be used in 1968." The answer is already published[2 3] (with references): the vaccine is "once again highly effective, as it was in the 1950s against the then-prevalent strains." The decline of the 1950s followed the initial introduction of vaccine,[4] acceptance of which neared its peak by 1957. Eradication seemed imminent. Then serotype 1,3 emerged in the 1960s: his own graphs[1] show how the decline decreased—until the vaccine was modified.

Thus, far from despising notifications or being in conflict with Colindale, I support Dr N D Noah's view (17 January, p 128) that "notifications . . . reflect trends in the incidence of *Bordetella pertussis* infection." But they are unreliable for evaluating vaccine, as it is difficult to diagnose mild cases clinically. The data of Dr Christine L Miller and Mr W B Fletcher (17 January, p 117) suggest that the new vaccine is very effective against illness that can be diagnosed more accurately—either severe cases or hospital admissions. In these groups only 10% of their children aged 1-2 years had been vaccinated, although there would be about three times as many vaccinated as non-vaccinated at risk. This implies that current vaccine is more than 95% effective, a figure which agrees with my recent (unpublished) data. Also, Professor Stewart pays only lip-service to the "desirability of bacteriological confirmation." His claim[1] that "antigen 3 . . . did not . . . protect against . . . the prevailing serotype 1,3 in 1974" is substantiated by only four cases of type 1,3 infection—and no indication whether even these had received the new vaccine.

He accuses me of asking people to "accept the new vaccine as being non-toxic." On the contrary, I said[2] that "its safety is rightly being examined." However, I have never seen a vaccine-damaged child, though many severely ill with whooping cough and cultures from some of them post mortem. But those who have recorded possible vaccine-damage[5 6] admit that they cannot compare the risks of natural infection and vaccination; and even *World Medicine*[7] now talks of an "occasional —and possibly receding—hazard" with vaccine that "appears to be both good and safe." Mrs Rosemary Fox (21 February, p 458) still picks on pertussis vaccine as the culprit, though only 65% of her cases followed the use of triple vaccine. Moreover, she tells us nothing of the incidence of similar conditions in children who have not received *any* vaccine. Perhaps we should allow the Subcommittee on the Complications of Vaccination to study the problem as they think best.

Perhaps Professor Stewart may now follow his own advice and await parturition of *my* data.

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A place to be born

SIR,—Dr R Dingwall (14 February, p 396) has done well to remind your readers that the social aspects of childbirth can be the subject of systematic research, albeit in a mode somewhat different from that employed in clinical research. Too often statements relating to the social and psychological aspects are dismissed as "merely subjective," "just emotion," or matters of (pigheaded) opinion. As a sociologist, I believe that there may be more hazards in the way we handle childbirth than can be measured by perinatal and maternal mortality rates and that we should take account of these.

At a recent seminar at Warwick University funded by the Nuffield Foundation, where obstetricians and social scientists met together to discuss mutual problems, Dr Iain Chalmers produced evidence, using conventional obstetric outcome measures, which suggested that the active management of labour did not result in the benefits claimed for it. If this is so there can be no doubt that social and psychological variables should be taken into account, as should the views of the women themselves. The predominant impression with which most of us emerged from that day of talking at Warwick was that there was a long way to go before mutual understanding was achieved. The correspondence in your columns confirms this impression. For example, it is suggested that hospitals should be made more home-like, that women there should be given more choice and be more involved in the birth—all proposals which I personally would applaud. But there seems no recognition of just how difficult such goals are to achieve. A hospital is a totally different sort of social organisation from a home; it is not possible for a woman to be treated there as she is at home. Social scientists can help by analysing and explaining these differences so that the problems may be better understood.

I am glad to learn that in various parts of the country social scientists are getting together with obstetricians to try to establish a dialogue so that the latter may come to some understanding of the sociological and psychological hazards of childbirth, while the social scientists learn more of what are seen by obstetricians as medical imperatives. Let us not go blindly forward, perhaps doing unintentional damage, which is no less real because it is not immediately visible or readily measurable.

MARGARET STACEY

Coventry

SIR,—In your leading article "A place to be born" (10 January, p 55) you make comparisons between the results of the British and the Dutch systems of obstetric organisation. As you brought our country in and we share your interest in promoting all aspects of maternal and child care as much as possible, we feel compelled to make some remarks.

(1) You quote De Haas-Posthuma as follows: "De Hass-Porhuma [*sic*] has shown that those parts of Holland with the highest incidence of hospital confinement have the lowest perinatal mortality rates." According to the list of references this statement is to be found on p 220 of the *Proceedings of the Organisation for Health Research, Series A, No 11.* On that page we cannot find the quoted sentence. On p 211, however, we read: "Although home confinement still strongly predominates an increasing tendency towards institutional confinements is to be found in the Netherlands also: 27½% in 1960 as against 22% in 1952 or a relative rise in hospital confinements of 25% in 8 years. During the same period perinatal mortality fell from 31 per 1000 in 1952 to 25 per 1000 in 1960. Even if a causal relationship were to exist between hospitalisation and falling perinatal mortality—a point that has not been proved—this would not yet mean that the tendency towards hospitalisation should be encouraged indiscriminately. An excessive degree of hospitalisation should be guarded against."

(2) The decline in the percentage of home confinements in the Netherlands has continued since then. In 1973 this percentage was 51. Perinatal mortality in 1973 went down to 16·3 per 1000. In that same year 84% of the home confinements took place in co-operation with the so-called Organisatie inzake Kraamhulp (Maternity Home Help). Perinatal mortality in that group was 4·5 per 1000. Hospitalisation of the newborn during the first 10 days post partum took place in 2½% of all cases. In 1960 perinatal mortality of the same group of home confinements was 14 per 1000. This means that from 1960 to 1973 hospitalisation went up from 27·5% to 49% (a relative rise of 78% in 13 years); perinatal mortality fell from 25 to 16·3 per thousand (a relative decline of 34%). Perinatal mortality in home confinements with maternity home help fell from 14 to 4·5 per thousand in that same period (a relative decline of 68%).

(3) From the facts now available we can conclude that any correlation between the percentage of hospital confinements and perinatal mortality by region or municipality is very poor or even nonexistent. It seems that other factors must be responsible for the differences in perinatal mortality in the various parts of the Netherlands.

(4) In a recent study stimulated by the obstetrical department of the University of Amsterdam one of us (D van A) followed accurately a group of 916 women who were pregnant with their second child and who were selected for normality and home confinement in accordance with the Dutch list of "medical indications for hospital confinements." From this group 24 women (2·6%) were transferred during labour to the hospital. In this group of transferred women there was one artificial delivery (vacuum extraction) and one case of perinatal mortality. Of the whole group of 916 women 892 were delivered at home or in a simple home-like maternity unit at Wormerveer, where only midwives or family doctors were present and where no hospital facilities and no possibilities for artificial delivery or blood transfusion existed. These 892 women gave birth to 893 children (one unrecognised twin pregnancy). Among the 893 children perinatal mortality was zero.

We do not make propaganda for home confinements but we protest against the simplification that total hospitalisation should be the aim of an ideal obstetrical organisation. In the Netherlands for example we can show that improvement of the care in our hospitals will be of considerably more importance than compelling every pregnant woman to have her baby in hospital. Before we are entitled to demand total hospitalisation it is our duty to make every hospital a place for "the best way to be born."

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Dangerous labelling

SIR,—The varicose vein sclerosing fluid called "S.T.D." (a proprietary preparation containing 3% sodium tetradecyl sulphate) is labelled "for intravenous use" on the bottle and the carton, with no indication of the sclerosant nature of the contents. The fluid is available in many operating theatres.

Although this method of labelling has apparently been passed by the Dunlop Committee, I consider it to be extremely dangerous as the fluid could be drawn up into a syringe and handed to an anaesthetist or surgeon in an emergency and injected into an arm vein, in which case it might not only

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produce morbidity but could, in fact, be fatal. These cartons should be labelled "for varicose veins only."

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Dispersal of biliary calculi by irrigation

SIR,—I read with interest Mr G T Watts's counsel (6 March, p 581) against my procedure used to clear the common bile duct of residual calculi (7 February, p 340). However, he does not so much condemn my practice as put forward his own. Perhaps I may be allowed to comment on his letter.

While I accept that a choledochoscope allows inspection of the bile ducts, I would question, in view of my experience, that it is the "only sure method" of guaranteeing that the bile duct is free from stones. Whereas I am able to support my practice with figures, his statement has no such backing. I, of course, appreciate that urologists employ cystoscopes to inspect the urinary bladder, but I must point out that they use contrast radiography to visualise the ureters—surely a closer analogy to the biliary ducts than the urinary bladder. On what basis does Mr Watts say that irrigation of the bile ducts strongly enough to flush out residual stones is hazardous, for I have used this procedure in 50 patients, in none of whom has there been any complication, whereas he apparently has no such experience?

S J A POWIS

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SI units and blood pressure

SIR,—At their recent meetings in Sydney, Australia, the Scientific Council on Hypertension of the International Society of Cardiology and the International Society of Hypertension unanimously accepted the following resolution regarding the units for the measurement of blood pressure:

"The International Society of Hypertension resolves that the millimetre of mercury (mm Hg) should be retained for blood-pressure measurement in both clinical and clinical laboratory use and in related scientific publications. It is the opinion of the society that the use of SI units (kilopascal (kPa) or millibar (mbar)) in such circumstances is totally inappropriate."

FRANZ GROSS

Chairman of the Scientific Board,
International Society of Hypertension

Heidelberg,
W Germany

An eye-pad hazard

SIR,—I wish to draw the attention of readers to a potential hazard that unsuspecting patients may be subject to while wearing eye pads that are on standard issue to many hospitals.

An 82-year-old patient with a diagnosis of senile paraphrenia was prescribed eye pads, supplied by John Dickinson and Co Ltd, as part of her treatment for blepharitis. She wore these over the right eye and was also having chloramphenicol 0·5% drops and atropine 1% drops during the day and chloramphenicol 1% cream at night to the affected eye. While wearing one such pad she succeeded in igniting it while lighting a cigarette. The result was that she suffered full-thickness burns to her forehead corresponding to an area of about half a palm, with a considerable area of erythema and singeing of the hair. Luckily her eyes were unaffected.

A similar eye pad was subjected to an ignition test. It ignited within two or three seconds with a flame from a standard cigarette lighter, and combustion was completed within 50 seconds.

The potentially serious consequences of wearing such eye pads is not difficult to imagine. It would seem to be advisable that these pads should be made of flame-proof material and that patients should be discouraged from smoking while wearing them.

R WALL

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Whither scabies?

SIR,—Your leading article (14 February, p 357) suggests that the waxing and waning of the incidence of scabies may be associated with some form of "herd immunity." This may play some part, but I am sure that a more important factor is the accuracy and immediacy of diagnosis and the thoroughness of treatment, including that of possible contacts.

Towards the end of the last war every general practitioner was so familiar with scabies that any patient who itched was treated almost automatically for scabies and often only when the itching failed to clear up was a further diagnosis considered. Following this the incidence of scabies fell dramatically and for 10 years many of my students never saw a case of scabies; thus a generation of doctors grew up who knew not scabies. Gradually scabies returned but the diagnosis was often missed and the patient was allowed to continue spreading the disease to the community. Even when the correct diagnosis was made the treatment of contacts, which was so effective during the war, was often neglected. More recently the situation has been aggravated by the almost universal prescription of local corticosteroids for any itching (and undiagnosed) rash. Scabies will wane again when doctors become more alert to the diagnosis and adept in its treatment.

F F HELLIER

Leeds

GMC election

SIR,—As the last day for the receipt of voting papers for the General Medical Council is not until 20 April there may still be a little time for rethinking.

The reason for some of the members to be elected instead of nominated is presumably to make the GMC a more democratic body. I pointed out to the Merrison Committee in personal (written) evidence that the average doctor in, say, Middlesbrough was unlikely to know the average doctor in, say, Shropshire and that a truly democratic election presented great difficulties. I suggested an alternative scheme based on a more local selection of candidates, but I presume that this was thought to be impracticable. The outcome is exactly as I foretold. As few of us know more than perhaps half a dozen of the 34 candidates the BMA has selected eight for us (20 March, p 723). Those who for want of other guidance follow the BMA line will no doubt vote for them. Election addresses of the eight are published. Of the remaining 26 candidates (mentioned by name only) at least four are women (I am not sure of the sex of some with exotic forenames) and at least four are, to my certain personal knowledge, people of outstanding merit (and I don't mean merely academic merit), two of them recognised for their services by the OBE.

I suggest that the following guidelines might help those who have not yet voted: (1) The *BMJ* should publish brief election addresses of the 26 ignored candidates. (2) Voters should try to find out from local or other sources something about the candidates they may be voting for. (3) They should consider the merits of the BMA-discarded candidates. (4) There is no *need* to vote for more than one candidate. Voters should vote *only* for candidates about whom they have, or can get, some personal information. This will help the ones they really support to get in. (5) Voters should only vote "blind" (if at all) for the whole of the eight BMA-sponsored candidates if they are satisfied that BMA policy in recent years has been meritorious and could not be improved by the presence of some elected GMC members who were not committed to BMA methods.

PLATT

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Treatment of myeloma kidney

SIR,—Dr T G Feest and his colleagues (28 February, p 503) are to be congratulated on their success in rescuing their patient with myeloma kidney and severe renal failure. However, their paper gives a false impression of the power of plasmaphoresis. They show a fall in IgG from 44 g/l to 5·5 g/l following a single 1180-ml plasma exchange. Unless their patient was extremely small his plasma volume must have been of the order of 2·5 l, and it is extremely unlikely that exchanging two-fifths of the plasma volume would remove nearly 90% of the paraprotein. This is especially true since IgG is not confined to the intravascular space but distributed in the extracellular fluid. Our own experience with plasmaphoresis in myeloma indicates that a plasma exchange of between 2 and 3 l will reduce the level of paraprotein by about 40%.

Dr Feest and his colleagues also report the abolition of Bence Jones proteinuria. It is difficult to see how this can be attributed to plasmaphoresis. It seems much more likely that the improvement was due to the course of chemotherapy which the patient received.

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How much can ancillaries take over?

SIR,—Dr Anne Savage (3 January, p 27) found that patients in Africa were reluctant to see a nurse as the person of first contact. This seems

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