use should be considered when dealing with animal products. One firm concerned with bone meal production is already considering this.

Mr. M. Ellis (10 February, p. 354) is, I think, a little harsh in his criticism of my paper. Failure to mention the use of Sclavo's serum was certainly an omission, but on the other hand medical readers would surely know that hides and other animal products are potential sources of anthrax infection. My article was one of a series on "A New Look at Infectious Diseases" and it was not meant to be a comprehensive account of anthrax, which can always be found by consulting a standard textbook of medicine. Rather was it meant to look at anthrax infection today in the light of prevention among workers exposed to infection, recognition of the accidental infection where there is no history suggestive of exposure, and, of course, effective chemotherapy. I am grateful, however, to Mr. Ellis for his comments.—I am, etc.,

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1 Anderson, E. S., et al., *The Times*, 24 January 1973, p. 17.

Puerperal Thromboembolic Disease

SIR,—Mr. Peter Jackson (3 February, p. 263) found a low incidence of ^{125}I -detected deep vein thrombosis in a group of puerperal patients considered to be at high risk. His study included 36 patients who were delivered by caesarean section and these patients all had normal isotope scans with no evidence of deep vein thrombosis. This was in keeping with the findings of Friend and Kakkar,¹ whose study included 20 patients delivered by caesarean section, all with negative scans. A similar study carried out at this hospital included 33 patients, 20 of whom were delivered by caesarean section and 13 with forceps. There was only one case of ^{125}I -detected deep vein thrombosis; this patient had a history of two previous deep vein thromboses and there was a positive scan in one femoral region after delivery by caesarean section. This low incidence of deep vein thrombosis is in contrast with the incidence of 30% in patients over the age of 40 having surgical operations.²

In our study patients were found to develop relatively high counts over the breasts when these became engorged with milk and it was confirmed when milk was expressed that it contained ^{125}I . It was also noted that although one of the usual regimens of prophylactic iodine (85 mg of sodium iodide given intravenously 30 minutes before the dose of ^{125}I -labelled fibrinogen, followed by 60 mg of potassium iodide three times daily by mouth) was prescribed to protect the thyroid gland against uptake of ^{125}I , the counts taken over the neck gradually rose and by the seventh day were usually higher than the precordial count.

We agree that the ^{125}I -labelled fibrinogen test cannot be recommended for routine screening in the puerperium because of the low incidence of leg vein thrombosis, but it can be used to confirm or exclude a suspected thrombosis. Mr. Jackson refers to the use of the Doppler ultrasound device in detecting pelvic vein thrombosis. In our ex-

perience this tends to be unsatisfactory in the puerperium and is of value only in examining flow in the external iliac veins.—I am, etc.,

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- 1 Friend, J. R., and Kakkar, V. V., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1970, 77, 820.
- 2 Flanc, C., Kakkar, V. V., and Clarke, M. B., *British Journal of Surgery*, 1968, 55, 742.

Hazard of Ultrasonic Detection of Deep Vein Thrombosis

SIR,—Drs. J. N. Brown and A. Polak (13 January, p. 108) and Mr. D. W. Bracey (17 February, p. 420) indicate the potential danger of pulmonary embolism while squeezing the leg for the ultrasonic detection of deep venous thrombosis. We recently attempted the removal of an isolated femoral thrombus from a 22-year-old woman. After the femoral vein had been opened the calf was firmly squeezed, resulting in the rapid expulsion of a 10-cm thrombus from the distal end of the femoral vein.

We now use observation and gentle palpation for the routine clinical examination of limbs for deep venous thrombosis; squeezing and Homan's manoeuvre to elicit pain are not carried out.—We are, etc.,

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Intestinal Pseudo-obstruction

SIR,—In your interesting leading article (13 January, p. 64) no mention was made of a type of intestinal pseudo-obstruction which we believe to be a clinical entity—namely, that associated with respiratory disease and aerophagy. We have both encountered several examples of this. Initial management in hospital with enemas (in particular Veripaque, containing oxyphenisatin) has often been successful and a reassuring barium-enema examination may then be performed. If, however, the colon has distended past the point of no return and bowel sounds have ceased, with resulting "hinge-kink" obstruction at the flexures, operative decompression is essential either by caecostomy or transverse colostomy.—We are, etc.,

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Obstetric Prevention of Mental Retardation

SIR,—I enjoyed reading the excellent article by Professor Philip Rhodes (17 February, p. 399), which high-lighted the factors which influence both physical and mental retardation in pregnancy, but I would like to add a brief comment about the significance of labour asphyxia, a contributing factor to mental retardation. Special attention should be focused on the dangers of prolonged labour, particularly if this is permitted where the fetal development is already known to be retarded from uteroplacental insufficiency

during the pregnancy—or if prolonged labour follows a postmature pregnancy.

Professor Rhodes has rightly emphasized the value of pregnancy monitoring. Permit me, therefore, to make a further plea for carefully controlled monitoring in labour, and all that monitoring implies—namely, the demise of domestic midwifery, better equipped obstetric departments, and doctors and midwives who are well trained in the monitoring techniques. Some patients are categorized as being "high risks," and the reasons for this are well understood; but every patient should be so labelled, and every labour should be scientifically monitored.—I am, etc.,

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SIR,—As one of our research interests is the association between obstetric complications and mental retardation and as we also have responsibility for teaching medical students about the organization and delivery of medical care, we would welcome an opportunity to comment on the article by Professor Philip Rhodes (17 February, p. 399). The article, while leaning heavily on numerical evidence to make its point, ignores many of the fundamental principles used in the interpretation of population data. The following are some examples of this.

Selection of Data.—Recent evidence from many sources that there is little or no association between mental retardation and obstetric phenomena is ignored. To quote one example from many, Barker¹ identified 607 children with subnormal intelligence from a population of 73,687 singletons for whom obstetric data had been recorded, and concluded that "recognized complications of pregnancy and labour play little part in the aetiology of low intelligence."

Clarity of Definition.—The terms mental subnormality, mental retardation, and mental backwardness are used interchangeably throughout the paper and without definition. Even assuming that there is an association between mental backwardness and light-for-dates, this would not necessarily mean that there is an association between mental subnormality and light-for-dates. Furthermore, the implications to society of mental backwardness are very different from those of mental subnormality.

The unpublished retrospective survey quoted by Professor Rhodes of 120 light-for-dates babies with no control group cannot be accepted even as evidence of an association between immaturity and subsequent mental development, and certainly not as evidence of causality. If light-for-dates and mental backwardness are both found to be associated with primary fetal abnormality, then obstetric intervention in the third trimester will not alter outcome. The reported absence of mental retardation in 50 light-for-dates babies is unconvincing evidence of the effectiveness of high-intensity screening. The effectiveness of this procedure can be judged only by a randomized comparative trial, the results of which would certainly not be assessed as early as 12 months.

Regional differences in the distribution of "central nervous system anomalies," cerebral birth trauma, maternity hospital beds, social class, and urban/rural obstetric accident rates are all utilized to develop the hypo-