¹²⁵I-fibrinogen in the diagnosis of deep vein thrombosis

SIR,—I read Dr V C Roberts's paper on this subject (3 August, p 455) with great interest. I agree with him that standardisation of the method is important, as it is used in different ways in many clinics. However, I believe Dr Roberts's plea for standardisation will be difficult to implement clinically. Any new way of using the method would have to have considerable advantages compared with those described by Browse and Negus¹ or Kakkar *et al.*²

My plea is for an improvement of the method by using instruments with a greater accuracy than those commonly used. The choice of the instrument may also reduce the time of the investigation. In ¹²⁵I-fibrinogen studies many clinics are using a simple count ratemeter with direct readings on the scale (percentage of the heart count). Counting ratemeters are useful when one is measuring high activity in blood circulation studies. In static situations, such as ¹²⁵I-fibrinogen scanning, the accuracy and precision of the scaler are always greater than that of the ratemeter.³ For example, at 5000 counts/min and the time constant of 15 seconds the equilibrium time is more than one minute. In practice the superiority of the scaler is also greater as the investigation time is reduced.

As a suitable instrument I am using a portable mini-scaler and a detector with a diameter of 50 mm. The total reproducibility, including the expected statistical error and geometrical error, was found to be 5% with repeated measurements over the heart and the legs. The investigation time is less than five minutes.⁴ In addition, the background activity is always subtracted.

KRISTER FORSBERG

Division of Haematology,
Karolinska Sjukhuset,
Stockholm

¹ Browse, N L, and Negus, D, *British Medical Journal*, 1970, 3, 615.

² Kakkar, V V, *et al*, *Lancet*, 1970, 1, 540.

³ Charkes, N L, *Lancet*, 1973, 1, 1191.

⁴ Forsberg, K, *Läkartidningen*, 1975, 42, 4040.

C-Film as a contraceptive

SIR,—Dr M V Smith and his colleagues of the Family Planning Association, reporting the results of a clinical trial of C-Film used as the sole method of contraception (2 November 1974, p 291), recorded nine pregnancies among 45 women during 175 person-months of exposure to risk. This represents a use-effectiveness pregnancy rate of 62 per 100 woman-years.

We were surprised at these results because they were so much at variance with our own preliminary data. This study has now been completed.¹ My colleagues and I assessed C-Film as the sole contraceptive at three family planning clinics in Sweden, including the WHO Clinical Research Centre at this hospital. It was used by 237 women for a total of 1866 months. During this time 14 pregnancies occurred, which gives a use-effectiveness pregnancy rate of nine per 100 woman-years.

Most of the failures were the result of incorrect use, the true method failure rate (theoretical effectiveness) thus being about 2 per 100 woman-years. While we would not recommend C-Film as an alternative to

oral contraception or the intrauterine device, we consider it offers good contraception for the reliable user—always provided she receives proper instruction.

Almost certainly the explanation for the very different results lies in this question of reliable usage and proper instruction. A pregnancy rate of 62 per 100 woman-years, as reported by Dr Smith and his colleagues, would ordinarily be expected in women using no contraceptive method at all.

N RAABE
OLLE FRANKMAN

Department of Obstetrics and Gynaecology,
Karolinska Sjukhuset,
Stockholm

¹ Frankman, O, Raabe, N, and Ingemansson, C A, *Journal of International Medical Research*, 1975, 3, 292.

Sight in new-born babies

SIR,—Many of your readers will have seen a pamphlet, "Keep Baby Warm" (Cat No CW6), issued by the Health Education Council. It is one of "a series of practical hints to parents on the everyday health and safety of their young children."

The advice and the facts given in the pamphlet appear unexceptionable except in one important detail. The second sentence, commenting on new-born babies, reads, "Although their eyes are open, they cannot see." There is now abundant evidence to show not only that new-born babies can see but that they are perceptually alert. Although this error does not detract from the central message of the pamphlet it is, nevertheless, a serious oversight since it may inhibit parents from important interaction with their babies in the first few days and weeks of life. I feel sure that general practitioners and paediatricians, in particular, will wish to take every opportunity to correct this error.

RONALD DAVIE

Chairman,
Developmental Psychology Section,
British Psychological Society

University College,
Cardiff

Long-term prophylaxis with beta-adrenoceptor blockade after myocardial infarction

SIR,—We read with interest the paper from the multicentre study on this subject (27 September, p 735). We have reported¹ a similar trial. In this 500 patients admitted to a coronary care unit, usually by mobile coronary care service, received either practolol 300 mg 12-hourly or an identical placebo by random selection. The tablets were started in the patient's home. In those with infarction there was no overall difference in mortality, reinfarction, or important complications during the two-year follow-up. In one subgroup, those with an initial tachycardia, there was a reduction in mortality, which was still present at one year.

Unlike the multicentre trial, we found no preferential effect in patients with anterior infarction. Practolol did not influence the subsequent progress of patients admitted to the coronary care unit who did not have myocardial necrosis. Our results therefore differ from those of the multicentre trial and of Wilhelmsson and others,² although, of

course, the design of the trials was different. We feel that the use of beta-blockade in patients presenting with acute myocardial infarction and tachycardia requires further study.

J M BARBER
D MCC BOYLE

Cardiac Department,
Ulster Hospital,
Dundonald, Belfast

¹ Barber, J M, *et al*, *Acta Medica Scandinavica*, in press.

² Wilhelmsson, C, *et al*, *Lancet*, 1974, 2, 1157.

GP obstetrics in the future

SIR,—I was interested in the suggestion of Mr M Elstein and others (27 September, p 765). I would entirely agree that intrapartum obstetrics should be carried out only by those adequately qualified, and that the present requirements for the obstetric list are inadequate. Shared care offers a satisfactory compromise, although I feel that Dr Elstein's term "office obstetrics" gives the wrong impression of what general practitioner care should be.

I differ from them in the suggestion that GPs from different practices should arrange a rota for inpatient care of each other's patients. The unique value of the general practitioner obstetrician system is that it allows the GP continuity of care. This is the one thing my patients seem to value and it is the one thing that allows us to reach as high a standard of care as that of routine hospital obstetrics. We know our own patients to a degree that the hospital obstetricians can never match. Once we sacrifice our continuity our standards of care will fall and, from the patient's point of view, we might as well have referred them to the full-time obstetricians for care in the first place.

M P ROSEVEARE

London SE27

Side effects of clobetasone butyrate

SIR,—In their paper on the activity of clobetasone butyrate and its effect on pituitary-adrenal axis function (13 September, p 626) Dr D D Munro and Miss Lyn Wilson refer to hydrocortisone 17-butyrate as "a preparation claimed to be as safe as hydrocortisone." I would be interested to know in which scientific paper this claim was made. In 1973 Hendrikse and Moolenaar¹ reported suppression of hypothalamic-pituitary-adrenal function by hydrocortisone 17-butyrate applied under occlusion to the whole body surface.

Of course we are all looking forward to a preparation with as favourable a ratio as possible between therapeutic effects and side effects, local as well as systemic. The local side effects of corticosteroids are the most obnoxious; systemic side effects are to be feared only with gross overtreatment. The fact that epidermal thinning of pigskin treated with clobetasone 17-butyrate is less than when treated with fluocinonide, the same as when treated with triamcinolone acetonide, and more than when treated with hydrocortisone is rather weak evidence that clobetasone 17-butyrate will cause less atrophy in the human dermis than corticosteroids of comparable therapeutic effectiveness. It is regrettable, however, that