When all results were considered together the urine tube immunoassay (Model) gave 100% sensitivity and specificity as well as 100% predictive values for normal and abnormal results. The serum tube enzyme linked immunosorbent assay, while showing 100% sensitivity, was less specific, and the dipsticks were intermediate in value.

Comment

Our results are sufficiently encouraging to suggest that measurement of urinary hCG with ultrasensitive tube or dipstick assays should be the first line investigation in women presenting with non-specific abdominal complaints. Results equivalent to those of qualitative rapid radioimmunoassays may be obtained and appropriate further investigations such as laparoscopy, ultrasonography, and culdocentesis instituted. Qualitative tests do not differentiate ectopic from intrauterine pregnancy but offer a rapid and convenient assessment of secretion of hCG. The current assays may be simplified, and preliminary results using a two minute test (Icon, Hybritech) have been as good as those obtained with the assays described here (paper submitted for publication). These relatively simple, convenient, and commercially available enzyme labelled assays should be widely available in outpatient departments and wards for 24 hour use.

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Restraint of babies in cars

Adequate restraint considerably reduces death and injury to infant passengers in car accidents.[1,2] The official recommendation in Great Britain for the restraint of babies aged 0-6 months (weight <9 kg) is that the baby should be laid in a carrycot that is held in the rear seat by straps fixed to suitable anchor points on the car body. We determined the degree of compliance with this recommendation by questionnaire and by observation.

Subjects, methods, and results

During December 1984 and January 1985 public postnatal inpatients in the Princess Anne Hospital were studied with the approval of the consultant obstetricians and Southampton ethical committee. The women were assigned to an interview or a control group according to the postnatal ward of admission; the designation of wards was changed midway through the study. Mothers who did not have access to a car or whose babies stayed in hospital for more than 12 days after delivery were excluded. Those in the interview group were questioned about access to a car, knowledge of the recommendations for carrying babies in cars, and their intended practice. Those in the control group were given a sham interview (breast feeding survey) in which we determined whether they had access to a car; no other reference was made to cars or to safety. Interviews were stopped when 100 had been successfully completed in each group (this required 258 interviews altogether). A follow up questionnaire was sent to all subjects three or four months after the birth of their child. The key question asked was: "When you last took your baby out in a car how did you carry him/her?"

Altogether 138 women replied to the questionnaire. The interview group showed lower compliance with the recommended practice than the control group, and therefore the interview did not artificially improve compliance. Data were pooled to give a total compliance of 55/138 (40 (binomial SD 4)%). The reasons for lack of compliance were elicited by a check list (table). When questioned about the proportion of journeys in the car for which their baby was restrained 67 respondents said that they never used restraints and only 29 that they always used them. Of 49 mothers in the interview group who had intended to restrain their baby, only 19 had done so on the most recent journey.

Observers waited at the exits of several large supermarket carparks. Of the 295 babies seen in cars, only 129 appeared to be adequately restrained (compliance 44 (3)%). There was good agreement between the results of the questionnaire study and this observational study, which was performed before the follow up questionnaire was administered.

Reasons for lack of compliance with recommended practice for restraint (n=138; multiple responses allowed)

Car unsuitable	69
Too much bother	36
Too expensive	26
Baby gets fed up on long journey	26
No room in car	24
Baby doesn't like it	21
Lack of knowledge	13
Not worth using on short journey	11
Own two cars, use restraint in only one	8
Don't think they are worth while	0
No reason given	8
Always use restraint	34

Comment

Only about 40% of babies carried in cars in Southampton are adequately restrained. This is much lower than the figures found in observational studies in Australia (70%), New Zealand (66%), and the United States (60%).[3-5] The reasons for non-compliance (table) may be summarised in three points: (1) inconvenience, cost, and lack of understanding about fitting restraints; (2) lack of room in the car; and (3) lack of information and understanding about the benefits of restraints.

The problems of inconvenience, lack of room in the car, and resistance by the baby could be alleviated by modifying British practice to recommend restraint systems which hold the baby in a semireclining position facing the back of the car. The problem of cost has been overcome in New Zealand by an organisation supported by the government making suitable restraints available at low rental. The problem of education and information is one that should be accepted by the medical profession and other groups as a challenge to be jointly overcome.

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Glucomannan and risk of oesophageal obstruction

Glucomannan (glucose/mannose polymer) is considerably hygroscopic and on contact with water swells and becomes a viscous gel. In this form it is a normal Japanese foodstuff. Like guar (galactose/mannose) it has been used to treat diabetes mellitus.[1] Recently, dry, non-expanded glucomannan has been marketed in Australia as an aid to dieting, the claim being that it inhibits the appetite by swelling in the stomach, producing what one