bromides" should have been 20-30 gr., not 20-30 mg.

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