favour in our resource conscious health service, particularly when an analysis of simple clinical factors and EEGs is done correctly.

The Royal College of Physicians' study showed that younger age, a family history of epilepsy or of febrile convulsions, and a seizure occurring between midnight and 8 am were factors associated with recurrence if all three factors were present the recurrence rate at one year was 56% (95% confidence interval 42% to 70%); if two factors were present it was 43% (35% to 51%); if one factor was present it was 30% (25% to 36%); and if no factors were present it was 18% (7% to 28%). The study by Dr van Donselaar and colleagues also showed that younger age and seizures occurring at night or on waking were associated with recurrence. If these factors were present the frequency of seizures and the well the probability of recurrence why bother with electroencephalography?

The sensitivity of the first electroencephalogram in detecting epileptic discharges in patients after a first seizure in the study by Dr van Donselaar and colleagues was 16/151 (11%), and even if the recording was repeated after partial sleep deprivation (combined electroencephalograms) the number rose to only 35/151 (23%)—this with an interobserver agreement about clinical EEG readings of only 5/5. The authors were at pains to exclude all cases that were of doubtful idiopathic seizures. This low sensitivity (detection rate) of epileptic discharges in those who had had unconfirmed seizures should remind physicians that electroencephalography cannot be used to "diagnose" a doubtful event. The authors quote the specificity of combined electroencephalograms as being 91%—that is, a false positive rate of 9%. It is not clear what they mean by this as all patients in their study had truly had a first seizure.

Neurologists traditionally interpret written electroencephalography reports in the light of the clinical history. Perhaps we should be more hand

cared. Clinical neurophysiologists would do us all a favour if they were more explicit about the sensitivity, specificity, and odds of being affected and give a true positive result for a variety of clinical disorders. Prior et al. (1975) analyzed the use of sphenoidal electrodes in this way in 1975.5 Clinical neuro-
physiologists should surely build on this.

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Ovarian hyperstimulation
Sir.—In the editorial by Dr Blair H Smith and Professor Ian D Cooke the only preventive measure mentioned for the avoidance of the ovarian hyperstimulation syndrome in assisted reproduction was aspiration of follicles. In their letter in response to the article Messrs Martin S Mills and Peter G Wardle mentioned an alternative possibility—proceeding to oocyte retrieval and freezing all the oocytes with them being replaced.2 This avoids the chance of pregnancy, which can aggravate any hyperstimulation syndrome.

There is an alternative approach that in our hands has been a very successful method. The approach involved is that in cycles controlled by gonadotro-

phin releasing hormone antagonists it is possible to withdraw gonadotrophin stimulation and have confidence that the surge of luteinising hormone will not occur. We adopted this approach after having three patients with serious hyperstimulation in 1987. Since mid-1988 we have applied this policy and have had no cases of the hyperstimulation syndrome in an in vitro fertilisation clinic operating more than 500 cycles a year. By maintaining the gonadotrophin releasing hormone antagonist down regulation and restimu-

lating with gonadotrophins when the ovarian follicles have regressed, good pregnancy rates are obtained in such cycles.3

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Sir,—The well conducted hospital based study by Dr Ces A van Donselaar and colleagues on the recurrence of a first idiopathic seizure has replicated to some extent the results of a previous British survey.4 We would, however, make the following comments:

The diagnosis of epileptic seizures is particularly difficult in its early stages. In 28% of patients enrolled in a community based study of epilepsy the diagnosis of the seizures was still unclear six months after entry.5 In the Mayo Clinic study 20% of patients with their first seizure to diagnosis exceeded two years in more than 30% of patients.6 Dr van Donselaar and colleagues studied only patients attending hospital with a well defined single attack, and the overall recurrence rate in this group may be different from the true rate of recurrence in less selected patients in the general population (78% in a recent population based study).7

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I desparately needed to see my son
Sir,—Ms Sheila Awooner-Renner reminds us all that grief is a very personal experience.1 Guidelines are written in journals and in hospitals to assist in the care of the bereaved person. The main role of staff, and other relatives, is to follow the relatives’ and the patient’s expression of grief to be uninhibited by the pressures of social acceptance. There is no proper way to grieve: in this tragic situation the response that feels right to the individual is right.

It is probably best that the grief taboo, present in society, is not brought to Western society. People are scared to talk of the dead—their language becomes an entanglement of euphemisms, and the recently bereaved are socially isolated.

In hospital many feel the need to protect recently bereaved people from "any more distress" by guiding them through the grief process. We should be accompanying them through this difficult journey but not deciding their route. No one should be afraid to talk to them, is there anything you want to do? Is there anything you want to do?" With a simple question we can dispel the agony of the hospital routine and leave them to cope. These people can do things—"What are your wishes—are you people in the hospital and not to help others who is seen as a friend rather than a figure of authority. We are not thought to have other work on their hands. Relatives are more open with her and ask her questions more freely. Discussion with an apparent lay person is often less clinical but more informative at this stage. Clinical detail may be added by medical and nursing staff. Her continued contact over the next few weeks allows the opportunity to ask those often forgotten questions. Our link worker has received many letters and calls of thanks from bereaved relatives. The only concern is, from a young person, questioned the need for such vigorous resuscitation and her exclusion at the time of death—the decision of a doctor, not the link worker.

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1 Awooner-Renner S. I desperately needed to see my son. BMJ 1991;302:356. (9 February.)

Triage of x ray films?
Sir,—Drs I G H Renwick and colleagues have identified that the early reporting of radiographs obtained in accident and emergency x ray department is becoming increasingly difficult.1 Their results show that radiographers should not be expected to take on the task because of a consider-

able error rate.

I agree that triage of x ray films "can be of use to casualty officers." At this hospital the department of radiology provides a "red dot" system, whereby radiographers triage x ray films before their interpretation by casualty officers. All x ray films are reported by radiologists. Important diagnostic errors are identified and rectified by our audit process. Over a recent 10 day period 352 radiographs were ordered by casualty officers, of which 40 showed abnormalities. Casualty officers had a false positive rate of 1.7% of all films. Of the 40 abnormal films, eight were judged to be normal by both the radiographer and the casualty officer, giving a combined false negative rate of 20% of all radiographs, and 16% of those who were abnormal.

All abnormalities detected by radiographers were confirmed and properly treated by casualty officers. Further discussion of their limited diagnostic role focused the casualty officers’ attention on the presence of an abnormality and was thought