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## RECURRENT ABORTION

There can be few greater disappointments to a woman than that of seeing menstruation regularly recurring when she has long been hoping for a pregnancy to end her infertility. Again, we have all experienced a pang of sympathy for her tears when she miscarries after having been overjoyed at the knowledge that she is with child. What can compare with the frustration and despair of patient and doctor alike when this happens again and again?

The incidence of abortion in all pregnancies is 18-20%. Of 100 women becoming pregnant, 20 will abort once, 4 will abort a second time, and 1 will possibly abort thrice in succession, these abortions being from random as well as recurrent causes. The chances of a successful pregnancy are reasonably high after two consecutive spontaneous abortions, but after three the outlook is much worse and there is an overwhelming likelihood that a true recurrent cause is present. Malpas[1] put the chances of a subsequent pregnancy continuing to term after one abortion at 78%, after two 62%, after three only 27% and after four 6%.

What is the nature, then, of the truly recurrent causes? Unfortunately, more often than not no cause can be found. Deformities, e.g. bicornuate uterus, damage to the internal os by previous instrumental delivery or by dilatation and curettage or amputation, and displacements such as persistent retroversion, can be held responsible; but even in the presence of these factors pregnancy usually proceeds uneventfully to term.

Much has been written and much research done regarding hormonal influences, placental insufficiency, uterine tone, etc. Stilboestrol and progesterone, vitamin E, etc. have been used therapeutically in many controlled series with varying success. Equally good results have been reported with rest and reassurance alone.

It is now generally accepted that the administration of oral progesterone has no value except possibly psychological. Injections of the same hormone, held to be more efficacious, have to be in large doses. Wilkins *et al.*[2] recently drew attention to an alarmingly high incidence of non-adrenal female pseudo-hermaphroditism in girl babies born to women so treated for habitual abortion. Encouraging results, however, have been reported after the implantation of progesterone in pellet form (Stallworthy[3]). One 100 mg. pellet implanted early in pregnancy is sufficient to maintain an adequate level of progesterone until the placenta has, after the 4th month, taken over production of the hormone. The pellet is implanted with the aid of a trocar and cannula under a short general anaesthetic, the procedure taking a few minutes. When the steroid has been administered in this form and dosage, no cases of masculinization of female babies have been reported to date.

The Smiths' scheme of therapy with increasing doses of stilboestrol[4] is based on the concept that it stimulates the secretion of oestrogen and progesterone by the placenta, and many practitioners will recall cases successfully treated by this means, beginning with 5 mg. a day and working up to 12 mg. by the 36th week. Others have not been able to reproduce the same success rate as the Smiths. Perhaps it is because the authors of this plan believe so strongly in it and impart their confidence in its success to their patients. There is no doubt that there is a very strong psychological factor involved, particularly when the period of pregnancy is approached at which the previous abortion occurred.

For this reason, one *must* have some scheme of therapy. Neither a progesterone implant nor increasing doses of stilboestrol, nor both, have been conclusively proved worthless and, since they have not been shown to have deleterious effects, they are suitable to employ and the practitioner *must show faith* in their use. Some doctors give thyroid in normal dosage in addition, the rationale being promotion of the growth response of the uterus.

There is a small group of women who abort regularly between the 4th and 7th months of pregnancy. Shirodkar[5] believed these abortions to be due to an incompetent internal cervical sphincter and devised an operation bearing his name whereby this sphincter is purse-strung with fascia lata. Of those operated upon, he later delivered a gratifying number by Caesarean section at term. Various modifications of the Shirodkar operation have now become commonplace, and many gynaecologists in South Africa can report successful cases. The simplest procedure is a purse-string suture of braided nylon or similar non-absorbable material, inserted to encircle the cervix in the region of the fornices at the level of the internal os, taking bites on the way round of the vaginal skin *and* the fibromuscular substance of the cervix. This suture is cut when labour commences. Not infrequently fibrosis in relation to the suture is now found, paradoxically, to make the cervix 'super-competent' and Caesarean section is then not out of place to ensure safe delivery of the precious baby.

1. Malpas, P. (1938): J. Obstet. Gynaec. Brit. Emp., **45**, 932.
2. Wilkins, L., Jones, H. W. Jr., Holman, G. H. and Stempfel, R. S. Jr. (1958): J. Clin. Endocr., **18**, 559.
3. Stallworthy, J. A. (1955): *British Obstetric and Gynaecological Practice*, 1st ed., p. 353. London: Heinemann.
4. Smith, O. W. (1948): Amer. J. Obstet. Gynec., **56**, 821.
5. Shirodkar, V. N. (1953): J. Obstet. Gynaec., Ludhiana, **3**, 287.

## DIE BEHEER VAN STUIPTREKKINGS

Dit word taamlik algemeen aanvaar dat daar 'n groot aantal sogenaamde ‚idiopatiese' epileptiese toestande is waarvoor geen organiese oorsaak op te spoor is met behulp van die metodes van ondersoek wat vandag tot ons beskikking is nie. Dit is ook 'n kliniese feit dat 'n groot aantal van hierdie epileptiese toestande onder redelike goeie beheer gehou

kan word deur die gebruik van geskikte middels wat die neiging tot stuiptrekkings onderdruk. As gevolg van hierdie toestand van sake is die ontdekking van enige nuwe middel wat stuiptrekkings beheer of beëindig altyd van groot belang vir almal wat belangstel in die behandeling van die epileptiese pasiënt.

Die ou bekende staatmaker-middels by die simptomatiese behandeling van epilepsie bly nog maar een of ander vorm van barbituur-preparaat en hidantoine (vir die *grand mal* aanval) en die dione groep van middels (vir die *petit mal* aanval). Spielman en sy kollegas het egter in 1948 aangetoon dat sommige asetielurea-verbindings ook 'n goeie anti-stuiptrekkende uitwerking het, en prof. Frommel[1] van Genève het in 1953 op grond van uitgebreide ondersoeke met proefdiere hierdie bevindinge bevestig. En nou het Sharpe *et al.*[2] in Engeland 'n interessante kliniese ondersoek onderneem om die uitwerking van fenieletielasetielurea te toets.

Op grond van die werk wat reeds ten opsigte van hierdie middel gedoen is, is dit nie net bekend dat fenieletielasetielurea 'n goeie anti-struiptrekkende uitwerking het nie, maar ook dat hierdie uitwerking beduidend verhoog word as dié middel saam met ander bekende anti-stuiptrekkende middels gebruik word. Die middel wat deur Sharpe en sy medewerkers ondersoek is, is in Engeland bekend as ‚trinuride' en dit bestaan uit die volgende kombinasie van middels: Fenieletielasetielurea 0·20 g., difenielhidantoine 0·04 g., fenobarbitone 0·015 g., mengmiddel 0·4 g. Die doel van die ondersoekers was om uit te vind of hierdie middel wel 'n goeie anti-stuiptrekkende uitwerking het, of dit ongewenste newe-uitwerkings het en of dit maklik en sonder ongerief deur die epileptiese pasiënt gebruik kan word.

Die bevindinge van Sharpe en sy medewerkers is bemoedigend. Hulle het hulle toetse uitgevoer met epileptiese pasiënte wat reeds die bestaande ander middels ontvang het. Die pasiënte is geleidelik oorgeplaas op behandeling met dié nuwe middel ‚trinuride'. Die enigste bykomstige faktor was dus fenieletielasetielurea wat in die middel vervat is.

Die finale gevolgtrekking van die ondersoekers is dat ‚trinuride' 'n samestelling is wat besondere anti-stuiptrekkende kwaliteite het as dit gebruik word by die behandeling van *grand mal* epilepsie. Hulle voel dat verdere kliniese ondersoeke sterk aangemoedig behoort te word.

1. Frommel, E. *et al.* (1953): Arch. Int. Pharmacodym., **92**, 368.
2. Sharpe, D. S. *et al.* (1958): J. Ment. Sci., **104**,834.

## THE NAUDÉ APPEAL FUND

The attention of readers is called to the letter from the Hon. Secretary of the Transkei Branch of our Association appealing for donations to make up the fund launched to recoup Dr. W. J. Naudé for some of the loss he sustained in the case of Naudé versus Whittle.

Dr. Naudé instituted proceedings in the Supreme Court at Grahamstown in respect of defamatory statements about himself made at an annual meeting of the Zwartberg Farmers' Association. The Court found that the statement was defamatory, highly misleading and altogether untrue, but Dr. Naudé lost the case on a question of law, the Court ruling that the occasion was privileged. Nothing daunted, Dr. Naudé took the case to appeal, and the Appeal Court reversed the judgment, found in favour of Dr. Naudé, and awarded him £800 with costs.

If the original judgment had stood, medical practitioners, as we stated on a former occasion, would have found 'that the circumstances under which defamatory statements might be made against them with impunity were much wider in scope than they had hitherto supposed'. From this and every point of view Dr. Naudé in fighting this case single-handed was fighting the battle of the whole profession.

Notwithstanding an effort already made by the Transkei Branch of the Association Dr. Naudé is still over £500 out of pocket, and it is hoped for the honour of the profession that a generous response will be made from all parts of South Africa to the appeal which the Transkei Branch has now made.