only form of uterine stimulation that I allow. If low amniotomy alone fails to effect full cervical dilatation in a reasonable time my reaction is to regard the problem as essentially one of a mechanical impediment to adequate progress in labour, to eschew the use of oxytocics, and generally to advise caesarean section regardless of the apparent strength of the uterine contractions or one's impression of the relative dimensions of the presenting fetal part and the maternal pelvis.

The fact that only 36 of Mr. Studd and his colleagues' 50 multigravidae had spontaneous deliveries suggests that inertia may not always have been the only reason for the delay in cervical dilatation. Furthermore, the particularly high instrumental delivery rate in unstimulated labours may not have been so much the "penalty of non-stimulation," as suggested by the authors, as a vindication of the wisdom of those managing the patients in their withholding of oxytocic stimulation in a potentially dangerous situation. In the past seven years I have encountered three cases of uterine rupture following the administration of oxytocics to improve contractions in multigravidae thought to have been suffering from simple uterine inertia.

Friedman's partogram¹ was valuable in that it distinguished the different phases of the first stage of labour. The routine use of graphic recording of cervical dilatation on some sort of nomogram seems to me a limited and tedious way of diagnosing delay in labour which can be recognized more simply and comprehensively by reference to an easy-to-remember table.² If graphic recording, by placing too much emphasis upon a standard rate of cervical dilatation, leads to the unnecessary and potentially dangerous use of oxytocic stimulation it may prove less than a major advance in modern obstetrics. —I am, etc.,

D. D. MATHEWS

This isolate was not available for serotyping. At birth the child weighed 1940 g. The duration of labour was 12 hours.

The third infant was noted to be limp, with shallow breathing, five hours after birth and by 12 hours had deteriorated markedly, with tachypnoea and cyanosis. At this time throat swab, blood, and C.S.F. were taken and benzylpenicillin and gentamicin were started. By 19 hours there was evidence of clinical improvement. A group B streptococcus, serotype Ia, was isolated from throat swab and blood. At discharge, aged 18 days, the baby was considered to be normal. This infant weighed 2740 g and labour lasted five hours.

The three cases occurred within a few days of each other, but serotyping demonstrated this clustering to be fortuitous. It is of interest to note that the case of late-onset meningitis was due to serotype III, which is in accord with other reported cases in the literature.¹ The source of infection and the reason for the delayed onset of meningitis remain obscure. In our case the baby was healthy, of normal weight at birth, and had been at home for seven days. Serotype I (a and b) is said to be the most pathogenic subtype in the immediate neonatal period. Of our two babies who became ill soon after birth, the one infected with serotype II died, while the one with respiratory distress due to serotype Ia survived. Though only the latter was treated, the former died less than eight hours after delivery, possibly too rapidly for therapy to have had effect.

Since 1967 there have been 13 other cases of group B streptococcal infection of early onset in this hospital. Eleven of these babies died. None had evidence of meningitis. We would like to endorse Dr. Reid's view that the group B streptococcus is an important pathogen in the neonatal period.—We are, etc.,

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¹ Friedman, E. A., *Labor. Clinical Evaluation and Management*. New York, Meredith, 1967.

² Mathews, D. D., *British Medical Journal*, 1972, 4, 487.

Group B Streptococci in Perinatal Infections

SIR,—We note with interest Dr. T. M. S. Reid's article (7 June, p. 533). We have recent experience of three severe perinatal infections due to group B streptococci. The infants were born by spontaneous vertex delivery, labour having been induced in each case by artificial rupture of the membranes.

The first infant was readmitted to this hospital, aged 10 days, with a history of sudden onset of grunting respiration and tachypnoea and was moribund two hours later. A group B streptococcus, serotype III, was isolated from cerebrospinal fluid and blood cultures. Though benzylpenicillin was administered promptly after microscopic examination of the C.S.F. deposit, the baby died 22 hours after the onset of symptoms. At birth the infant had been healthy and weighed 3400 g following a short labour—approximately four hours. No group B streptococci were isolated from nose, throat, or high vaginal swabs taken from the mother after the child's death.

The second infant suffered respiratory distress within an hour of birth and died seven hours later. At post-mortem there was bilateral pulmonary consolidation, and a group B streptococcus, serotype II, was isolated from blood culture. A group B streptococcus was also isolated from the mother's high vaginal swab taken three days after delivery.

¹ Barton, L. L., Feign, R. D., and Lins, R., *Journal of Pediatrics*, 1973, 82, 719.

Agency Nurses

SIR,—For the first time in the history of the Health Service a Secretary of State is prepared to risk the welfare of patients in order to achieve an administrative objective—an objective, moreover, which is neither realistic nor economical. In a circular addressed to regional and area health authorities and boards of governors she is calling for the elimination of the use of agency nurses from the N.H.S., though she acknowledges the value of the contribution made by agency nurses and in spite of the fact that she "appreciates that a short term risk may have to be accepted in order to achieve the longer term aim of a more stable nursing force."

Even if her objective were likely to be achieved by such elimination this could not justify "short term risk" to patients. The fact is, however, that the elimination of agency nurses would inflict long-term harm on the N.H.S. There are two factors which seem to be completely ignored by the Secretary of State: (1) It will be no cheaper to run the Health Service without agency nurses. This has been admitted time and time again in answers to parliamentary questions by Ministers in successive

Governments.¹⁻³ (2) If agency nurses cannot nurse through their agencies, over half will leave nursing completely. This fact was established by a survey⁴ carried out by this organization in 1974 and reflects the views of the agency nurses themselves.

Lastly, the Secretary of State suggests that, while it is wrong to use nurses from agencies, it is quite proper to use nurses from nurses' banks set up by the hospitals themselves. All the alleged inconveniences of agency nursing are equally present with nurses supplied by nurses' banks and the only difference between the two systems is that one is operated by nurses in private enterprise whereas the other is operated by nurses in public service. Nurses' agencies have no quarrel with nurses' banks but see any widespread extension of this system as an inefficient method of replacing the services that agencies already offer.

My purpose in writing this letter to you is to alert your readers to the fact that a Secretary of State is prepared to allow N.H.S. patients to suffer rather than accept a system of private enterprise which is controlled by law and which has worked satisfactorily for many years.—I am, etc.,

DONALD J. CROPPER
Secretary-General,
Federation of Personnel Services of
Great Britain Ltd.

London W.1

¹ Hansard, House of Commons, 17 November 1969, Written Answers, col. 197.

² Hansard, House of Commons, 23 November 1971, Written Answers, col. 315.

³ Hansard, House of Commons, 19 February 1975, Written Answers, col. 392.

⁴ Federation of Personnel Services of Great Britain Ltd. *The Temporary Nurse: An Investigation into the Reasons Why Nurses Do Temporary Work and a Report on Their Attitudes to Their Profession*. London, F.P.S.G.B., 1974.

Anabolic Steroids in Athletics

SIR,—Dr. D. L. J. Freed and others (31 May, p. 471) showed that performance improved significantly (range 0-15%) among weightlifters taking anabolic steroids; their body weights also rose by about 3 kg.

In weightlifting nine weight classes are defined, and the contestants take care to keep their weight just within the permissible maximum (except the 111 + kg group). If steroids increase body weight the contestants would have to compete in the heavier weight groups. The figure shows the increase in the weightlifting capability in the heavier weight groupings. The gain in performance attributable to steroids has to be matched with the initial weight and the weight gains; for the same weight gain the lighter weights have to perform far better than the heavier weights.

The ethical considerations as to the use of anabolic steroids and the question of athletes using steroids to gain an unfair advantage need reviewing. The real advantage of using anabolic steroids from a performance point of view lies in the throwing (discus, hammer, shot) and rowing events. The javelin throw involves an initial run and the extra weight will be a handicap to the thrower. The throwing and rowing events are contested among the tall, where even the six-footer (183 cm) is short (range of eight finalists in shotput, Munich Olympics 1972, 186-202 cm; range of winning rowing team, 183-196 cm (excepting coxswain who was of average height, 175 cm)). A tall competitor has two