to be emphasized that topical application of steroid preparations to the skin lesions of herpes zoster is not only useless, but could be quite harmful.

Dr. Pearce stated that he knew of no double-blind controlled trials on the effects of corticosteroids in acute zoster, but in fact such a trial was conducted by Eaglstein *et al.*³ in the U.S.A. Unfortunately they only included 34 patients, of whom 19 were controls and 15 treated, and only 24 out of the 34 were over the age of 59. I should think most people will agree that there is no case for giving steroids to patients under the age of 60 years. Nevertheless, Eaglstein and his colleagues found that in the over-sixties 73% of the control group had postherpetic neuralgia (which they define as pain which has persisted for more than two months from the onset), while in the treated group only 30% developed postherpetic neuralgia.

I think, therefore, that there is a good *prima facie* case for a large-scale double-blind controlled trial as suggested by Dr. Pearce.—I am, etc.,

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¹ Elliott, F. A., *Lancet*, 1964, 2, 610.

² Gold, S. C., *Practitioner*, 1972, 209, 204.

³ Eaglstein, W. H., Katz, R., and Brown, J. A., *Journal of the American Medical Association*, 1970, 211, 1681.

Sedation in Pregnancy

SIR,—Your leading article "Neonatal Behaviour and Maternal Barbiturates" (14 October, p. 63) and Professor Philip Rhodes's recent address on the obstetric prevention of mental retardation (17 February, p. 399) make it plain that in the present state of knowledge central nervous system depressants should not be administered to women at any stage of pregnancy except when absolutely indicated. In current obstetric practice the most frequent and prolonged use of sedation is in the treatment of pregnancy hypertension, where it is believed to augment the effect of bed rest in hospital in providing the "absolute mental and physical rest" these patients are thought to require. If this usage of sedation could be minimized, many fetuses would be spared the potential loss of cerebral capacity that they are at present being exposed to.

That it can be minimized was strongly suggested by the results of the Sheppey experiment,¹ in which admissions for toxæmia were reduced by some 70% and sedatives were eschewed even in severe cases. Bringing these results up to date, the 286 cases of pregnancy hypertension seen up to the end of 1972 were treated with one maternal loss from accidental haemorrhage, caesarean section, and chronic cardiomyopathy; two instances of eclampsia (one antenatal before referral to the hospital, the other 10 hours postnatal after a normotensive pregnancy); and eight perinatal deaths, including three from obstetric accidents during labour and one from congenital malformations incompatible with life. Such overall results could hardly have been obtained if bed rest and sedation were as important in the management of toxæmia as has so often been claimed.

In addition to the potential dangers of sedation for the baby and the doubts that

must now exist regarding its necessity in the management of toxæmia, the positive advantages of a policy of non-sedation should also be considered. Only the un-sedated mother can give the obstetrician a useful account of her own symptoms and the activity of the baby. Modern writers seldom even mention symptoms in their communications on allegedly severe toxæmia but their prognostic value was fully appreciated by established authorities such as Theobald,² who stated unequivocally that they are a better index of the likelihood of eclampsia supervening than the degree of hypertension or albuminuria. Certainly, the only common factor in the two cases of eclampsia mentioned above was that both were preceded by intense and increasing headache.

Has not the time come for the toxæmias of pregnancy to be rescued, like the temples of Philae, from the sea of sedation that has buried them for so long.—I am, etc.,

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¹ Matthews, D. D., Patel, I. R., and Sengupta, S. M., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1971, 78, 610.

² Theobald, G. W., *Pregnancy Toxæmias*, p. 236. London, Kimpton, 1955.

The Placenta—An Environmental Problem

SIR,—Dr. D. I. Rushton states in his recent review (10 February, p. 344) that primary placental insufficiency is probably not a pathological entity and that correlation between placental function and pathology is frequently very limited. While I agree wholeheartedly with the first half of this statement, I find it difficult to accept that the latter is true.

In a recent publication Miss J. M. Jordan and I¹ have shown an 88% correlation between morphological study of the placenta and paediatric assessment of the baby, the placentas being examined blind without foreknowledge of the mother's or baby's condition apart from the expected date of delivery. We were also able to show that the degree of placental insufficiency (measured by a simple scoring system) could be correlated with blood sugar levels in the baby except in some cases of postmaturity.

Up till now the main drawback in pathological examination of the placenta has been the tendency to lay too much stress on the individual lesions without consideration of the placenta as a whole and the extent to which pathology interferes with function. Examination of the cord and membranes has also been largely ignored. Such factors have all been included in the new scoring system, which is graded as follows: normal, less than 10; borderline 10-14; and placental insufficiency 15 or more. Many cases giving a high score on naked-eye examination can be diagnosed in the labour room and need not await pathological examination.

This is an obvious advantage to the paediatrician, but reviewing the problem purely from the angle of the obstetrician Dr. Rushton states that morphological studies are mainly of academic interest and contribute in no way to the obstetric management of individual pregnancies. While this is true, we feel that by delineating the problem more clearly and assessing to what extent failure of placental growth, patho-

logical change in the placenta, or both play a part one may eventually be able to recognize types of placental insufficiency which are liable to recur.—I am, etc.,

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¹ Scott, J. M., and Jordan, J. M., *American Journal of Obstetrics and Gynecology*, 1972, 113, 823.

Non-pharmacological Influences on Therapeutic Efficacy

SIR,—I cannot help thinking that the letter by my old friend Dr. A. Káldor and his colleagues (10 February, p. 352) has been written with their tongues in their cheeks. They tell us that the sphygmomanometer when applied to the arms of hypertensive patients who are taking hypotensive drugs is not affected by "fibs" that the doctor tells his patients. Great news, indeed, but telling fibs bears no relationship, as claimed, to "interactions between doctor and patient" or "the therapeutic efficacy of the doctor's attitude."

What is meant by the doctor's attitude to his patient (which indeed does affect and influence patients both emotionally and somatically; references on request) has been explained at great length by Dr. Káldor's former fellowcountryman, the late Dr. Michael Balint, in his book *The Doctor, His Patient and the Illness*. If Dr. Káldor and his colleagues really want to assess the influence of the doctor and his attitude on the effects of hypotensive drugs, I would recommend that they form two groups of patients. One group should be treated like the patients mentioned in Dr. Káldor's letter, it being immaterial whether or not they are being told fibs about the variation of their blood pressure. A second group should be treated by a doctor evidently interested in his patients as human beings, in that each patient would be permitted to talk freely about his personal and emotional problems (in private) and be "listened" to (in the sense in which this word has been used by Balint) and then the state of their physical and emotional health determined by something more than just the rise or fall of the sphygmomanometer.

Then, and only then, will clinical pharmacologists be able to determine whether the attitude of the doctor affects drug action. Incidentally, the experiment would also throw light on the meaning, genesis, and appropriate treatment of raised blood pressure and its concomitant symptoms and signs.—I am, etc.,

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¹ Balint, M., *The Doctor, His Patient and the Illness*. New York, International Universities Press, 1964.

Results of Renal Transplantation

SIR,—We read with great interest the article by Mr. P. R. F. Bell and others (18 November, p. 408) reporting their experience of renal transplantation in 33 patients in Glasgow and were impressed by the survival figures, which represented a dramatic improvement on most published results. We are concerned that their graft survival figures of 85% at one year and 82% at two years