

thyroiditis is common (7-8% of palpable goitres in our material) and a considerable number of these cases will turn up within some years with manifest myxoedema and often advanced coronary disease if not previously treated with thyroxine in the thyroiditic phase of the disease.

Fine needle biopsy may be valuable in the diagnosis of thyroid cancer but it is indispensable for the diagnosis of thyroiditis and thus for the prevention of myxoedema. It is a simple and innocuous method—but it is, of course, possible to manage thyroid disease also without it.—I am, etc.,

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SIR,—With trepidation a physician joins the argument about the radical treatment of the histologically—but not clinically—malignant thyroid nodule by total thyroidectomy. Histological malignancy in the thyroid nodule, as in the prostate, cannot have the same implication of biological malignancy as in other sites: witness the small number of patients dying from thyroid cancer. Radical thyroid surgery will create some hypoparathyroidism and damage to laryngeal innervation. The damage is likely to involve more patients than will be benefited.—I am, etc.,

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#### False Interpretation of Fetal Heart Monitoring

SIR,—In reply to Professor R. W. Beard's letter (17 November, p. 420) concerning the false interpretation of fetal heart records we should like to present a case in which fetal monitoring was in use during an intra-partum death.

An unmarried 17-year-old primigravida was admitted at 34 weeks' gestation with abruptio placentae. The fetus was presenting by the breech. Low amniotomy was performed and an electrode applied to the fetal buttock. The fetal heart rate at this stage was 140/min., but after some episodes of bradycardia it became unreadable on the monitor (see fig.) and inaudible with the Pinard stethoscope and a Sonicaid D205 ultrasonic detector. Gain adjustment on the fetal heart monitor to its maximum value produced a regular reading of 60/min., which did not appear to correlate with the

maternal pulse. Thinking there might be a chance that the baby was still alive the patient was prepared for immediate caesarean section. A few minutes later in the operating theatre there was no evidence of fetal life with either ultra-sound or the electrode (viewing the signal with an oscilloscope). The patient was allowed to continue in labour, and five hours later a fresh stillborn baby was delivered vaginally. The placenta was grossly infarcted and there was evidence of recent separation.

The monitor used is built to our own design and incorporates two features which make false interpretation unlikely—namely, manual gain control and direct audio presentation of the fetal E.C.G. We were therefore able to recognize that the signal had degenerated (point A) and that the 60/min. tracing was not a true fetal heart record but either maternal-derived or a spurious oscillation. We conclude that fetal E.C.G. activity ceased shortly after point A. Machines such as the Hewlett-Packard, with automatic gain control, would indeed have switched from the fetal E.C.G. to the smaller signal without being noticed by the obstetrician. One of us (R.J.P.) has a further tracing showing the same pattern of replacement of the fetal heart signal by a low-frequency oscillation with eventual still-birth delivery, but not being present cannot verify that the events occurred as reported above.—We are, etc.,

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#### Confidentiality

SIR,—Anyone who believes in the confidentiality of patients' records, hospital or otherwise, is out of touch with reality. For example, in this area, as no doubt in most, general practitioners' requests for consultations are made on letter forms with a gummed margin. The clinical details are sealed inside and only the patient's name, address, etc., is open for inspection. Over the years I have, on occasion, presented these forms personally at various hospitals in this area. At first I was startled at the non-chalance with which the ladies behind the counters tore open the forms and studied the contents. It was explained to me, and I now accept, that this is necessary for administrative reasons. Some of your readers might disagree. On those occasions when the clinical details are particularly confidential I attach a note to the form saying: "To be

opened only by Dr. X or his immediate deputy." I have never presented such a note personally but have no doubt that such a request is respected.

Even so there is no certainty of avoiding a breach of confidence. After one such referral the patient later chided me for describing her in my letter as "rather odd." She admitted having read my letter in the consultant's office. Patients not infrequently report that their hospital records have been "lost." This usually means temporarily mislaid but leaves scope for breach of confidence. Similar comments could be made on the handling of general practitioners' records. To err is human.—I am, etc.,

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#### Screening for Phenylketonuria

SIR,—We are concerned with the many severely subnormal persons whose condition is of unestablished aetiology.<sup>1</sup> To this end we suggest that consideration should be given to screening pregnant primiparous women with the Guthrie test<sup>2</sup> rather than screening all infants for phenylketonuria.

Whatever the eventual situation with reference to variants of phenylketonuria it appears that women with an elevated level of serum phenylalanine are at risk for having retarded children.<sup>3</sup> Stern<sup>4</sup> says: "There is probably no absolutely safe level because of the multifactorial nature of the problem. There may be slight risk even to the child of a heterozygous mother because the placenta concentrates phenylalanine." A further complication may arise in the child of a heterozygous mother; not only will the phenylalanine be concentrated but the child's own enzymes may be deficient.

By screening the mother's blood for phenylalanine when blood is taken for W. R., grouping, et cetera attention will be focused on the heterozygote and homozygous mother and appropriate steps taken for those at risk even if the child is eventually shown not to have classical phenylketonuria. An awareness of this state may have obstetric advantages since Saugstad<sup>5</sup> found an increase of perinatal problems (abnormal pregnancy, difficult labour, and neonatal asphyxia) in phenylketonuric infants and also felt that the heterozygous state of the mother could contribute to early problems.

For those to whom economic considerations are of prime importance, there is the added advantage that once a woman is found to be normal (as far as phenylalanine is concerned) there will be no need to test her again or to screen any of her subsequent offspring.—We are, etc.,

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- 1 Crome, L., in *The Brain in Unclassified Mental Retardation*, ed. J. B. Cavanagh, p. 169. Edinburgh, Churchill Livingstone, 1972.
- 2 Guthrie, R., and Susi, A., *Pediatrics*, 1963, **32**, 338.
- 3 Wallsman, H. A., in *Proceedings of the International Symposium on Phenylketonuria and Allied Disorders*, Washington, U.S. Department of Health Education and Welfare, 1969.
- 4 Stern, J., in *The Brain in Unclassified Mental Retardation*, ed. J. B. Cavanagh, p. 42. Edinburgh, Churchill Livingstone, 1972.
- 5 Saugstad, L. F., *Lancet*, 1972, **1**, 809.

