haemopoiesis. Interestingly, improved survival in this trial was not accompanied by any striking change in blood counts, but Kerndrup *et al* and Clark *et al* have shown a reversion of both neutrophil myeloperoxidase activity and abnormal cell surface markers towards normal as a consequence of treatment with tretinoin,^{8,9} and leucocyte function may improve.

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Not all travellers need immunoglobulin for hepatitis A

SIR,—The leading article by Drs Jonathan H Cossar and Daniel Reid (13 June, p 1503), which was commented on by Drs G Kudesia and E A C Follett (11 July, p 118), reopens the argument about the cost benefit of screening for immunity to hepatitis A before foreign travel and before the administration of prophylactic normal human immunoglobulin.

The value of pretesting in regular business travellers is beyond question.^{1,2} Not only have they probably had greater past exposure to infection but they will also need repeated injections of a preparation that, although safe, is costly and painful. Screening would identify immune subjects, reducing the numbers requiring prophylactic treatment. On the other hand, the need for screening holiday travellers, who generate most of the requests for immunoglobulin, depends on age, socioeconomic backgrounds,³ and also the travellers' place of residence in the British Isles.

The figures for hepatitis A immunity in Avon (table) are much lower than those quoted by Drs Cossar and Reid for the west of Scotland, and pretravel screening in our area would not be cost effective below the age of 40. A recent report from Japan shows how rapidly susceptibility to hepatitis A may increase in a community as a result

of rising living standards.⁴ It is important to review figures for local antibody prevalence in the United Kingdom regularly to give the most helpful advice. This should take into account not only the country to be visited but also the duration of stay and the lifestyle of the traveller while abroad.⁵

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Reduction in postprandial energy expenditure during pregnancy

SIR,—Unlike Dr A M Prentice and colleagues (25 July, p 266), who used a method for measuring diet induced thermogenesis that is derived by exclusion with an estimate for physical activity, we actually derived our results by direct measurement of the thermic response to a meal (20 June, p 1573). We found a reduction in this response in all of our pregnant women in the second trimester. We measured the thermic response for only two hours after ingestion of the meal and would agree that this probably represents about two thirds of the total response induced by the meal. If this is the case and we extrapolate using the Cambridge group's own reported calculated intake for pregnant women in the second trimester—namely, 8.1 MJ—then the energy savings amount to 94 kJ, about 1% of total energy expenditure, as Dr Prentice and coworkers point out. If this is compared, however, with the rise in resting metabolic rate during the second trimester of 288 kJ/24 h then it represents an energy saving of one third.

An actual fall in resting metabolic rate would be a much more important energetic adaptation as the resting metabolic rate accounts for over 70% of total energy expenditure in humans. We were, therefore, interested to note that Dr Prentice and colleagues observed such a reduction in four out of seven women in the second trimester, as has been reported by Durnin *et al* in Glasgow women.¹ The direction of change in the resting metabolic rate may ultimately depend on the energy intake in each case. We therefore stand by our conclusion that the pregnant woman shows evidence of enhanced energetic efficiency in the second trimester, some more than others, which would reduce the need to consume as much extra energy as official estimates would have us believe.

Our data, nevertheless, indicate that even if dietary energetic savings are taken into account the

pregnant woman still needs to consume extra energy. In our women the calculated minimum extra intake necessary for energy balance was 310 kJ and 420 kJ a day during the second and third trimesters, respectively. These figures are much lower than the 630 and 1470 kJ officially recommended but, interestingly, somewhat nearer to those reported by Durnin *et al*.¹

Dr Prentice and coworkers also emphasise the various estimates of energy intake observed by others, indicating a possible figure of 1 MJ for the rise in energy intake during pregnancy. This contrasts with their own work, which we quoted in the introduction to our paper, which showed no appreciable rise in intake.² As they recently have shown the unreliability of such measurements in giving a true picture of energy intake, we think that little reliability can be placed on those of others in evaluating a precise figure of energy intake by using similar methods.³ This is best achieved by accurate measurement of energy expenditure.

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Delivery after caesarean section

SIR,—In one of the largest published series Dr B G Molloy and colleagues (27 June, p 1645) report a low incidence of both elective and emergency repeat caesarean section. Their conclusion that these figures represent the lowest incidence of abdominal operative delivery in a group of patients after one caesarean section must be interpreted with caution, however, as the populations in the studies cited were not defined. We believe that these results reflect the patient population rather than their obstetric management.

As an example, we presented a review of 260 such patients at the 1987 meeting of the Bavarian Society for Obstetrics and Gynaecology. These women were delivered in the department of obstetrics, Grosshadern, at the University of Munich, which serves as a referral centre for high risk patients. Consequently, we assume that the patients cannot be compared directly with those described by Dr Molloy and coworkers. Of 260 patients, 26.5% were delivered by elective repeat caesarean section compared with only 18% in Dublin. The difference may be explained by analysing the percentage of infants born weighing less than 2500 g as an indicator of high birth risk. In our population 8.5% of infants fell into this category compared with 4.9% in Dublin. Low birth weight plays an important part in the decision to perform an elective repeat caesarean,¹ particularly when the fetus presents as a breech.²

The low proportion of emergency repeat caesarean sections reported (9%) compares with 22.3% in our study. If the population is analysed 62.3% of the patients described by Dr Molloy and colleagues had already delivered at least once vaginally compared with only 13.5% of our patients. It is well recognised that women who have had previous vaginal deliveries have a better chance of delivering vaginally after a trial of labour.^{3,4}

Proportion of patients immune to hepatitis A, September 1985 to July 1987

	Age (years)					
	1-9	10-19	20-29	30-39	40-49	50-59
Patients screened for immunity alone						
No examined	0	16	85	103	103	95
No (%) ELISA IgG positive		0 (0)	7 (8)	16 (16)	36 (35)	43 (45)
All patients tested except those with hepatitis A						
No examined	38	207	444	378	284	265
No (%) ELISA IgG positive	5 (13)	23 (11)	93 (21)	110 (29)	139 (49)	146 (55)
						112
						92 (82)

ELISA = Enzyme linked immunosorbent assay.