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New Zealand College of Midwives
P O Box 7063
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New Zealand College of Midwives [Inc]

NEWSLETTER

Volume 4, Number 2 : November 1991

NEW ZEALAND COLLEGE OF MIDWIVES INC.

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Place of Work _____

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Full member (Registered Midwife Full or Part Time)	$74.00
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Please tick your choice of payment method.

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Name _____

Address _____

Telephone _____ Home _____ Work

Date of Birth _____ NZNA member: Yes/No

Type of Membership

Full : Waged ❒ Associate : Waged ❒ Affiliate ❒
: Unwaged ❒ : Unwaged ❒

Place of Work _____

Please return completed form (together with money, if applicable) to your local Treasurer.

NEWS & VIEWS

Meeting with the Minister

On 24 October 1991 Katherine O'Regan met with representatives of the NZCOM and NZMA.

The Minister began the meeting by confirming the government has no intention of revoking midwifery autonomy, gained in the Nurses Amendment Act 1990.

Intense lobbying by the medical profession had suggested there are many problems, however, when questioned by the Minister the NZMA stated that midwives were expressing their concerns to Doctors about the extended time payment during labour care.

A further concern is "Risk Lists". It was suggested that midwives frequently take on more than they are capable of doing.

The midwives pointed out that a midwife's perception of risk is quite different from the medical view, e.g. we could never accept all first babies as a risk.

The Minister requested the Department of Health set up a meeting with the NZCOM and the NZMA to:

1) discuss the maternity benefit schedule. (She anticipates it will stay centralized for at least another year.)

2) define normal/low risk care. (Karen suggested the "Choices and Safe Options" Department of Health paper, which was widely reviewed by both practitioners and consumers, could be used.)

3) examine the issue of shared care.

Restructuring

The National Committee Meeting Workshop on Restructuring identified that it is essential that the NZCOM has a paid worker to deal with the workload. Paid secretarial support and financial expertise is also vital.

Karen has applied for funding through Women's Suffrage Centenary funding. If the application is successful a full-time worker will be possible.

There will be a Special General Meeting on Friday 14 February 1992 at 6.30pm.

IAS **IMMUNISATION AWARENESS SOCIETY**

INTERNATIONAL SYMPOSIUM
Sat 21 & Sun 22 MARCH 1992
KARAKA SALES CENTRE, KARAKA, AUCKLAND

THE VACCINATION DILEMMA

This symposium has been organised for health care professionals, parents and its members. Included in the two-day programme will be:

- an overview of the issues surrounding the practice of vaccination
- the challenges ahead for doctors and healthcare professionals
- the dilemma for parents
- the immune system function
- vaccine research and side effects
- ethnic groups differing immunity
- the operation of the US Vaccine Injury Act
- overseas trends and attitudes

Crèche facilities will be available – children will not be permitted in the auditorium.

thought provoking
stimulating
challenging
informative

BE PART OF THIS IMPORTANT EVENT
CONTRIBUTE TO THE DEBATE

We are delighted to announce the following speakers

Professor Campbell Murdoch
Professor of General Practice. Otago University

Dr Archie Kalokerinos
GP. NSW Australia

Dr Anthony Morris
Vaccine Researcher. Maryland USA

Dr Roger Booth
Immunobiologist. Auckland Medical School

Hilary Butler
Vaccine Researcher. Auckland

Wendy Lydall
MA. Vaccination Historian. Auckland

Dr Glen Dettman
GP Victoria. Australia

Dr René de Monchy
GP. Wellington

Patrick Potae
Parent. Waiheke Island

A CONFIRMED PROGRAMME AND ORGANISATIONAL DETAILS WILL BE POSTED IN EARLY FEBRUARY 1992 TO THOSE WHO HAVE REGISTERED. LIMITED SEATING – REGISTER BY **15 DECEMBER 1991** TO ENSURE A PLACE.

REGISTRATION FORM

NAME: PH No WK:

ADDRESS: HM:

PAYMENT ENCLOSED – PLEASE MAKE CHEQUES PAYABLE TO IMMUNISATION AWARENESS SOCIETY

IAS MEMBERS $70 ☐ NON-MEMBERS $90 ☐

COST *INCLUDES* CATERED LUNCHES, AFTERNOON TEAS, GST.

RECEIPT REQUIRED ☐ YES, I WOULD LIKE MORE INFORMATION ABOUT IAS ☐

Midwifery Solidarity Needed

At this time midwives need to stand together and support each other. To those who feel the midwives who are claiming the Maternity Benefit are overpaid, ponder this.

The benefit is only payable for the hours you work. In labour, this you cannot control (you may have a run of very quick labours with minimal payment).

You get paid $20 for a Postnatal visit – it might take most of a morning.

You get paid nothing for phone calls (women often ring and talk for about 30 minutes).

If no clients request your services you get no pay.

No holiday pay.

No sickness benefit.

You must pay ACC levies.

You must take bookings, file claims, keep records in your own time.

You are on call 24 hours a day and seven days a week.

If continuity of care is provided midwives can only care for approximately 6 women a month. This is a good income, certainly not excessive.

However, it is the midwives' choice, the work is very rewarding and knowing the woman you care for is wonderful.

Hospital midwives get a steady income, penal rates, sick leave, may get study leave, long service leave, she is paid when there is no work.

The law was changed because women wanted continuity and choice. We claimed that midwifery continuity of care would lead to lower intervention rates and increased consumer satisfaction.

The hospital midwife can also claim her professional rights. This will not be given, midwives must ensure hospital boards allow midwives to function to their full professional capability.

Professional maturity demands we talk to each other about our concerns and gripes.

Women's wishes and choices must be the central consideration.

Direct Entry

We are still hoping the courses will begin in 1992. Lobbying to ensure all courses are funded and ongoing would be valuable.

FUTURE EVENTS

6-8 December 1991: *The Domiciliary Midwives November Meeting*
5.00pm, 6th December, at Riverside Community. Saturday 7th highlight – Karen Guilliland. Meeting concludes at 4.00pm Sunday 8th.
Accommodation at Riverside needs to be booked. Confirm your place (and pick up from the airport) by phoning Bronwen Pelvin on (03) 526 8722.

26-27 March 1992: *ICM Regional Meeting* – Melbourne, Australia.

14-17 June 1992: *10th International Congress of Psychosomatic Obstetrics and Gynaecology* – "Reproductive Life"
Contact: Congress Secretariat, CONGREX, International Society of Psychosomatic Obstetrics and Gynaecology (ISPOG) - 92, PO Box 5619, S-114 86 Stockholm, Sweden. Tel: 46 8 32 69 00. Fax: 46 8 32 62 92.

4-7 October 1992: *Second International Homebirth Conference*
Sydney, Australia. Reclaiming our Heritage, Creating our Future.
Contact: Conference Secretariat, GPO Box 2609, Sydney, NSW 2001, Australia. Tel: (02) 241 1478, (02) 247 6940. Fax: (02) 251 3552.

1-4 November 1992: *The Fourth International Conference for Maternity Nurse Researchers* – Taipei, Taiwan, The Republic of China
Contact: Yueh-chih Chen, RPN, PhD, Director, School of Nursing, College of Medicine, National Taiwan University, 1, Jen-Ai Road, Section 1, Taipei (10018), Taiwan, The Republic of China.

9-14 May 1993: *International Confederation of Midwives 23rd International Congress*
Vancouver, BC, Canada.

MANAWATU-WANGANUI AREA HEALTH BOARD

Wanganui Hospital, Heads Road, Wanganui

Delivery Suite
WANGANUI HOSPITAL

SPA BATH

In September 1989 a spa bath was fitted into Delivery Suite at Wanganui Women's Unit. After two years of use, and many gallons of water later, we thought it was about time we evaluated the spa bath.

The use of warm water ie bath/spa bath etc as a form of comfort/pain relief for labouring women is in my opinion an undervalued aid for women in labour, but it is also very difficult to evaluate its use. One of the measurable ways to do this was of course to see if the spa bath had affected the amount of narcotic analgesia we used. The birth rate for Wanganui Women's Unit over the past three years has been fairly static at 960-1,000 births per year, with no change in the epidural anaesthetic rate.

From September 1989-August 1990 we had a 5.6% reduction in the use of Pethidine.

From September 1990-August 1991 we had a 15.5% reduction in the use of Pethidine.

As you can see 'wow', in $ terms this is quite a saving. The effect of the use of the spa bath on women more importantly is so subjective and very difficult to measure. I can only give you my opinion and my fellow Midwives' opinion that the spa bath has aided/comforted women in labour and has enabled them to make choices and stay in control of their birth experience.

Because of the great utilisation of the spa bath during labour we of course have had many deliveries in the spa bath with and without water! We now offer planned water births to selected clients. We hope to have a second spa bath fitted into our small unit in the near future.

Yours faithfully

Young

(L Young)
Charge Nurse
on behalf of
Wanganui/Taranaki Region of the
New Zealand College of Midwives

This is the last Newsletter for 1991 (there will be an issue mid-January 1992 with remits for the Special General Meeting).

We appreciate the support we have received throughout the year. The College has achieved an immense amount in its short life. This is due to the hard work of those involved in running the College at Regional level, the commitment and energy of our President Karen Guilliland, and the belief that midwives as a profession should respond to the women who support midwifery.

Merry Christmas. Best wishes for 1992

BOM

MIDWIVES

If you have an unexpected outcome which involves maternal or fetal morbidity or mortality and you are insured with either NZNA or NZNU ensure you contact them and lodge a claim application as soon as possible after the incident. You cannot hire legal council and proceed by yourself and then claim from the insurance company.

MIDWIFE NEEDED FOR

BUSY CITY PRACTICE, CHRISTCHURCH AREA

PLEASE CONTACT

JULIE RICHARDS,

Ph: 03) 772 732, home: (03) 355 957

SPECIAL GENERAL MEETING

14 February 1992 at 6.30pm

Wellington Polytechnic

School of Nursing and Health Studies

Restructuring of NZCOM to be voted in

For further information contact your Regional Chairperson.

It is important you make your views known.

Remits in the next Newsletter.

ADDENDUM: 21 August 1991

Radiation

A relationship between microwaves and cot deaths has been postulated on the theory that the brain acts as some kind of radio receiver for microwaves which impairs brain function.

A research of 632 cases of cot death disclosed that almost without exception they occurred when the baby was either close to an unusual magnetic field or to a strong electric current.

Professor Milton Zaret, New York School of Medicine, one of the world's foremost authorities on medical consequences of microwave radiation, suspects that "outside currents" may interfere with nervous system function. In the case of cot death, he believes that the radiation may, in some way, cause the baby's brain to "forget" to breathe and/or to maintain the heartbeat. (Timothy Hall, The Invisible Killers, pp6/7.)

In seven years of research the US Navy discovered that electromagnetic radiation can "alter behaviour of cells, tissues, organs and organisms; alter hormone levels; alter cell chemistry; ... cause up to six times higher fetus mortality rate in lab animals than in controls ...". A Dr McBirnie is quoted as saying that "E.L.F. signals generate tiny, unfelt vibrations inside various brain parts, which shake loose the barrier, creating leaks in it ... They also reduce the ability of brain cells to hold calcium, a vital element in the action of nerves ... The electrical signal can move ions (such as sodium or calcium) across the membrane of the cell, unleashing a chain of chemical reactions within the cells itself, which may ultimately lead to the unravelling of DNA ..." (Electromagnetic Radiation and Your Health, Today's Herbs, May 1989.)

Information on electromagnetic radiation is available from:

The Caeteris Centre
PO Box 88
Greenhithe
Auckland.
Ph: (09) 413 9619

References

1) NZ Women's Weekly, September 1990.
2) Professor J L Emery, Lancet 1981, ii: 176-178.
3) NZ Herald, 29 May 1986.
4) Evening Standard, 14 June 1991.
5) Spanninga, Truus & Aller, Letter, The Listener, 27 August 1990.
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7) Sprott, J, Soil & Health, June 1989.
8) Prevention – no date.
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10) Steincamp, Jacqueline, Options 37.
11) Denborough, M, Australian University, Canberra, Lancet, 15 July 1989.
12) Canadian Journal Neurology, reported in NZ Herald, 6 April 1991.
13) Logan, J A, NZMJ, 12 February 1986, p72, Letter.
14) Logan, J A, NZMJ, 27 May 1987, Letter.
    Undernutrition in 18 Indian mothers showed lower CP levels in cord blood and a significant correlation was observed between baby weight and serus CP capacity of the newborn. (Krishnamachari, J Obstet Gyn Brit Comm 1972: 79: 162-5).
15) Holborrow, P, NZMJ, 26 September 1990, Letter.
16) Prevention, February 1979 (Reported in BMJ, 1958).
17) Mowie, A, PhD, RN, FACBS, Australian Nurses Jnl, August 1982: 24-32.

MIDWIFERY IN CHINA

From observations at: Red Cross Hospital, 38 Huan Cheng Dong Road, Hangzhou, Zhejiang 310004, People's Republic of China.

The Hangzhou Red Cross Hospital (built by Jesuits in 1928) is a combined Traditional Chinese Medicine (TCM) and Western Medicine (WM) hospital. On the one hand there is a large pharmacy with 7500 traditional medicines, professors and doctors who practice acupuncture, herbal medicine and tuina (infant massage). There are also those who practice WM and liberally prescribe antibiotics for viral infections and prednesone for nephritis – which is very common.

The maternity services have been captured by WM – the result is an attempt to use first world technology in third world conditions. Philosophically they are where we were in the 1950s – newborn babies bundled into bassinettes behind glass in a nursery, fed on a four-hourly schedule and given milk mixtures. When we visited, all the babies were crying – until it was time to wheel them out. They proudly showed us their hygienic procedures – wearing gowns, hats and masks on entering the nursery and every attendant was required to spray her throat with a disinfectant from a common atomiser before entering the nursery. They were also proud of their milk mixture procedure etc. Despite all this most women breastfeed for 10-11 months.

The labour/delivery room had three beds in it. When we visited there was one woman in labour – lying quietly and passively flat on her back, hooked up to an oxytocin infusion, because, they said, her contractions were not very strong. There was an attendant (midwife) sitting on a chair across the room. When we went in, the female obstetrician and midwives proudly demonstrated the merits of a very sophisticated sonicaid. On the shelf were two pinnards – so I picked one up and asked why they used the sonicaid instead of the pinnard – telling them that midwives in New Zealand used a pinnard in preference to the sonicaid. So they invited me to use the pinnard to listen to the fetal heart without asking the woman. I asked the woman through an interpreter if it was OK. I palped her and listened. Then they pointed to

the oxygen bubbling away because they said the fetal heart was irregular at times. (It sounded OK when I listened to it.) I gasped and asked how come she was lying flat on her back? So they (obstetrician and midwives) rolled her over on her side. She was wearing her shirt and her trousers off on one leg. On turning over she was lying in a puddle – her membranes had ruptured – but the attendant, when asked, didn't know when.

I later found out she had a normal delivery about two hours later.

They examine women rectally – less danger of infection than PVs, they told me. They have a 20% c/section rate and do routine episiotomies – 70% of women have episiotomies. As there is a national policy of one child families, all their women are primips, and most also have oxytocin infusions. They were very proud of their laser machine used to treat mutilated perineums!

Postnatally there were four women in each narrow room. They go home in six days.

I spoke to them (the obstetrician and about 12 midwives) afterwards. Told them about the difference between the medical model and the midwifery model of childbirth, demonstrated the positions women delivered in here – especially at home etc. etc.

Also told them the importance of joining ICM. China is not a member of ICM.

On my way home I contacted Ruth Wong in Hong Kong, Block 1B, 6th Floor, Julimont Garden, 8-12 Fukin Road, Taiwai, Shatin, Hong Kong (phone H. 699 3603, W. 766 6387). Ruth told me that she has been trying for some time to interest Chinese midwives in becoming ICM members. Taiwan and Hong Kong are members and the China Nurses Association are members of ICN – with their capitation subsidised by their Government. President of the China Nurses Association is Lin Ji Yin Ph D (USA). She lives in Beijing and was at the ICM Congress in Kobe as a guest of the Japanese nurse-midwives.

calorie intake imposed by the Japanese.[16]

Today's high intake of refined carbohydrate/junk food could be creating a similar condition. Further, deficiency of thiamine (and biotin) is closely related to adequate levels of Vitamin C.

VITAMIN C: A comprehensive review of SIDS in the Australian Nurses Journal, 1982, concludes that the principle underlying cause of SIDS is sub-clinical scurvy. "Sub-clinical scurvy in infants will in time demonstrate its very real presence when the baby begins to show some difficulty in breathing, experience(s) apneic episodes, shows signs of hypoxia, cardiac irregularities, a degree of larynxial spasm, a marked lack of resistance to mild infection, biotin and thiamine deficiencies, immunological depression, physiological shock and eventual death."[17]

This is based on the work of Dr Archie Kalokerinos (NSW), who found a high association between routine infant immunisations and SIDS. He also found that if the infant was supplemented with generous amounts of ascorbate (Vitamin C) the tendency towards illness was markedly reduced and deaths ceased to occur.

Kalokerinos told the 1977 First International Conference on Human Functioning, Wichita, Kansas, that "the immediate cause of SIDS is really an immunological one ... (and) that acute vitamin C deficiencies are due to two main causes – dietary deficiency and an increased need because of stress, injury or illness ...".

His colleague, Dr Glen Dettman told the Australasian College of Biomedical Scientists, NSW, that "in almost every sound hypothesis suggested by SIDS researchers, an acute ascorbate or vitamin C deficiency is the only known common factor which can be empirically demonstrated". (1978).

In response the 'establishment' closed its doors to Kalokerinos & Dettman, as it did many years previously to Dr Frederick Klenner of North Carolina when he concluded that SIDS was mainly due to acute infantile scurvy.

The Australian Nurses Journal says that SIDS is "really no longer a problem of Clinical Medicine, but definitely is one of Medical Politics" and quotes from Herbert Spencer that "mankind never tries the right remedy until it has exhausted every possible wrong one ...".

Zealanders. (Both the South Island and Tasmania have low selenium soil levels.)[10]

Further research by Christchurch veterinarian Cliff McGrouther on piglet survival in relation to selenium supplementation was followed by the work of Dr Barbara Dellamore, Christchurch School of Medicine, who pioneered the use of selenium and vitamin E for pregnant animals to prevent the deaths of their offspring.[10]

More recent research at Christchurch School of Medicine by Dr Christine Winterbourn has found that glutathione peroxidase (GIP) deficiency may be at the root of some New Zealand cot deaths. Normal GIP processes depend on adequate amounts of selenium and vitamin E. In the Christchurch neonatal unit Winterbourn found "some of the lowest levels (of GIP/selenium) ever recorded in humans".[10] Unfortunately, Winterbourn and Dellamore are unable to assess these levels in SIDS due to

- lack of funds;
- autopsies do not assess levels of selenium, GIP and vitamin E; and
- nutritional factors have not been included in the questionnaires completed by cot death parents.[10]

One Brazil nut a day or regular helpings of fish would solve the selenium problem, as would consumption of lamb's liver and brains.[15] Other foods are eggs, garlic, onions and kelp. Iron supplements used in pregnancy could compromise an infant where there is a selenium or vitamin E deficiency.[15]

Other Nutritional Factors

THIAMINE: Vitamin B1 is a primary catalyst. In the absence of thiamine the body cannot utilise oxygen or sugar. Prior to the Second World War and the Japanese occupation of Hong Kong, there was a high incidence of infant deaths at 3-4 months of age. The Japanese cut the rice ration drastically – and the SIDS incidence dropped dramatically, only to reappear when the Japanese left the colony. It was postulated that the high calorie white rice, deficient in Vitamin B1, created a low level of beriberi which deficiency was transferred to the breastfed infants. This deficiency was more dangerous than the low

As China is a very large country with numerous provinces, and as midwives are not yet organised, Ruth is of the opinion that they will have to organise through Chapters of the China Nurses Association.

I had already talked to the Hangzhou midwives about getting organised. Ruth is contacting Joan Walker, ICM Acting Secretary General to send the necessary information re ICM to Lin Ji Yin and to Zhou Li (a charge midwife at Hangzhou Hospital who is very interested) and to Wang Ming who is a nurse and was our main interpreter and is also the hospital political cadre.

Ruth will also directly contact Lin Ji Yin, Zhou Li and Wang Ming. I have already sent Zhou Li and Wang Ming the above information and am in the process of organising information on episiotomies and oxytocin infusion etc. to send back to China.

Zhou Li and Chang Yi May are very interested in getting organised. Wang Ming is the political cadre who can assist in the formation of a Chapter in Hangzhou.

Joan Donley

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August 1991

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BOOKS — Leader price in brackets. Does not apply to all books.

Breastfeeding

___	The Womanly Art Of Breastfeeding, *LLLI*, Bulk Rate: 5 for $80.00	$22.00 ($18.00)
___	Bestfeeding: Getting Breastfeeding Right For You, *Arms, Fisher & Renfrew*	$28.50
___	Breastfeeding Matters, *Minchin*	$24.50 ($21.75)
___	Breastfeeding Your Baby, *Kitzinger*	$28.00
___	The Politics Of Breastfeeding, *Palmer*	$24.50
___	Working Woman's Guide To Breastfeeding, *Dana & Price*	$21.00

Tyler subscribes to numerous causes of SIDS which he calls the N.E.S.T. (Non-Disease Environmental Stress Trauma) as opposed to what he calls the "lethal Cot-Death syndrome hoax".

Enzyme Deficiency

Since babies have been put to sleep on their tummies since time immemorial, why do so many babies sleeping on their tummies today, succumb?

According to Jacqueline Steincamp, Christchurch, worldwide research points to enzyme deficiencies often of an hereditary nature, and thought to be related to deficiencies in diet and minerals in the soil.[10]

The Malignant Hyperpyrexia (MH) referred to earlier is due to deficiency of an enzyme, IP3 phosphotase, which allows a buildup of calcium ions causing muscular spasm resulting in heat stroke and death. This can also cause anaesthetic deaths.[11]

More recently, L Becker and E Cutz of the University of Toronto say that in the multi-step process of SIDS, the slow development of an area of the brain that regulates breathing is the first thing to go wrong. Slow development leads to chronic shortage of oxygen in the blood which further delays brain growth. These babies appear to suffer from underdeveloped chemoreceptors that monitor oxygen levels and regulate the heart and lungs.[12]

Perrin (Toronto) believed there was an intrinsic abnormality in the neurosecretory cells. This is supported by the finding of decreased levels of dopomine-beta-hydroxylase (DBH) in the carotid bodies of 18 SIDS brain stems. This enzyme is copper-dependent and apparently uses ascorbate in its reactions with molecular oxygen.[13]

Copper in the form of two cuproenzymes – cytochrome c oxidase and caeruloplasmin (CP) – is also needed to free stored hepatic iron for attachment to transferrin. CP is low in the human foetus rising to a plateau by six months.[14]

Donald Money, Wallaceville Animal Research Centre, in a study of 250 New Zealand and Australian (Christchurch & Hobart), SIDS, 1978, found excessive iron storage in the SIDS livers indicating either an excessive iron intake or a defect in iron mobilisation and possibly in the synthesis of haem.[14] This was followed by a Dunedin research by Dr Marion Robinson which documented low selenium levels in New

In former times babies slept on mattresses filled with husks supplied free by the Northern Roller mills.[6]

The inhalation of toxic gases is the basis of Dr Jim Sprott's theory for the increase in cot deaths. Sprott is a New Zealand-retired industrial chemist and forensic researcher now living in Vancouver, BC Canada. He claims that it is the New Zealand housewife's preference for detergents and fabric softeners that may underlie this country's high cot death rate.

Synthetic detergents such as salts of dodecylbenzene sulphonic acid formulated with foam stabilisers are usually based on long chain substituted amindes. Fabric softeners contain "quaternary ammonium" compounds.

Sprott suggests that in some cases SIDS babies have been overcome by a lethal gas generated in their clothing and bedding. Possible gases are hydrogen cyanide or alkyl cyanide, cyanogen and mono- and di- or tri-chloraine, and chloroform. He feels that the most likely gas is hydrogen cyanide (HCN) generated either as such or from cyanogen (C2N). This is extremely poisonous and readily absorbed by breathing or by absorption through the skin, causing babies to stop breathing. A baby's high metabolic rate makes it especially susceptible to even trace amounts of toxic gas which is further increased by the baby's "foetal blood" which does not have as high an oxygen-carrying capacity as does adult blood.[7]

Three New Zealand 'medical authorities' predictably 'dismissed' Sprott's theories. However, as far back as 1967 the US Medical Tribune reported that in St Louis, nappies rinsed in the hospital laundry with an anti-mildew agent, sodium pentachlorophenol had caused two baby deaths and seven to become seriously ill with high fevers, laboured breathing, tachycardia, irritability and liver changes followed by extreme lethargy.[8]

Biochemist Jim Tyler also believes that one of the keys to the cot death mystery is inhalation of toxic gas. He targets ammonia gas which causes respiratory arrest through pulmonary oedema and damage to the lung capillary and alveolus membrane. Urea, excreted in the urine, is inherently unstable, and easily converted into ammonia through action of faeces sealed in by the plastic pressure of disposable nappies. Like Sprott, Tyler also believes that the nitrosamines and chloromine released when bleach (sodium hypochlorite or percarbonate) react with urine and faeces produce toxic gases.[9]

answer".[1] Some studies have correlated prone sleeping with a tightly wrapped baby snugly tucked down causing it to become overheated (hyperthermia). It can then develop heat stroke with profound disturbances of consciousness, convulsions and coma, possibly 'malignant hyperpyrexia' (MH), although this condition is associated with an enzyme deficiency.

A baby's metabolic rate rises rapidly after the first two weeks of life so that heat production per surface area is high by the age of two months. Further, the ability to sweat develops only slowly to one year of age.[2] When a baby is prone, heat loss from the face is impaired, neither can it sweat from its face in this position.

However, there is more to hyperthermia than the prone position. Babies dressed in and covered by insulating synthetic materials are more likely to conserve heat than those dressed in/covered by cottons or woollens. Although the Department of Health denied that there was a link between man-made fibres and SIDS[3] the 1990 publication distributed by the Department now says: "Too much clothing or bedding, especially if synthetic, makes it hard for a baby to lose heat if she gets too hot ... REDUCE RISKS OF COLD AND OVERHEATING BY ... using light, woollen and cotton, clothing and bedding where possible."

Prone Position and Poisonous Gases

Prone, sleeping babies with their faces buried in their bedding are more likely to inhale toxic fumes than those whose faces are exposed. A number of sources of toxic fumes have been implicated.

It has been postulated that the chemicals used to fireproof PVC cot mattresses give off a toxic gas responsible for SIDS. The Chief Medical Officer, Sir Donald Acheson, says there is no evidence to support this theory.[4] The UK Government, on the other hand, called for an inquiry into synthetic PVC-covered mattresses following the finding of the fungus Scopulariopsis brevicaulis in 50 PVC-covered mattresses taken from the cots of SIDS victims.

This fungus feeds on the chemicals used for fireproofing PVC, producing exceedingly poisonous compounds of arsenic, phosphorus and antimony which are several hundred times more toxic than carbon monoxide. Being heavier than air, the fumes tend to linger near the fabric – where a prone baby would be especially likely to inhale a lethal dose.[5]

Study supports breast self examination

A breast cancer screening programme involving 33,000 women has provided new evidence pointing to the benefits of self examination.

The seven-year study found that the number of deaths from breast cancer could be reduced by nearly 20 per cent if women take time to examine themselves on a regular basis.

Opponents of self examination have argued it is not a very effective method of detecting cancer and could give women a false sense of security.

But Dr John Phillip, clinical director of the Pennine Breast Screening Assessment Clinic, and the doctor in charge of the Huddersfield-based research, announced last month that the study showed self examination should be complementary to mammography.

In the study 33,000 women were given detailed instruction on self examination. After seven years, 91 women had died from the disease, compared with a national average which would anticipate 112 deaths - a difference of 18.75 per cent.

N2 Doctor
Oct 91

Nappy specimens

Disposable diapers are just as good for collecting urine specimens as the sterile bags normally used, British doctors have found.

Doctors from Royal Victoria Infirmary in Newcastle upon Tyne said that urine squeezed out of wet disposable nappies was just as reliable a specimen as urine collected in the sterile bags, as long as the diapers had not been worn more than four hours and were not soiled with faeces.

But they said the highly absorbent brands, which contain gel beads, do not work.

They noted that this method is particularly useful for GPs, since the specimen usually arrives with the patient.

Better pap smears

US researchers have developed a new method of collecting and analysing pap smears that improves the test's accuracy by as much as 24 per cent, according to new studies.

The new process, called ThinPrep and manufactured by Cytyc Corp, is designed to make the collection of a cervical sample and its analysis easier, consistent and more accurate.

In a study financed by Cytyc and conducted by the New England Medical Centre, 449 samples were collected both with the ThinPrep method and by conventional means. Researchers said the ThinPrep system produced 24 per cent more slides suitable for analysis.

Under the new technique a doctor gathers a sample with a soft, brush-like device and rinses it into a small vial containing a preservative. In a fully automated lab process the sample is separated, under a microscope and ana-
lysed by computer

Frozen eggs raise ire

A technique developed by Australian scientists may allow women to freeze their ova when young and conceive children into their 50s, raising the prospect of young career women delaying birth until later in life. The technique, developed primarily to help conception in women made infertile by disease, has raised the ire of some feminists and anti-abortion campaigners.

Researchers at Melbourne's Royal Women's Hospital said last month they had applied to the state government of Victoria for permission to thaw frozen human ova and test their viability.

The new in vitro fertilisation method allows an ovum to be frozen for an indefinite time, and implanted into a woman in later years or when she develops medical complications, such as cancer, that would prevent her from conceiving naturally.

"This would benefit those women who are at risk of sterility through the treatment of leukaemia and cancer," said Dr John McBain, leader of the hospital's in vitro research unit.

He said his group had successfully frozen and thawed human ova for three years. They now wanted to fertilise the thawed ova with sperm, and experiment with the resulting embryos over a 22 hour period to ensure their genetic structure had not been damaged in the process.

Anti-abortionists say the technique would allow "egg banks" to be created for young professional women who wanted to postpone pregnancies.

"What possible advantage could there be in deliberately choosing to have children in your 50s?" said Margaret Tighe of the Right to Life Association.

Dr McBain said that legislators would probably disallow its application in women over 50.

NZ DOCTOR OCT 91,

Local child care methods 'useful in cot death fight'

By SUSAN FURLONG

TRADITIONAL Hongkong child care practices may offer a model for Western countries in their fight against sudden infant death syndrome, a New Zealand expert suggested yesterday.

Professor Tanya Gunn, of the University of Auckland, said a three-year study of cot deaths in New Zealand underscored the value of certain practices common in Hongkong such as putting babies to sleep on their sides or backs.

Sixty-four per cent of cot deaths covered by the New Zealand study occurred after babies were put to bed on their stomachs.

Until recently, Western doctors had recommended babies sleep in a prone position to avoid the risk of choking if they vomited, Professor Gunn said.

In Hongkong, however, parents generally avoided laying infants on their stomachs for fear of suffocating them, according to an article in the Hongkong Journal of Paediatrics.

"After the study, it appears we are recommending traditional Chinese things," Professor Gunn said.

Sudden infant death syndrome (SIDS), or cot death, cannot be fully explained by *post mortem* examinations.

In most Western countries, SIDS claims the lives of two babies in 1,000, but a Hongkong survey in 1987 found that only 29 infants in 100,000 suffered cot death.

During her stay in the territory, Professor Gunn hopes to consult local doctors and examine popular child care methods to better understand the reasons for the rarity of cot death in Hongkong.

Pediatricians have speculated that the territory's cramped living conditions may be one important reason for the low rate of the problem.

Many infants have cribs in their parents' bedroom, where noises may provide "breathing cues".

Professor Gunn said babies should not actually sleep in their parents' bed.

"We found that sleeping with the mother doubled the risk of cot death," Professor Gunn said. "Babies should sleep in a bassinet beside the mother's bed."

She was invited to Hongkong by the Royal Regiment of Wales, whose members have suffered three cot deaths in the past five years.

There are only 350 families in the battalion, which is stationed at Stanley Fort and about 600 children. In such a small sample, three cot deaths were unusual, Professor Gunn said.

Although the reasons were unclear, families of soldiers had been identified as a high risk group, she said.

Meanwhile, members of the Royal Regiment of Wales have decided to fight back.

They are staging a fair at Stanley Fort tomorrow to raise money for the UK-based Foundation for the Study of Infant Deaths.

SUDDEN INFANT DEATH SYNDROME (S.I.D.S.)

REVIEW

J Donley
July 1991

Sudden Infant Death Syndrome is one of the biggest killers of babies in New Zealand. Two-thirds (62%) of all infant deaths between one month and one year are cot deaths. This gives New Zealand one of the highest cot death rates in the western world while our post-neonatal death rate is nearly double that of any other developed country, and this has not improved in 20 years.

The incidence of SIDS is highest in the 1 to 5 month age group and is higher in the South Island – 7 per 100 births – compared to 4/1000 overall. Maoris have twice the incidence of SIDS as do Europeans.

A New Zealand Cot Death Study funded by the Medical Research Council spanning three years (October 1987 – October 1990) researched 128 cot deaths in Auckland, Hamilton, Rotorua, Napier, Hutt, Wellington, Christchurch, Dunedin and Invercargill.

This identified three major risk factors classified as 'odd ratio' or 'increased risk factor':

- prone sleeping – odds ratio – 3.53
- maternal smoking – odds ratio – 1.87 for 1–9 per day
  – 2.64 for 10-19 per day
  – 5.06 for 20+ per day
- not breastfeeding – odds ratio – 2.93

Outside of breastfeeding, this study did not research any environmental or nutritional factors either antenatally or postnatally, although the 'Cot Death' brochure prepared by the Canterbury Cot Death Society in consultation with medical experts and distributed by the Department of Health says "there is no known cause ... no factor stands alone as a possible cause".

While prone sleeping is given the highest ratio, Dr Shirley Tonkin of the Cot Death Division of the National Children's Health Research Foundation, Auckland, says "stomach sleeping alone cannot be the

advice on avoiding listeria infection

Health
Vol 40 no 16
Winter 1991

The Department of Health has for some time been concerned about the risk of listeriosis to some people, and took the opportunity of increased public attention following a recent outbreak of cases in the Wellington area to promote positive health education about the disease. Its approach to doing this was three faceted.

Firstly, it advised pregnant women, the elderly and those whose immune system is not functioning well because of other illness or medication to avoid pre-prepared chilled foods.

Secondly, it organised a major meeting with representatives of the food industry to discuss what steps it can take to prevent listeria infection through better education and food handling practices.

Thirdly, it advised the general public to take greater care with the preparation and storage of foods in the home.

Listeria is a common bacterium which can grow in raw or cooked foods if they are chilled and kept after cooking. "Listeriosis is not new," says Len Weldon, the Department's spokesperson on food quality and hygiene. "It is a disease which has always been with us. However as more research is done on it internationally and with greater use of pre-prepared chilled foods, the Department of Health is taking further steps to increase education about the disease and minimise the risks of infection."

Listeriosis can result in miscarriage, stillbirth or infant death. There have been six cases of perinatal listeriosis in Wellington this year resulting in four foetal deaths.

"While this is obviously of great concern, it is not part of a nationwide trend. There have been 12 cases of listeriosis reported so far this year in New Zealand, compared with 14 for the same period last year," said Mr Weldon.

Listeriosis is a notifiable disease, and although it is relatively rare in New Zealand, it has a serious outcome for at risk groups when it does occur. The risk is greatest when ready to eat chilled foods are stored for long periods or where safe food practices are neglected. Keeping foods in the refrigerator does not protect against listeriosis because it can grow at low temperatures.

"The best way for those groups of people who are at risk, such as pregnant women, to protect against listeria infection is to be careful about which foods they eat," said Mr Weldon.

"Thorough cooking destroys listeria, and all canned foods, dry goods and freshly cooked foods are safe. If food is heated in the microwave, it is important that it be cooked right through and left to stand for the required time."

However, he advises that those at risk from listeriosis eat only freshly cooked or freshly prepared foods, and avoid the foods which carry a higher chance of containing listeria bacteria. These may include some pre-prepared meat, fish, salads and dessert products.

Unpasteurised milk may pose a problem but pasteurisation kills listeria. Dairy products on sale in New Zealand are quite safe because they are always made from pasteurised milk, said Mr Weldon.

Listeriosis does not normally affect healthy adults. The only symptoms they may feel would be similar to a mild dose of the 'flu. It is treatable, and if people have any reason to suspect that they may have listeria infection the Department advises them to go to their doctor.

DOMICILIARY MIDWIVES SOCIETY OF N.Z.

NOTICE OF MEETING

8/11/91

URGENT URGENT URGENT

The Domiciliary Midwives November Meeting at Riverside will be held on:

6th, 7th, 8th December 1991

The Meeting begins at 5.00pm on 6th Dec at Riverside Community.

7th Dec, Saturday Highlight: KAREN GUILLILAND, President, College of Midwives.

Meeting concludes at 4.00pm Sunday 8th Dec.

Accommodation at Riverside needs to be booked. Confirm your place (and pick up from the airport) by phoning BRONWEN PELVIN on (03) 526 8722

Domiciliary Midwives meetings will be held twice a year, before each Home Birth Conference in May and at Riverside in November. - To give us an opportunity to talk and share about the special features of Home Birth. Politically, the College of Midwives is our arm & voice, and the C.O.M. Newsletter our way of communicating. Therefore we will not be producing our own Domiciliary Midwives Newsletter. Our communication will be via the C.O.M.

*** * SPREAD THE WORD * ***

*** * TELL ALL THE HOMEBIRTH MIDWIVES YOU KNOW * ***

Signed: Bronwen Pelvin
& Sian Burgess.