pated in the first survey. Of the 13 respondents, 11 of whom had returned the previous survey, only two commented that population based data could be produced, while another two could supply hospital based datasets. The obstacles encountered by regional coordinators in providing data for 1993 and 1995 are given in the table.

Comment

Obtaining comparable national data on births from NHS sources is difficult for even the most basic items, and the situation is worsening rapidly. Undoubtedly, the loss of the information gathering function of former regional health authorities has had an important impact. However, a few coordinators mentioned a new factor: contributing to national data had a low priority. They blamed purchasers and the Department of Health, but many doctors also show little interest.1

If we are to have national data on births, risks and benefits will have to be identified for the NHS Executive, the Department of Health, purchasers, doctors, midwives, and data entry clerks. Once these groups are convinced of the importance of this work, a coalition of committed participants could be formed to resolve the difficulties illustrated by this study.

A recent study showed that only 60% of midwives could retrieve useful information from local maternity systems, while those working regionally and nationally find data almost unobtainable.5 With such an imbalance between the high effort to input data and the low utility of output, is collecting dozens of details for every birth worthwhile?

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A full report is available from the Confidential Enquiry into Stillbirths and Deaths in Infancy Secretariat, Chiltern Court, 188 Baker Street, London NW1 5SD.

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Abortion rates in England in 1995: comparative study of data from district health authorities

Veena Soni Raleigh

British developmental aid for developing countries prioritises greater reproductive choice for women through improved contraceptive services. But is enough being done in the United Kingdom to reduce unwanted pregnancies? I studied lifetime fertility, abortion rates, and the proportion of pregnancies resulting in induced abortion in 105 district health authorities in England.

Subjects, methods, and results

I analysed data on births and legal abortions during 1995 by district health authority as compiled by the Office for National Statistics. Total period fertility rates are a conventional measure of the mean number of live births that a woman would have if she experienced the current age specific fertility rates throughout her childbearing years. These rates were calculated by summing the 5 year age specific fertility rates at ages 15-49 and multiplying by 5. Total period abortion rates were similarly calculated. The total period pregnancy rate is the sum of the total period abortion rate and total period fertility rate. Stillbirths and spontaneous abortions were excluded.

In 1995, 147 851 abortions occurred among women resident in England compared with 613 257...
Embryonic abnormalities at medical termination of pregnancy with mifepristone and misoprostol during first trimester: observational study

G Blanch, S Querby, E S Ballantyne, C M Gosden, J P Neilson, K Holland

Accurate data on the incidence and nature of embryonic and fetal abnormality during the first trimester and of non-viable pregnancy are needed so that women who have experienced miscarriages can be counselled, and abortion and early prenatal diagnostic services can be improved. New medical techniques for abortion in the first trimester enabled us to collect and analyse data on undamaged first trimester pregnancies.

Subjects, methods, and results

Between November 1994 and August 1996, 506 healthy women chose medical termination of their pregnancy before nine weeks' gestation in the dedicated day care abortion unit of the Liverpool Women's Hospital. Women attended twice (firstly for oral mifepristone and then for oral misoprostol), and most aborted after receiving misoprostol and while still in the unit. Altogether, 293 passed products of conception in the day care unit (all within six hours of receiving misoprostol); 225 of these had given informed consent to study of the tissues. Women who were ineligible for study included 76 who had passed products of conception after receiving mifepristone but before readmission to the day care unit for misoprostol and a further 127 who passed products after discharge from the day care abortion unit. In only 10 women did the medical termination of pregnancy fail.

All specimens were examined macroscopically on the day of termination and fixed in 4% paraformaldehyde. The embryos that appeared structurally abnormal on macroscopic examination were further examined histologically. Strict criteria were used to distinguish structural abnormality from traumatic damage. Agreement among three investigators (GB, SQ, and ESB) was required before a classification was


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