The term "single tumour" is rather confusing, and "dominant" or "definitive lump" might have been a more precise description. The group emphasised the fact of clinical error in that 26% (22/84) palpation suggested cancer. One would like to have read more on the false cytologically suspicious readings (13/84). The proportion of cases having surgical intervention for cystic disease, 36% (16/44), is significantly higher than in many series.[6 7] Perhaps repeat aspirations were not regularly practised in this group.

The value of direct provisional reporting to the surgeon at the time of first attendance cannot be denied for many though not all women. Reassurance about the absence of malignant cells is perhaps the greatest boon. Whether the gain is enough to justify deviation of resources I rather doubt. Dr Duguid and her team are to be congratulated on a significant achievement.

There is one important error in the references. The name of Dr Paul Lopes Cardozo is misspelt and his mammoth atlas was published in 1979.

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Fetal malnutrition—the price of upright posture?

SIR,—Dr André Briend (4 August, p 317) interestingly examines the "faltering of growth" in the last few weeks of human fetal life and wonders whether it may be evidence of fetal malnutrition as a consequence of our upright posture.

Since his article was "for debate," I would like to ask whether anyone else shares my own scepticism about the alleged "faltering" in normal fetuses? As Dr Briend says, "This picture has been derived from *cross-sectional* studies based on the *weights* of normal live-born infants of varying gestational age" (my italics). But it is axiomatic that cross-sectional studies can tell us little about individual growth curves. What evidence have we, for example, that the apparently "faltered" birth weight of any individual near term in his figure arrived at this point by the trajectory he shows? It might have taken a lower road to the same place. The high road of the normal cross-sectional curve could in this case be accounted for by some influence of fetal weight on time of parturition, though I do not think I believe it.

Dr Briend's answer is that the faltering is "confirmed by longitudinal measurements of the fetal biparietal *diameter* using ultrasonic cephalometry." But here he is surely wrong. Diameter, like circumference, is a linear measurement, and a curve of its growth is not to be compared with one of weight, which is a volume dimension. Curves of biparietal diameter do *not* indicate head growth, if by the latter is meant growth in weight or volume. This can be proved two ways: firstly, by a simple mathematical conversion of the biparietal diameter to skull volume, when a plot of head growth completely loses its faltering tendency[1]; secondly, by a plot of brain weight, which is inevitably cross-sectional but which, far from faltering, is actually accelerating at this time.[2]

At all events, longitudinal curves of biparietal diameter cannot be recruited in support of late gestational faltering, as they very frequently are, especially by ultrasonographers. If only we could convincingly compute fetal body weight from suitable ultrasound measurements we might be nearer to solving my dilemma. I think "faltering" of fetal weight probably does occur towards term. Or does it?

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[1] Dobbing, J, and Sands, J, *Early Human Development*, 1978, **2**, 81.
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SIR,—I was most interested to read Dr André Briend's paper on fetal growth and its relationship to physical demands on the mother in the weeks before birth (4 August, p 317). His hypothesis corresponded with my own impression of my pregnancy, now at 38 weeks. (An ultrasound scan at 12 weeks' gestation confirmed accuracy of dates.)

For financial reasons it was essential for me to continue working as long as possible. I continued to do so until 34 weeks, when progressive fatigue forced me to cease working. At this stage I was admitted to hospital for two weeks' rest. Since then my environment has been such that I am relieved of all physical and day-to-day demands, and am able to indulge my natural inclination to rest.

My postural pattern over 24 hours tends to be 12 hours in bed, mainly in a lateral position because this is the most comfortable and a large proportion of the other 12 hours in sitting, with minimal periods in the upright position. Sitting is less comfortable than lying; standing and walking are limited by the discomfort of pelvic pressure.

At 33 weeks the ultrasound biparietal diameter measurements were compatible with a 31-week (±10 days) fetus and the head was engaged in the pelvis. From 31 to 36 weeks (on dates) my fundal height was two weeks lower than expected. Clinically it was felt that this was probably due the head being engaged. Several medical and lay people commented on my small-for-dates appearance.

At 36 weeks the ultrasound biparietal diameter measurements were compatible with a 36-week (±10 days) fetus with the head still well engaged in the pelvis. Currently, at 38 weeks, the head remains in that position, while my fundus is now at the xiphisternum. My impression in recent weeks has been of significant growth of my baby, which I can only attribute to the removal of environmental pressures, which has freed me to rest as my body dictates.

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Breast or bottle

SIR,—How truly Dr Paula H Bolton-Maggs has summed up the experience of breast-feeding (11 August, p 371). Like her I have just breast-fed my first child and as a result am much keener to promote breast-feeding, and much more able to do so.

Without experiencing it, I would never have believed how much encouragement is needed during the first week or so. What with sore nipples, frequent feeds, general weepiness, and a perineum on which sitting was agony, I would have given up, had I not been determined to succeed, and had I not been supported. My midwife, though helpful, seemed to think that at 32 I was really past being able to feed; my GP was encouraging; but my mother, a breast-feeding veteran herself, kept me going. A little practical experience, I am sure, is worth a great deal of theorising.

Nor must we overlook the support given by the husband. Mine (non-medical) is enthusiastically promoting the breast, on the grounds that it is less smelly, cheaper, and more convenient—no paraphernalia of bottles, jugs, and hot water flasks to cart around. His advice to any mother is—buy a poncho; under this the baby can be fed in such diverse places as a wood yard and a mountain top.

I believe public opinion is swinging a little. It will go further when someone in *Crossroads* or *Coronation Street* has a baby and feeds it on the screen, although I appreciate this will be difficult to arrange! With some diffidence, I fed in the "Ladies" of John Lewis's expecting some shocked looks; but a stream of passing women stopped to admire, comment what a lovely sight it was, and point it out to their children—a very commendable attitude. As a friend's 6-year-old said after watching a feed, "I thought it would be rude but it's lovely." Perhaps above all it is the loveliness we should emphasise to future mothers.

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Care of children in general practice

SIR,—A paediatrician may perhaps comment on "Care of children in general practice" (21 July, p 190), particularly as the *BMJ* purveys Dr Stuart Carne's concepts to future GPs. He says that the view of the 1950s that maternity care should be the foundation for general practice is now only true to a degree and that "today what matters most to the GP is not the actual delivery but the health of the child"—who accounts for 25% of consultations. He also refers to some communication problems.

Brevity is a virtue, but the precise meaning of these phrases is not clear. Dr Carne apparently feels that GPs need not be much concerned with pregnancy and perinatal events but does not say quite how he will ensure the *health* of the child. Instead he refers to the management of *children's diseases*, and, though this is in commendable statistical perspective, an emphasis on health care would have been more timely. "Looming on the horizon is a new aspect of preventive paediatrics: the possibility of being able to influence the morbidity and mortality patterns in later life."

After this exciting statement Dr Carne contents himself with the stock aspiration of children's doctors that modification of infant diet may prevent that scourge of modern society premature vascular disease. Certainly respiratory problems predominate acutely in general practice but chronic psychosocial and psychosomatic problems are more important and common. For the latter some parents will not seek help, many do not think it "available" at their surgery, some attend accident and emergency departments. Are their needs recognised? How many doctors (in or outside