problems during pregnancy than other patients, as shown by recent perinatal figures—for example, on patients attending the East Birmingham Hospital. It is rather misleading to say that the perinatal mortality among women booked under their general practitioner was 10·1 per 1000 and that these figures are high as they include women booked for home deliveries, most of whom presumably were never seen by a consultant obstetrician. Furthermore the figure of 10·1 has not been corrected to exclude congenital defects and extreme prematurity as was that of 3 per 1000 quoted from Oxford.

On further analysis it seems that of 378 women transferred to consultant care antenatally, 267 (71%) had a normal delivery; and so what is remarkable about that? Yet the authors make no comment on the fact that 52 patients (14%) had a caesarean section. Do they not consider that to be high? Lastly, the outcome of pregnancy among 259 patients transferred to consultant care during labour was that 191 (74%) had a normal delivery and the rate of caesarean section was 15%.

My idea of an integrated unit is one where the consultants and the general practitioners can work in happy unison, but the general practitioner always has to remember that at any time the consultant may be called on to take over the management.

I think that most general practitioners in Britain now would accept that they are perfectly capable of providing excellent antenatal and postnatal care but that much of that care could be equally well provided by experienced midwives at far less cost to the NHS. But there seems to be no trend to suggest that the midwives are going to be given the autonomy that they so greatly seek. Perhaps consultant obstetricians feel that this would detract from their position of ultimate authority. It would have been interesting to learn, for example, whether consultants in Bradford feel that there should be no home deliveries at all. This would certainly upset many experienced midwives and not a few patients.

I think that most general practitioners, whether they carry out intrapartum obstetrics or not, believe that the condition that a general practitioner who does carry out intrapartum care has to attend only five deliveries a year really is not sufficient qualification at all. I believe that most general medical practitioners, including myself, feel now that, in general, general practitioners are really capable only of delivering the placenta and suturing up an episiotomy and that that work is done perfectly well by experienced midwives under the supervision of their consultant obstetric colleague. I for one was not convinced by the comments of Dr Bryce and colleagues that general practitioners' lack of care is the only factor in causing this unacceptably high perinatal mortality and neither was I surprised that 70% or so of all deliveries were normal. I certainly am concerned that the rate of caesarean section is as high as 15% and that we seem to be approaching slowly but surely the 25% rate, which is purported to be the level in the United States, where fear of litigation because of delivery of a handicapped child drives the obstetrician to carry out a caesarean section when in other circumstances he or she might have been content to let the patient continue and deliver normally.

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1 Bryce FC, Clayton JK, Rand RJ, Beck I, Farquharson DIM, Jones SE. General practitioner obstetrics in Bradford. *Br Med J* 1990;**300**:725-7. (17 March.)

SIR,—I was saddened to read of the apparent poor standard of general practitioner obstetric care in Bradford in the article by Dr F C Bryce and colleagues.[1] The report raises several important issues, including booking criteria, training of general practitioner obstetricians, and obstetric audit.

There are several possible explanations for the high perinatal mortality in women booked under general practitioners who were subsequently transferred to consultant care. Simplistically it seems that general practitioners are booking "high risk" women under their sole care and that this alone is responsible for the high mortality. But there is no good evidence that obstetric intervention in high risk cases improves neonatal outcome,[2] so why should such women not be booked under general practitioners? If general practitioners had access to open laboratory and radiology facilities I would contend that they could care well for some high risk women after suitable training, provided that the women were booked for delivery in an integrated unit. No evidence is presented about general practitioner access to such facilities.

Secondly, it may be that the standard of care that general practitioners in Bradford provide is poor. Indeed, the paper supports this view in that only 37 of 255 women seem to have been visited by their general practitioner during labour despite developing problems. This is appalling if true, and certainly not in line with the recommendations of the joint Royal College of General Practitioners and Royal College of Obstetricians and Gynaecologists working party.[3] Surely it is part of a general practitioner's moral duty to attend a woman in labour who is booked under his or her care and who has developed problems.

It is also possible that the women had chosen to be booked under a general practitioner for other reasons—for example, language problems, different culture, fear of hospitals—or that they had different social variables to the women booked under a consultant. It is well known that such social factors affect perinatal mortality, and again the paper presents few data on this aspect.

No conclusive evidence is presented that the high perinatal mortality (which unfortunately has not been corrected for birth weight or lethal congenital malformation) is due to general practitioners booking high risk women per se. The present nationally accepted booking criteria are based on data that are over 30 years old[4] and may well not be relevant to modern obstetrics practised by competent general practitioners in integrated units. If general practitioners audited their care then through audit, continued education, and local informed discussion with consultant colleagues agreed booking policies could be implemented (as in Bath Health District, R Porter, personal communication) and adhered to by all concerned. Subsequent audit will then show whether the booking criteria are correct and permit change. The proposed joint working party of the Royal College of General Practitioners, Royal College of Obstetricians and Gynaecologists, and Royal College of Midwives is thus timely. It is very important that the difference between good general practitioner care in peripheral and integrated units is appreciated and that different booking criteria should apply to the two settings.

Finally, the paper's proposal to appoint another consultant to improve the perinatal mortality may not achieve its aim. Perhaps the appointment of more community midwives to reach women in the community and encourage them to attend for antenatal care might be more effective.

The pregnant women whom we care for deserve high quality informed obstetric care, based on sound practice and scientific fact and not on outdated opinion. This principle applies equally to midwives, general practitioners, and consultants. The recently formed Association of GP Maternity Care intends to promote this path of informed and committed obstetric care.[5]

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Non-steroidal anti-inflammatory drugs and peptic ulcers

SIR,—Dr C J Hawkey's recent review[1] highlights the importance of awareness about the use of aspirin or non-steroidal anti-inflammatory drugs in the assessment and management of dyspepsia and peptic ulcer. These drugs have also been implicated in oesophageal disease. Of patients attending for an initial dilatation of oesophageal stricture, 22 of 76 (29%) had been taking them regularly, in contrast with 10 of 70 (14%) age matched controls without oesophageal disease.[2] Furthermore, more than two thirds of patients taking non-steroidal anti-inflammatory drugs long term have subclinical inflammation of the small intestine or occult blood loss.[3] A small number may develop a condition resembling Crohn's disease.

Dr Hawkey pointed out that peptic ulcers associated with non-steroidal anti-inflammatory drugs are more likely to be silent. A subsequent article by Drs T M Shallcross and R V Heatley confirmed that the use of non-steroidal anti-inflammatory drugs seems to alter the profile of symptoms in dyspepsia caused by ulcers or not caused by ulcers.[4] Dr Hawkey suggests that one possible explanation for this could be that doctors are reluctant to prescribe non-steroidal anti-inflammatory drugs for patients with dyspepsia. This may be true of many, but many more do not seem to appreciate the potential problem. A survey in general practice identified 198 patients receiving repeat prescriptions for non-steroidal anti-inflammatory drugs. Forty (20%) were found to have an active, inactive, or suspected ulcer.[5]

I surveyed 100 consecutive new outpatients with dyspepsia at the Royal Hallamshire Hospital, Sheffield, towards the end of 1988 and repeated the exercise at Middlesbrough General Hospital in mid-1989. All referrals were by letter from a general practitioner and it was clear that the problem was thought to relate to the oesophagus, stomach, or duodenum. I asked all patients about the use of two doses or more of aspirin or non-steroidal anti-inflammatory drugs in the two months before referral and compared their replies with information in the general practitioner's letter. In Sheffield 42% had taken such treatment compared with 30% in Middlesbrough. Ten of 42 (24%) and seven of 30 (23%), respectively, had been treating themselves with some form of aspirin or "over the counter" ibuprofen. Overall, the general practitioner's letter mentioned the treatment in only 16 of 42 (38%) cases in Sheffield and 17 of 30 (57%) in Middlesbrough. There was no mention for any of the self treated cases, and if these are excluded the reporting rates rise to 16 of 32 (50%) and 17 of 23 (74%). Three patients in the Sheffield series and one in Middlesbrough were taking two non-steroidal anti-inflammatory drugs concurrently but this was not mentioned in the referral letter. Twenty five of the 200 patients had been taking aspirin compared with 47 using a non-steroidal anti-inflammatory drug. The mean ages and proportions of women within the patients referred to the two centres were 53·7 years and 48% in Sheffield and 59·6 years and 50% in Middlesbrough.

Doctors should give more thought to these drugs

before referring patients with dyspepsia. Those receiving referrals must ask specific questions and not rely on the information in the letter.

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Blood transfusion services and the European Community

SIR,—Dr John D Cash, in his editorial on blood transfusion services and the European Community,[1] shows an admirable and proper concern for the public availability of essential and safe processed blood products for therapeutic purposes, but it is a pity that he gives a misleading impression of the intention of the European Commission directive to which he refers.[2]

He states that the "directive seeks to outlaw the paid donor in Europe and to forbid products derived from paid donors from entering Europe," and because of "a heavy and frightening burden on the non-profit making or public sector plasma procurement and fractionation institutions . . . reduce access to new plasma products for the people of the European Community in the 1990s." He implies that the outcome of the directive will be to transfer the processing of voluntarily donated human plasma to commercial processors for gain and that this could possibly inhibit and diminish the supply.

Among other requirements, the directive's aim to ensure that member states take the necessary measures recommended by the Council of Europe and the World Health Organisation to prevent the transmission of infectious disease associated with plasma products, whether produced in the public or the private sector, and that imported materials of a similar nature should meet the same standards. The directive states that "the Community entirely supports the efforts of the Council of Europe to promote voluntary unpaid blood and plasma donation to attain self-sufficiency throughout the Community in the supply of blood products, and to ensure respect for ethical principles in the trade in therapeutic substances of human origin."

Although I disagree with the impression given of the effect of the directive on blood donations, I share Dr Cash's reservations about the attitude of the British government. There are times when the Department of Trade and Industry is the lead department in matters that have a major health interest in Britain. Other European Community governments seem to collaborate more closely with their professions and give greater support to their contributions to committees within the European Commission. I believe that the Department of Health should strengthen its European section and its links with the Department of Trade and Industry to ensure that professional organisations in the United Kingdom are consulted at a time when directives concerned with the provision of health care are in preparation and are still capable of modification.

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Tryptophan and eosinophilia myalgia syndrome

SIR,—As Minerva reports, up to mid-February 1269 cases of eosinophilia myalgia syndrome related to the ingestion of tryptophan have been reported in the United States to the Centers for Disease Control.[1] These cases include 13 deaths, of which one has been confirmed as clearly due to ingestion of tryptophan.[2,3] The Food and Drug Administration has stopped the sale of tryptophan and urged recall of all tryptophan products containing more than 100 mg per daily dose (FDA, press release, 25 January). Eosinophilia myalgia syndrome has also been reported in France.[4]

Tryptophan is still being prescribed in Britain for depression, though it has been withdrawn here as a non-prescription item. In a letter alerting doctors to eosinophilia myalgia syndrome the Department of Health concluded by recommending that patients should continue to take prescribed tryptophan. So does the Committee on Safety of Medicines.[5] In my opinion this conclusion is unwarranted. How tryptophan products cause eosinophilia myalgia syndrome is not known. The contaminants suspected as the "probable" cause and cited by the Committee on Safety of Medicines have been searched for but so far not found; no sources of tryptophan have been identified as safe (FDA, press release, 25 January). There is no compelling medical necessity to expose patients to this potentially serious risk as many better antidepressants are available. Pending further clarification of the pathogenesis of eosinophilia myalgia syndrome tryptophan should not be prescribed.

To gather valid information, good case finding is essential. Cases of eosinophilia myalgia syndrome in the United States went unrecognised until doctors and the public were informed of the hazard and of the clinical picture, after which they looked for it—hence the sudden emergence of 1269 cases in less than four months. Patients who have been taking tryptophan in recent months should be specifically asked about symptoms that must then not be discounted as non-specific somatic complaints, somatoform disorders, etc. The markers to look for are myalgia sufficiently severe to interfere with ordinary activities, eosinophilia over 1×10^9 cells/l, and absence of other medical conditions that would explain eosinophilia. Symptoms may include rashes, dyspnoea, arthralgia, fever, weakness, and oedema of the extremities.[6] Symptoms do not necessarily or promptly stop when tryptophan is stopped, but often they improve gradually. No one yet knows the course or prognosis of the disorder.

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Management of patients with head injuries

SIR,—I was pleased to see in the notes section[1] a copy of the South East Thames Regional Health Authority guidelines for the acute management of patients with head injuries. The care of such patients continues to be of great concern, and the best outcome in this group will be achieved by the best possible care from the moment of injury to eventual rehabilitation.

I would like to make a plea for attention also to be paid to the availability of neurosurgical facilities for the definitive care of these patients—both the small group requiring surgery for intracranial haemorrhage and the larger group with diffuse brain injury. Neurosurgical unit facilities in the health authority are located at Brook Hospital at present. Of the 12 patients referred from Kent and Canterbury Hospital in 1989, only seven were able to be accepted at Brook Hospital because of shortage of care facilities in intensive therapy units or shortage of nursing staff. Of these, six were accepted for scanning and, after negative findings in terms of need for operation, were returned the same day for continued care at our district general hospital. The remaining patient underwent surgery and was returned for continued care a month later.

Two patients were children and were therefore admitted to Guy's Hospital because Brook Hospital does not have facilities for children. Both of these were cared for at and subsequently discharged from Guy's Hospital. Two patients were admitted to the Atkinson Morley Unit as Brook Hospital was unable to take them. One was operated on and died, the second was subsequently transferred to St George's Hospital for cardiothoracic care and later returned to Kent and Canterbury Hospital, where he died. The final patient went to Maudsley Hospital as Brook Hospital was unable to take him. He died on the day of transfer. Two further patients, after conversation with the neurosurgical unit, had subdural haemorrhages drained at Kent and Canterbury Hospital.

The prognosis for patients with diffuse brain injury is always poor, but I believe that any improvement in outcome will come not only from improved primary care but also from skilled monitoring and management in a neurosurgical unit. I hope that these services would be made available for all patients in this region.

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1 Anonymous. Notes. *Br Med J* 1990;**300**:546. (24 February.)

Trauma services in a district general hospital

SIR,—Dr S J Kinny and Mr D H A Jones with their study illustrate how the concept of regional trauma centres must be adapted for the idiosyncratic variations in geography, population distribution, and hospital services in the United Kingdom.[1] Their conclusion that the Royal College of Surgeons may have overestimated the requirement for trauma centres, however, requires comment.

The role of the district general hospital in a relatively isolated rural environment would be to recognise early those patients who require the skill available in trauma centres and to stabilise these patients before rapid and safe transfer. The use of