

ment and experience of living in other countries for both parents and their children. Good administration, however, should minimize the frequency of such moves.

It should be possible to amalgamate the three armed Forces medical services. Most regimental medical officers, naval surgeons in ships, and R.A.F. station medical officers come from the ranks of the medical cadet schemes. There is little shortage of them and they have no established service loyalty. What is needed is careful planning of career structures for permanent medical officers after this stage. In the clinical specialties there should be no problem about complete integration between the three services with the establishment of a central medical officers' appointments bureau, which would appoint specialists to service hospitals in accordance with their training programme and place on the clinical promotion ladder irrespective of their service branch. In the scientific fields there is little need for purely Navy, Army, or Air Force specialists. All three services fly aeroplanes and their problems in social or environmental medicine are not dissimilar—indeed, the problems of all three services surely would make for a more interesting career than one which was tied to one service. A combined services medical institute could deal with special problems of pure science. Though individual differences in administration exist between the services it would be preposterous to claim that a Navy administrative officer could not also do such work in the Army or Air Force.

It seems to me that it would be but a small step to make each service hospital in Britain a part of the general or district hospital facilities of the N.H.S. They could take their turn for emergency intake and become a district general hospital administered by the Ministry of Defence but totally and officially integrated with the National Health Service.—I am, etc.,

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Hazard to Fetus from Safety Harness

SIR,—Recently a primigravida aged 24 was admitted under my care at 34 weeks of pregnancy after a road traffic accident. The car which she was driving at a speed of approximately 40 m.p.h. (64 km p.h.) was in direct collision with another car crossing in front of her.

Probably because of the safety harness she was wearing her injuries appeared only slight. There were abrasions of both knees and the left arm. She had no abdominal pain nor was there vaginal bleeding. The fetal heart, however, could not be heard, though movements had been felt earlier in the day. Routine testing revealed a small amount of blood in the urine. Four days later she had a loss of 2oz (57 ml) of blood after which premature labour began. She delivered uneventfully a macerated 3-lb (1.4 kg) baby. Delivery of the placenta was accompanied by a loss of 4 oz (114 ml) of old blood clot.

The safety harness she was wearing was of the standard type consisting of lap and diagonal straps, and it would seem probable that the pressure on her uterus from the latter, as a result of the accident, was responsible for the abruptio placentae.

My object in reporting this case is to suggest that when women in advanced pregnancy are travelling by car the straps should be so arranged that direct pressure on the pregnant uterus is avoided.—I am, etc.,

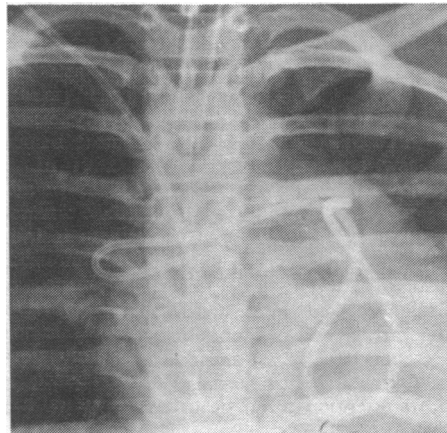
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Recovery of Catheters Lost in Vascular System

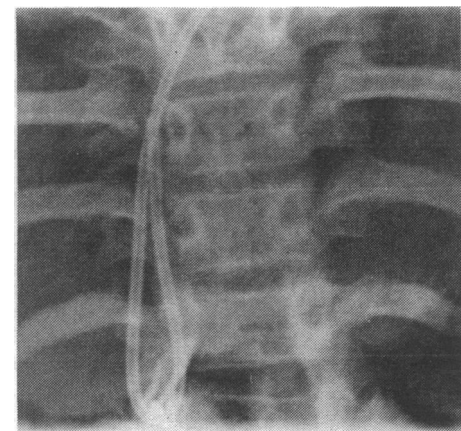
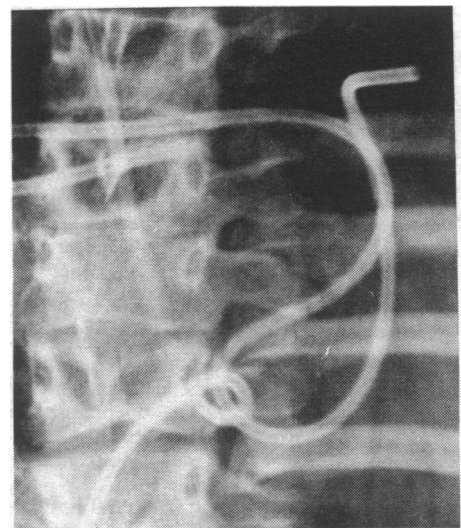
SIR,—In a comprehensive review of non-operative techniques for removing catheters lost in the vascular system Rossi¹ lists the use of endoscopy forceps, a ureteric stone catcher, a metal sucker, and a snare loop of guide-wire. To these he added the use of a hooked polyethylene catheter. McSweeney and Schwartz² described a further technique using a deflecting guide-wire system, and Ranniger³ a system using a spring guide-wire with three formable loops on it. We wish to report a further modification of the technique which was successfully used to remove the lost distal silastic catheter from a ventriculo-atrial shunt system.

A 9-year-old hydrocephalic child was admitted in coma thought to be due to failure of drainage of C.S.F. through a Spitz-Holter valve. X-ray examination showed that the distal section of the catheter had detached itself from the lower end of the valve and migrated to a complex position in the right ventricle and pulmonary arteries (Fig. 1). After the patient's condition had been improved by connecting a new distal catheter it was decided to attempt to remove the lost one without major surgery.



A 65-cm French size 7 Selector Catheter (Medi-Tech Ltd.) was introduced into the femoral vein by the Seldinger technique. It was rapidly manoeuvred into the right ventricle and a tight loop was formed around the existing loop of the silastic catheter (Fig. 2). Some difficulty was experienced in manipulating the looped catheter back through the tricuspid valve, but ultimately the whole system was withdrawn down the inferior vena cava (Fig. 3) and extracted from the femoral vein with a cut down. There were no complications.

There will probably be more such cases in the future. We would recommend that all catheters should be adequately radio-opaque. It should then often be possible to remove



them by one or other of the non-operative techniques. Possibly the best combination would be a variety of snare loops and a guideable catheter system. Thus it should be possible to entrap a catheter which is lying either straight or in a coiled position.

We are grateful to Mr. D. Forrest for his referral of this case.

—We are, etc.,

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¹ Rossi, P., *American Journal of Roentgenology*, 1970, **109**, 101.

² McSweeney, W. J., and Schwartz, D. C., *Radiology*, 1971, **100**, 61.

³ Ranniger, K., *Radiology*, 1968, **91**, 1043.

Selective Proximal Vagotomy

SIR,—Most gastric surgeons today would agree that if recurrent duodenal ulceration occurs after a truncal or bilateral selective vagotomy and drainage then vagal section on the oesophagus is incomplete. The recurrence rate, even in centres greatly experienced in vagotomy, may be as high as 10%. The series of Professor J. C. Goligher and his colleagues (1 January, p. 7) giving the late results of truncal vagotomy and pyloroplasty was done without a test for completeness of nerve section at operation. In all 12.2% of their cases came to further operation. These are the figures which we may expect when vagotomy is performed by experienced surgeons without a test at operation. He is not the first surgeon to suggest