

observer and interobserver variability.⁴ When the cardiocotogram is abnormal fetal blood sampling to assess the severity of fetal acidosis should be performed.

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SIR,—While inadequacies in fetal monitoring, forceps management, and supervision by senior staff were found to be common to most of the 64 cases of obstetric accident reviewed by Ms M Ennis and Dr C A Vincent and these conditions could not have increased the possibility of a safe delivery, the design of this study does not permit the conclusion that they were necessarily the cause of the disastrous outcomes.¹ The generalisation that disastrous outcomes would be avoided if these inadequacies were corrected is even less appropriate. Before identifying conditions as causes of death or damage one has to measure whether or not they were present also in cases of healthy survival.

In the opinion of one or a small number of experts fetal monitoring was inadequate, either because it was not carried out or because interpretation of the electronic traces did not prompt appropriate action. But correct interpretation of traces is notoriously difficult because there is a wide overlap between the recorded responses of healthy and distressed fetuses. Wide variation in interpretation has been reported between experienced observers,² and interpretation of a monitor's traces is often contradicted by analyses of blood samples taken concurrently from the fetal scalp.³ The present study does not mention results of such blood tests.

Whether or not a different interpretation of an electronic trace would have prevented disaster in the particular cases reviewed, obstetricians have not been able to show that, in general, electronic fetal monitoring has made birth safer.^{4,5} The benefit of a lower rate of neonatal neurological damage found in one study after continuous monitoring compared with intermittent monitoring had disappeared by early childhood, and the incidence of cerebral palsy was not reduced in the group randomised to electronic monitoring.^{6,7}

In most cases electronic monitoring confines the mother to bed, and because of her immobility she is more aware of her pain, which is often increased by oxytocin administration. She is more likely to be given epidural anaesthesia and thus more likely to need a forceps delivery. Certainly, obstetricians should learn how to apply forceps effectively if they are needed but the need is often created by earlier obstetric procedures as is the fetal distress which monitoring aspires to detect.

Correcting the inadequacies identified in this study should help to reduce the number of events judged as accidents by expert obstetricians but would reduce only marginally the total of deaths and damage associated with birth. The cause of many of these lies, ironically, in obstetric intervention itself.

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SIR,—Ms M Ennis and Dr C A Vincent emphasise lack of fetal monitoring in cases that led to litigation in obstetrics.¹ They fail, however, to mention that none of the nine randomised controlled trials (comprising over 54 000 patients) of continuous electronic fetal monitoring in labour showed any benefit in perinatal mortality and morbidity, pH values of blood from the umbilical cord, and Apgar scores. The largest trial included follow up of babies at 1 and 4 years and showed no difference between the study group and control group.² There was also wide disagreement concerning both interpretation of the cardiocotogram and strategies for intervention in two European studies by experts on perinatal monitoring.³

The American College of Obstetricians and Gynecologists informed its 35 000 members last year that, having carefully considered all the evidence from the monitoring trials, it concluded that intermittent auscultation and continuous electronic monitoring are equivalent methods of fetal surveillance in labour, even in high risk cases.⁴ In cases of prematurity a randomised study of fetal surveillance in labour has failed to show any improvement in the immediate outcome⁵ or in the neurological development at 18 months⁶ between infants monitored electronically and those monitored by auscultation.

Surely it is time that the courts, lawyers, and their medical advisers in this country based statements about continuous electronic fetal monitoring in labour on accurate scientific facts.

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Central pain

SIR,—In its commonest form, central post-stroke pain (formerly known as the thalamic syndrome) probably afflicts 2% of all stroke victims. As Dr L S Illis says in his editorial the pathophysiological division (if any) between central and peripheral neurogenic pain is blurred.¹ The two categories together may account for as many as 500 000 cases of chronic pain within the United Kingdom at any one time; the commonest form is postherpetic neuralgia, followed by painful diabetic neuropathy.

Diagnosis is indeed all important and relatively simple.² These pains are often described as burning

(more articulately, scalding or ice burn) and less often as shooting or stabbing, or both. When allodynia (production of pain by a non-noxious phasic mechanical stimulus such as contact with clothes but not by firm pressure) occurs it is pathognomonic. There is, as Dr Illis says, a partial somatosensory deficit (except in trigeminal neuralgia) which may easily be missed in segmental conditions such as postherpetic neuralgia. Perhaps most importantly, these pains are resistant to conventional analgesia, but I hope that this feature will not be used diagnostically because treatment with amitriptyline is most effective when given early. The role of anticonvulsants is emphatically secondary to that of amitriptyline except in trigeminal neuralgia. A recent double blind trial suggests that carbamazepine is of no value at all in central pain.³

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Primary survey in major trauma

SIR,—The spectre of precipitating quadriplegia in a patient with a damaged cervical spine is obviously horrific. Messrs Peter Driscoll and David Skinner suggest that "the in line stability of the neck must be maintained" during intubation and that orotracheal rather than nasotracheal intubation is preferred.¹ I assume that they mean some form of traction, even if only temporarily applied. But axial traction can aggravate displacement at fracture sites during orotracheal intubation of severely injured patients—nasotracheal intubation without axial traction is recommended if instability is suspected.²

Fibreoptic intubation of the awake patient with a cervical injury or a full stomach, or both, has been advocated,^{3,4} but this procedure often causes coughing and bucking and I cannot believe that it is a good idea when the spine is genuinely unstable.

I have not found any published account of spinal cord damage caused by intubation, and a request for details of such cases from other members of the British Cervical Spine Society at a meeting in Edinburgh in 1988 produced no result. It seems possible that cord damage during tracheal intubation of patients with unstable cervical spines is largely a theoretical problem that should not inhibit resuscitators intending to intubate the trachea in an emergency.

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Prevalence of asthma in children

SIR,—The recent report from Dr P G J Burney and colleagues suggests a real increase in the prevalence of asthma over time among children in England.¹ We have found a similar increase in symptoms among an adolescent population in rural