were in accidents of some importance per 100 million km travelled. If we assume that the length of cycle journeys in which a serious accident or death occurs is similar to the length of journeys in which any reported accident occurs, then 985 million km are covered per death or serious injury, which amounts to 66 million commuting journeys of 15 km each.

Thus it appears that the commuting journey is 29 times safer than an air flight, even if we compare the cyclists killed or seriously injured with air travellers actually killed. Twenty nine times is an underestimate for adult cyclists, since a substantial number of cyclist casualties are unfortunately children. No precise comparison can be drawn when the figures for air casualties depend so much on uncommon disasters, but the risk entailed in a single cycle journey should not be overestimated.

JOHN FORRESTER

Edinburgh EH10 5NS

Changes in blood lead concentrations in women in Wales 1972-82

SIR,—Dr E King (25 June, p 2059) raises three possible explanations for the apparent fall in blood lead concentrations in women in Wales during 1972-82 (14 May, p 1553).

Contamination of blood samples with lead from the container is always possible, and, as Dr King states, this is much less likely now than before because manufacturing processes have probably improved. We doubt if this is likely to explain much of the change in blood lead concentrations over time which we describe. From time to time we have sent a batch of five to 10 blank bottles for checking. Unfortunately, we have no records of these checks, but no appreciable contamination with lead was ever found. Contamination from the container would reduce the reproducibility of estimates made on duplicate samples of blood from the same subject. We do have good evidence on this, and, as mentioned in our report, reproducibility of blood lead estimation was high throughout all our surveys. For example, in 1972 the two laboratories concerned with our surveys had coefficients of variation of blood lead estimation of 6% and 12% (P C Elwood, H F Thomas, unpublished report to the Welsh Office, 1973). Important contamination seems unlikely.

The second explanation, laboratory drift, seems unlikely to account for much of the fall we describe because of the results we reported from another study (7 May, p 1515). This was based on blood samples which had been deep frozen since 1969 and were examined (blind) in 1982 together with samples taken from some of the same subjects in 1982. A fall of 20-30% is shown by these data, and none of this could possibly be laboratory drift.

Area differences could certainly generate the kind of changes we describe and, for that matter, the changes described in the National Health and Nutrition Examination Survey II (NHANES II) study in the USA. Our report, however, describes two pairs of surveys based on representative samples of subjects in the same area—the surveys in Caernarfon and in Gwynedd; and the two surveys in the old lead mining area. The changes in these are consistent with the overall fall we describe.

The one point Dr King makes with which I find myself in complete agreement is that we will probably never know the relevance of petrol lead to blood lead despite the confidence expressed by many commentators. Furthermore, whatever the reason for the falls in blood lead concentrations which we describe they are likely to continue and will be confounded with the fall, if any, which will occur consequent on the proposed reduction in petrol lead. Unless lead in every source, including the diets of representative samples of subjects, is monitored the arguments will continue.

P C ELWOOD

MRC Epidemiology Unit,
Cardiff CF2 3AS

Thiazides and amiloride in treatment of moderate hypertension

SIR,—Dr J P Thomas and Dr W H Thomson (25 June, p 2015) have made an important contribution to our knowledge of the use of diuretics in hypertension. Since thiazides are widely used as a first step in treating hypertension their recommendation that thiazides should be replaced by a potassium sparing drug such as amiloride has far reaching potential. Have they not underplayed the disadvantages of the potassium sparers and thus suggested the replacement of one set of problems with another?

Hyperkalaemia introduces a risk of cardiac arrhythmia and can occur after taking potassium sparing drugs at any age. This is a small risk unless there is renal impairment, when this group of drugs is strictly contraindicated.[1] Hyponatraemia is a hazard recently mentioned by two of your correspondents (18 June, p 1971). Nausea is a side effect occurring with all potassium sparing drugs.

The late George Pickering emphasised that hypertension is essentially a disorder for family doctors.[2] About 7% of the population aged 40 to 65 warrant treatment for hypertension on currently accepted criteria, and this group may well be extended in the future. Although laboratory facilities are available to most (though not all) general practices, only modest delays in the delivery of specimens make reliable serum potassium estimations unavailable to many.

May I suggest, therefore, that the risks, the side effects, and the need for biochemical control are probably as important when using potassium sparing drugs as in prescribing thiazides in moderate hypertension.

M J AYLETT

Wooler,
Northumberland

[1] Harrington JT. *Drug Ther Rev* 1977;**1**:100-6.
[2] Tudor Hart J. *Hypertension*. London: Churchill Livingstone.

Spontaneous preterm labour and delivery at under 34 weeks' gestation

SIR,—Dr R F Lamont and others (5 February, p 454) suggest that improved perinatal mortality follows the use of caesarean section for delivery of the breech infant with a birthweight of less than 1500 g. Unfortunately, they seem to have fallen into the methodological trap of the 11 other papers they cite.

The bias is to allow the smaller breech infant in any birthweight category to deliver vaginally. In fact, the same bias is evident in their own paper, as they have a policy of delivering the breech infant by caesarean section "if its birth weight is estimated to be over 1000 g."

From the overall outcomes they report it is likely that the 12 breech infants they delivered by caesarean section were all close to 1500 g, while the 19 who were delivered vaginally, with only a 63% survival rate, had several babies among them with birth weights of less than 1000 g. The survival rate for this birthweight category in the series was only 38%. It would have been interesting to know the outcome according to mode of delivery for those infants presenting by the vertex, stratified according to various birthweight categories and compared with breech presentation.

From our own study of 659 low birthweight infants,[1] of which 168 presented by the breech, we found that the caesarean section rate in breech presentation rose from 38% to 65% over two five year periods. The mortality however, improved only in parallel with vertex presentations, for which there had been no change in caesrean section rate over the corresponding times. We also found no significant difference in incidence of handicap between low birthweight breech survivors delivered vaginally or by caesarean section.

We believe therefore that caesarean section has not played a part in improving the outcome of premature breech infants with the possible exception of a footling presentation, where prolapse of the trunk or of the cord is clearly an appreciable risk.

S B EFFER
S SAIGAL
C RAND
D J S HUNTER
B STOSKOPF
A C HARPER
C NIMROD
R MILNER

Department of Obstetrics and Gynecology,
McMaster University,
Hamilton, Ontario L8N 3Z5

[1] Effer SB, Saigal S, Rand C, *et al*. Effect of delivery method on outcomes in the very low-birth weight breech infant: is the improved survival related to cesarean section or other perinatal care maneuvers? *Am J Obstet Gynecol* 1983;**145**:123-8.

An open letter to the General Medical Services Committee

SIR,—I was rather disappointed by Dr Gordon Taylor's placatory response (9 July, p 133) to criticism of proposals for criteria for part II of the new obstetric list. Are we once again to see a tergivisatory attitude on the part of the General Medical Services Committee to this problem such as occurred about 20 years ago? Some of my older colleagues may remember that, having negotiated (for that time) a reasonable fee for intranatal care, the profession was persuaded by its more reactionary members that it was not consistent "with our status as independent contractors and the clinical freedom which pertains to it" to link the payment with an actual requirement to attend the delivery. After pressure from the GMSC this injunction was withdrawn, with the result that the relevant fee has remained at a derisory level ever since. Clearly (in the eyes of the Department of Health and Social Security at any rate) doctors who are not prepared *routinely* to attend their patients in labour should not be overvalued.

With regard to current debate, however, I think that there is evident confusion between the theoretical knowledge and the practical skills necessary for modern obstetrics. Know-