viously, this cannot be done at the present time in Britain to give any useful data, but inquiries to the American Fertility Society would be helpful to the annual representative meeting in this respect.

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Ruptured abdominal aortic aneurysm presenting with ureteric colic

SIR,—The article by Mr C G Moran and colleagues (16 May, p 1279) acknowledges the difficulty of establishing the diagnosis of ruptured aortic aneurysm and highlights the trap of ureteric colic. Experience at Royal Perth Hospital supports this.

This hospital's experience of patients with acute renal failure requiring dialysis after repair of abdominal aortic aneurysm has recently been examined. In 29 of 33 such patients surgery followed emergency presentation. Seven of these patients reported symptoms that suggested a diagnosis of ureteric colic, and in four cases pain in or radiating to the testis indicated a ureteric origin. The finding of microscopic haematuria was considered further evidence for this. Back pain was a major symptom in seven other patients, and three patients were being investigated for renal or spinal disease when sudden hypotension or severe abdominal pain, or both, redirected the investigation.

Ruptured abdominal aortic aneurysm merits a prominent position in the differential diagnosis of ureteric colic in older patients. For the reasons outlined by Mr Moran and colleagues, the finding of microscopic haematuria should not exclude rupture of an aneurysm from consideration.

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Evaluation of portable haemoglobinometer in general practice

SIR,—Dr R G Neville's report of excellent results with the HemoCue system for haemoglobinometry when used in the laboratory and disappointing ones when it was evaluated by practice nurses (16 May, p 1263) is not surprising. Substantial analytical inaccuracies, financial waste, and other difficulties are reported in relation to the uncontrolled use of equipment in clinical areas outside the laboratory.¹ We firmly believe that the laboratory is the best place for equipment, however simple it may be, and that the medical laboratory scientific officer is the best operator. The stringent quality control procedures undertaken in the laboratory could not be matched elsewhere.

There are very few indications for estimating a patient's haemoglobin concentration alone. If what general practitioners need is a simple screen for anaemia we suggest the copper sulphate method currently used for screening blood donors on site.² An immediate result is obtained, no equipment is needed, the cost is very small, and the skill required could easily be achieved by practice nurses. The result obtained is qualitative rather than quantitative. The cost of purchasing, maintaining, calibrating, and controlling even the simplest of machines may not be justified in view of

the fact that a quantitative result is unlikely to alter the action taken by the general practitioner in managing his patient. After all, if a patient is found to be anaemic a full blood count at the local laboratory is necessary to determine the type of anaemia.

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Early versus late induction of labour in post-term pregnancy

SIR,—A serious deficiency in the paper by Dr Kåre Augensen and colleagues (9 May, p 1192) on induction of labour in prolonged pregnancy is their failure to confirm dating by early ultrasonography. They compare their results with those of Cardozo *et al*,¹ but these authors used ultrasound dating, which is generally agreed to be more accurate. We found that in 5% of 626 women with certain menstrual dates (by the same criteria used by Dr Augensen and colleagues) an ultrasound scan in the first half of pregnancy altered dates by more than 14 days (unpublished findings).

We found the incidence of prolonged pregnancy (>42 weeks) to be 3.4% by ultrasound scan dates, and we confirmed the findings of Grennert *et al* and Warsof *et al* that ultrasound scanning for pregnancy dating reduces the incidence of prolonged pregnancy.^{2,3} Dr Augensen and coworkers do not state their incidence of prolonged pregnancy, making it impossible to assess the validity of their numbers.

Doubt about the accuracy of pregnancy dating in their study is reinforced by the large number (27%) in their group 2 (not induced) who did not go into labour spontaneously in the 43rd week of pregnancy and by the large number of "failed" inductions. They do not, however, state their method of induction, and we are left to presume that it did not include amniotomy. Many would argue that induction without amniotomy hardly constitutes an adequate procedure.

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- 1 Cardozo L, Fysh J, Pearce JM. Prolonged pregnancy: the management debate. *Br Med J* 1986;293:1059-63.
- 2 Grennert L, Persson PH, Gennser G. Benefits of ultrasonic screening of a pregnant population. *Acta Obstet Gynecol Scand [Suppl]* 1978;78:5-14.
- 3 Warsof SL, Pearce JM, Campbell S. The present place of routine ultrasound screening. *Clin Obstet Gynaecol* 1986;10:445-57.

AUTHORS' REPLY—We acknowledge that routine early ultrasound was not in regular use when our trial started. With scrutiny of the case histories, however, including early human chorionic gonadotrophin tests and ultrasound when available, we managed to sort out 373, or 39.5%, of these 944 referred for suspected post-term pregnancy. During the study there were 12 265 deliveries in our department; of these, our study population of 409 plus 143 cases that were excluded for reasons unrelated to pregnancy duration constituted 4.5%.

We would emphasise how helpful thorough history taking can be. Let us remind our critics of the easily forgotten fact that all ultrasound nomograms are based on measurements of limited

numbers of fetuses of so called normal pregnancies with certain dates. Previous studies of pregnancy duration, based on certain menstrual dates, known date of conception, or known date of ovulation have concluded that the proportion going beyond 42 weeks is about 10%, or slightly less. Cardozo *et al* reported 6.6% and 6.3% in two series,¹ and Warsof *et al* 6.3% when ultrasound correction was used,² and so we are in good company. Grennert *et al* claimed that only 1.5% went beyond that limit after ultrasound correction, but they had excluded 152 of the 1000 consecutive cases, 148 of them because birth was induced.³

The fact that 27% of our non-induced study subjects did not go into labour spontaneously in the 43rd week is not at all surprising. Being a representative sample, they constituted 0.9% of the total birth population in the hospital. It is reasonable to expect a fraction of pregnancies of a sample of this size to pass the 43 week limit.

With regard to the method of induction, we believe that it was adequately described. Amniotomy was not performed before labour was clearly established, which is the usual practice in Norway. We would argue that a more aggressive approach in the face of a debatable medical indication may do more harm than good and lead to more unnecessary caesarean sections.

Finally, these points of debate do not seem to us to detract from the validity of the results, nor do they compel us to alter our conclusions.

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Ethics committees and research

SIR,—Professor Roger J Robinson (16 May, p 1243) discusses the membership of ethical committees and considerations with regard to research in children that are also relevant to research in adults. Guidelines that we have devised over five years may be helpful to other committees. A protocol is circulated in advance and talked through by the investigator at the meeting, and the guidelines remind the chairman of issues to raise.

Firstly, the ethical committee should consist of a clinical tutor, an undergraduate tutor, a vicar or priest, a member of the administrative staff, a member of the secretarial staff, and two consultants—preferably with some experience in the project under discussion. A consultant from a different firm or different hospital is probably most advisable, and a senior nursing officer should be present when needed.

With regard to the research itself: the project should not withhold essential treatment from patients; it should be of a good standard so that the result will be of some value, whether positive or negative; and it should not put the patients at unreasonable risk. A project designed merely to promote the use of a drug should not be passed by the ethical committee. The project should be explained to the patients and consent should be