

Delay in Labour

SIR,—Reflecting on your leading article (21 October, p. 126) and Professor R. H. Philpott's article (p. 163) on the graphic presentation of the progress of labour, I wondered if any of your readers would be interested in the simple tabular guide to when to start worrying about the duration of labour that I use in teaching the pupil midwives here. It is based on the times to send for medical aid in the second stage that every pupil midwife knows and works in multiples of two and four.

Delay in Labour: Times (in hr) to Send for Medical Aid

	First Stage		Second Stage
	Latent Phase	Active Phase	
Primigravidae	16	8	2
Multigravidae	8	4	1

In my limited experience of teaching midwives this simple table is invariably better received than the graphic guides upon which it is based, separates multigravidae from primigravidae, and covers the whole of labour from its onset to the birth of the baby.—I am, etc.,

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Nitrazepam and the Elderly

SIR,—Despite statements to the contrary made in advertising literature, nitrazepam (Mogadon) seems a particularly unsuitable hypnotic for old people. Members of this department have come to recognize a characteristic syndrome of disability caused by nitrazepam, of which the following case is typical.

A 75-year-old lady had been resident in an old people's home for six years. Before admission there she had made a good recovery from a slight left hemiparesis and had mild heart failure, well controlled by digoxin, but she was generally ambulant, continent, and orientated. She was referred to us with a diagnosis of having suffered a further stroke after two weeks of general mental deterioration, inability to walk, and incontinence of urine and faeces. She had become dysarthric, confused, and disorientated and, if left undisturbed, would sit staring blankly into space. She tended to fall to the left and to stumble when attempting to walk. Specific questioning elicited the information that she looked better and seemed mentally more alert when in bed than when sitting out and that she had been taking one tablet (5 mg) of nitrazepam nightly for at least a year. We advised stopping the nitrazepam and on review three days later she was said to be "completely her old self" and had gone out on a charabanc trip. After four months she remains well.

This case report illustrates several of the characteristic features of the syndrome.

(1) The symptoms may appear in a patient who has been taking nitrazepam without ill effects for some time.

(2) One tablet (5 mg) a night is enough to produce the condition. We have not encountered it in patients taking half a tablet (2.5 mg) nightly but this dosage, although recommended by the manufacturers for elderly patients, does not seem to be commonly used.

(3) An "unmasking" of old cerebral damage together with the mental confusion

may lead to an erroneous diagnosis of progressive brain disease.

(4) Symptoms suggestive of postural hypotension may be present; indeed, one of our first patients was under treatment for idiopathic postural hypotension before the significance of her night sedation was recognized. The observed fall in blood pressure on standing is, however, less than appropriate to the severity of the symptoms.

(5) Recovery is rapid once the drug is stopped and there are apparently no permanent ill effects.

(6) Night sedation is so much a part of modern life, both in and out of hospital, that patients and their doctors may not mention sleeping tablets when asked about medication.

(7) Nitrazepam is popular because of its rapid effect and is widely used in residential homes and elsewhere where it is convenient or necessary for old people to be "switched off" with the lights.

Prolonged behavioural changes, without subjective awareness of impairment, have been demonstrated in young adults after single doses of nitrazepam by Malpas *et al.*¹ It seems possible that in addition some elderly patients may have, or develop, a slow clearance of the drug, leading to cumulative effects. We have not found consistent evidence of generalized metabolic disorder in our affected patients.

Obviously a department of geriatric medicine sees only the most severe cases of any disease, so we wonder how many old people in the community are suffering from milder degrees of chronic impairment due to their sleeping tablets. We are currently seeing cases of this type due to nitrazepam at the rate of six or seven a month from a catchment area population of 450,000. Whatever its merits in younger patients, we would suggest that nitrazepam should join barbiturates in not being prescribed for the elderly except in carefully selected instances. There may conceivably be a place in general practice for a "geriatric" 2.5-mg tablet, but we find dichloralphenazone to be a safe and satisfactory hypnotic of first choice, its chief side effect being only excessive intestinal flatus. Probably other chloral derivatives would serve at least as well.—We are, etc.,

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¹ Malpas, A., Rowan, A. J., Joyce, C. R. B., and Scott, D. F., *British Medical Journal*, 1970, 2, 762.

Rheumatology and Rehabilitation

SIR,—Your leading article (28 October, p. 188) discusses the dissolution of the British Association of Physical Medicine and Rheumatology and the emergence of the British Association for Rheumatology and Rehabilitation. The overdue demise of "physical medicine" is welcome, but the continued association of rheumatology with other fields of medical activity is only perpetuating the confusion existing at present in the minds of those who received their education outside London. In other parts of England and in Scotland both rheumatology and medical rehabilitation, although sharing common ground, have been recognized as medical

specialties in their own right. The British Association of Physical Medicine and Rheumatology has been largely a feature of the London scene. In 1971 there were 131 consultants in physical medicine and rheumatology in England and 89 of these were employed in the London area; only six could be identified in Scotland.

The Mair report on medical rehabilitation¹ considers the pattern for the future in Scotland, where a more logical structure already exists. This report (not mentioned in your article) clearly defines the complex problems inherent in the development of a comprehensive service for the community as a whole. The management of rheumatology departments in hospitals would form a relatively minor part of the duties of consultants in medical rehabilitation.

The medical profession too often subscribes to the view that rehabilitation depends solely on the number of physiotherapists, occupational therapists, and social workers available to them. They prefer to remain ignorant of the grave difficulties which frequently obstruct the return of their patients to social and economic independence. Both the Tunbridge² and the Mair reports emphasize the urgent need for co-ordination and mobilization of all resources to solve these problems, and firmly establish the case for the appointment of consultants who, following further training, would devote their whole time to work in this field.

If the formation of the British Association for Rheumatology and Rehabilitation implies that only men trained initially as rheumatologists can become consultants in medical rehabilitation, or that medical rehabilitation is solely concerned with diseases of the locomotor system, this entirely erroneous conception must be firmly corrected.—I am, etc.,

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¹ Scottish Home and Health Department. *Medical Rehabilitation: the Pattern for the Future*. Edinburgh, H.M.S.O., 1972.

² Department of Health and Social Security. Central Health Services Council, *Rehabilitation*. London, H.M.S.O., 1972.

Orthopaedic Medicine and Rheumatology

SIR,—Dr. James Cyriax (4 November, p. 292) need not be so disconsolate. Through the years many rheumatologists have been exposed to his views at first hand and because of their previous training in general (internal) medicine have been able to assess his opinions with objectivity. In my view Dr. Cyriax's greatest contribution to the field will remain his meaningful methods of examination of the musculoskeletal system, with particular reference to common, and often neglected, soft tissue lesions. Manipulative methods of treatment are used where applicable in many reputable medical centres in this country, but it must be recognized that there are various means of achieving the same end in a field which is still largely empirical. In recent years there have been attempts critically to evaluate some of the methods of management advocated by Dr. Cyriax and I might in this context mention the scientific work of his successors on the staff of St. Thomas's.

The name "orthopaedic medicine" might