increased maternal as well as neonatal mortality and morbidity.

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¹ *Lancet*, 1978, 2, 1349.

SIR,—Neonatal morbidity after the use of Kielland's forceps is an important topic, but I wonder if Drs M L Chiswick and D K James (6 January, p 7) are justified in inferring that the increased morbidity they observed can be attributed to the use of the forceps themselves in as many of their cases as they claim.

The only circumstance in which there is an indication to use Kielland's forceps is that in which there is malposition of the fetal head in the second stage of labour, when for fetal or maternal reasons it is deemed desirable to expedite the delivery, and then only if there is no significant absolute cephalopelvic disproportion. In most cases where these forceps are used (66 cases out of 81 in the series reported) there is sufficient relative cephalopelvic disproportion, caused by deflexion of the fetal head (caused in its turn by the malposition), to prolong the second stage of labour; and this brings with it an increased risk of fetal hypoxia. It is also possible that the malposition of the fetal head alone could cause hypoxia, and there is some evidence for this in the paper (15 of the 81 fetuses in the forceps group were hypoxic without there being any delay in the second stage). Could it not be these factors which were responsible for the observed fetal morbidity, rather than the use of the forceps per se? If this is the case one should use Kielland's forceps earlier in the second stage, before the adverse effects on the fetus caused by the malposition of its head have been felt, rather than abandon their use altogether. These remarks do not apply, of course, to the neonatal morbidity caused by birth trauma; but its incidence in the series reported would have been markedly reduced if excessive force had not been used.

As an alternative to caesarean section, consideration might have been given in the discussion to the techniques of manual rotation or delivery by the Ventouse apparatus.

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SIR,—The results reported by Drs Malcolm L Chiswick and David K James (6 January, p 7) on the use of these forceps to overcome mid-cavity obstruction or delay are interesting and disappointing. They should not, however, be attributed to the type of forceps used.

The mid-cavity forceps operation, especially if rotation of the head is required, is a major procedure. Accurate diagnosis is essential, as are skill and gentleness, and in addition experience and courage—the two latter qualities in order to recognise when the operation should be abandoned and caesarean section performed. Great strength is not necessary. In my opinion these patients should not be entrusted, without supervision, to anyone below the rank of senior registrar.

I have on occasions thought that attempting the operation under pudendal block seemed to render it more difficult. As a result of this experience I am now of the opinion that the

operation is best attempted under general anaesthesia, administered by an anaesthetist experienced in obstetric anaesthesia.

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Trials in breast cancer

SIR,—On 23 November 1978 the Cancer Research Campaign sponsored a meeting to review the progress of the United Kingdom multicentre collaborative trial of adjuvant hormone-chemotherapy in poor-risk patients with early carcinoma of the breast. This meeting provided an opportunity for the steering committee of that study to meet with the organisers of the King's College Hospital breast cancer trials. Both groups agreed on the following points:

(1) It is justifiable to conduct adjuvant therapy studies in poor-risk early breast cancer patients while still retaining a control arm.

(2) There is sufficient evidence both on theoretical and experimental grounds¹⁻³ and in work done in advanced disease⁴⁻⁵ to study the potential advantages of combining chemotherapy and hormone therapy over either modality alone as adjuvant treatment.

(3) Both groups have launched trials of similar design that will study different aspects of this problem. Their cumulative results will be of great value but will depend on recruiting sufficient numbers of patients to each trial.

(4) It is regrettable that, despite the overwhelming evidence supporting the need for such studies, the majority of poor-risk early breast cancer patients in this country are not entered into any trial where the value of adjuvant therapy can be assessed. We therefore ask that clinicians in charge of eligible patients will give serious thought to collaborating with one or other of these studies.

(5) Centres which enter a substantial number of patients will be provided with secretarial or other assistance in order to facilitate the conduct of the trial.

Further information can be obtained from either of us regarding both trials, so that clinicians can choose which they would feel most appropriate for them to join.

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¹ Lippman, M E, *et al*, *New England Journal of Medicine*, 1978, **298**, 1223.

² Meakin, J W, *et al*, in *Adjuvant Therapy of Cancer*, ed S E Salmon and S E Jones. Amsterdam, Elsevier, 1977.

³ Braunberg, H, *et al*, *Lancet*, 1973, **1**, 163.

⁴ Tormey, D C, *et al*, *Proceedings of the American Association for Cancer Research*, 1978, **19**, 34.

⁵ Cavalli, F, in *Proceedings of 10th International Congress on Chemotherapy*, 1977, p 615. New York, Plenum Press, 1977.

Partial mastectomy for breast cancer

SIR,—I read with interest the report of Mr R E B Tagart (4 November, p 1268) on partial mastectomy for operable breast cancer. It is no surprise that 37% of Mr Tagart's patients who underwent partial mastectomy, without post-operative radiotherapy, had a recurrence in the breast within three years. After all, the incidence of multifocal microscopic cancer in

mastectomy specimens may be as high as 50%.¹ The purpose of giving radiation therapy following tylectomy is to sterilise such microscopic disease. Five thousand rads delivered to the entire breast with an additional 1500 rads to the area of the primary tumour will result in a local control rate of about 90%.²⁻⁴ The radiation doses delivered, following tylectomy, in those studies quoted by Dr Tagart were considerably lower than this and resulted therefore in a local recurrence rate which was as high as 20-25%.

It is also known that patients with a clinically negative axilla have about a 30% chance of having microscopically involved nodes on pathological examination. As may be expected, six of the 27 patients (22%) who had had no axillary dissection had a recurrence in the axilla. If these clinically negative axillae had received adequate irradiation (minimum tumour dose of 5000 rads in five weeks) the recurrence rate would have been less than 5%.⁴⁻⁷

I would have hoped that Dr Tagart, having observed the high incidence of local recurrences in his series, would have come to the natural conclusion of adding postoperative irradiation in adequate doses following partial mastectomy. Instead, unfortunately, he terminated his worthwhile trial in favour of total mastectomy.

We have yet to convince our colleagues, the surgeons, that surgery is necessary for the removal of gross malignant disease and that irradiation is necessary for control of microscopic deposits.

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¹ Rosen, P P, *et al*, *Cancer*, 1975, **35**, 739.

² Alpert, S, *et al*, *Cancer*, 1978, **42**, 2054.

³ Bataini, J P, *et al*, *Cancer*, 1978, **42**, 2059.

⁴ Calle, R, *et al*, *Cancer*, 1978, **42**, 2045.

⁵ Atkins, H, *et al*, *British Medical Journal*, 1972, **2**, 423.

⁶ Mustakallio, S, *Clinical Radiology*, 1972, **23**, 110.

⁷ Ghossein, N A, *et al*, *Radiology*, 1976, **121**, 455.

Cimetidine and duodenal ulcer

SIR,—Further to Mr J Alexander Williams's comments (20 January, p 169) on the lack of evidence for rebound perforation following cimetidine withdrawal, I report two cases.

A man of 65 with no previous gastric history had a successful repair of a thoracic aneurysm complicated by severe haematemesis. Gastroscopy showed acute stress ulceration. Bleeding continued despite medical treatment and Polya partial gastrectomy was performed. Histology later confirmed the diagnosis. Four days postoperatively, cimetidine in full dosage was restarted when fresh blood was aspirated from the stomach, being reduced to 400 mg at night at three weeks and stopped at 11 weeks. Three weeks later he was readmitted with perforation of a stomal ulcer, which was successfully oversewn. Serum gastrin concentration was normal and he remains well one year later.

A man of 19 with a six-month history of indigestion had a perforated duodenal ulcer. This was treated by oversewing, followed by cimetidine in full dosage. He stopped cimetidine at four weeks and six weeks later presented with reperforation of the same ulcer. This was treated by vagotomy and pyloroplasty and 11 months later he remains well, with normal serum gastrin concentration.

Only 3-5% of Polya partial gastrectomies are followed by stomal ulceration. A study of 360 cases did not include any developing within six months, and only one case of perforation was recorded.¹ Initially our first patient had