

surprised by the relatively low proportion of patients (two fifths) receiving internal mammary artery grafts according to the United Kingdom cardiac surgical register.

We analysed the last 100 consecutive patients who underwent coronary bypass surgery in our hospital from December 1989 to May 1990. Ninety nine patients received the following arterial grafts: left internal mammary artery (75); both internal mammary arteries (22); right internal mammary artery (1); both internal mammary arteries and gastroepiploic artery (1). A sequential left internal mammary graft was used in three patients, and a free right internal mammary graft was used in three patients. The mean number of distal venous graft anastomoses was 2.5. The operative mortality was zero. Two patients had postoperative mediastinitis; both recovered well.

We hope that our favourable experience with arterial conduits will encourage their increased use.

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1 Cameron EWJ, Walker WS. Coronary artery bypass surgery. *Br Med J* 1990;300:1219-20. (12 May.)

## Births resulting from assisted conception

SIR,—The data on the incidence of congenital malformations in babies resulting from assisted conception as reported by the MRC working party on children conceived by in vitro fertilisation<sup>1</sup> seem to be lacking in one important respect. Women who conceive after in vitro fertilisation (IVF) or gamete intrafallopian transfer (GIFT) would probably have access to skilled detailed fetal ultrasonography in the second trimester to detect congenital malformations, and pregnancies complicated by serious abnormalities may well have been terminated. While some terminations for malformations (three for anencephaly, one for achondroplasia, and one for translocation) are included it is not clear whether or not the working party made any attempt to ascertain all pregnancies that ended in therapeutic termination because of fetal malformation. Nor are there any obvious data included on any fetal losses that occurred before 28 weeks in pregnancies that may have been complicated by an abnormality. It is only with the addition of these data that the true incidence of congenital malformations in these pregnancies will be known.

A precise diagnosis of each malformation is required not only as good clinical practice in order to advise parents but also to stand any chance of assessing whether the handling of gametes or pre-embryos predisposes to errors in development. For example, it is surprising that achondroplasia was one of the disorders diagnosed early enough to allow a therapeutic abortion; in our experience in many such cases there turns out to be a more severe bone dysplasia on expert assessment. The authors point out that malformations like anencephaly occur more commonly in twin pregnancies, but this mainly applies to monozygotic twins. Presumably most of the twins reported in this series were dizygotic. If, indeed, a considerable number were monozygotic this could have implications with regard to the incidence of malformations and perhaps the adverse effect of gamete handling. Monozygotic twinning can be viewed as a malformation and therefore the incidence, for which there are good control data, should be monitored.

While we agree that it would be difficult to obtain ideally matched control data for all pregnancies, some form of prospective control

study with respect to monitoring fetal malformations may be feasible. The forthcoming Statutory Licensing Authority set up to regulate IVF services (and, it is to be hoped, to monitor GIFT services as well) should take the lead in this matter.

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1 MRC Working Party on Children Conceived by In Vitro Fertilisation. Births in Great Britain resulting from assisted conception, 1978-87. *Br Med J* 1990;300:1229-33. (12 May.)

AUTHORS' REPLY,—The MRC register was set up to establish whether the children resulting from assisted conception differed materially from children conceived normally. Thus we concentrated on viable pregnancies and on health outcomes that are reliably measured in the general population. For congenital malformations the emphasis was therefore on conditions diagnosed in liveborn and stillborn infants and on prenatally diagnosed fetal malformations in pregnancies that were terminated. We agree that our data do not include spontaneous abortions due to malformations and so do not necessarily give the "true" incidence of malformations. Adequate statistics for comparison do not exist, and a different study design would have been necessary to estimate the true incidence of malformations. Every contributing clinic was asked specifically about terminations because of malformations, and it is unlikely that any are missing as the clinics are particularly aware of such events.

We agree that the risk of various malformations does differ for monozygotic and dizygotic twins. Virtually all the twins resulting from assisted conception are dizygotic, and so we did not ask specifically about this. Among the 219 sets of twins in the MRC register 54 were both boys, 52 were both girls, and 113 were a boy and a girl, which is consistent with the sex distribution of dizygotic twins.

From 1 January 1989 the Interim Licensing Authority requires that data on the outcomes of in vitro fertilisation treatment cycles are collected by the clinics themselves and sent directly to the Office of Population Censuses and Surveys. We are continuing to collect information on babies born before then.

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## Allergy to peanuts

SIR,—The editorial by Dr Tony Smith and the short report by Dr E S K Assem and colleagues and Drs Kieron L Donovan and J Peters on peanut allergy highlighted the potential severity of reactions to peanuts and the importance of recognising this sensitivity.<sup>1,3</sup> To assess the prevalence of IgE antibody to peanut and 10 other food allergens we investigated the serum of 848 patients with suspected food allergy and found that peanut was the most commonly positive allergen (table). When a serum IgE value of radioallergosorbent test grade 3 or above was taken as a strong indicator of clinical importance<sup>4</sup> peanut sensitivity occurred in 70 patients, mostly in conjunction with sensitivity to other foods, though eight had positive results for peanut alone. This comparatively high prevalence of seropositivity and the potential serious consequences of inadvertent ingestion should encourage clinicians to include IgE to peanuts in their investigations of food allergy and alert sensitised subjects to check for peanut,

## Prevalence of sensitivity to food allergens

Allergen	No of seropositive patients (No singly seropositive)	Allergen	No of seropositive patients (No singly seropositive)
Peanuts	70 (8)	Barley	44
Wheat	67 (5)	Peas	34 (6)
Eggs	65 (18)	Fish	24 (5)
Oats	60 (5)	Shrimps	16 (2)
Rye	48 (1)	Tomatoes	16
Milk	46 (9)		

even in foods where this would be unexpected. For example, peanut, being a legume, can be included in the vegetable oil component of some foods.

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- 2 Assem ESK, Gelder CM, Spiro SG, Boderman H, Armstrong RF. Anaphylaxis induced by peanuts. *Br Med J* 1990;300:1377-8. (26 May.)
- 3 Donovan KL, Peters J. Vegetable burger allergy: all was nut as it appeared. *Br Med J* 1990;300:1378. (26 May.)
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## Management of the upper airway

SIR,—In response to Dr D Watson's article<sup>1</sup> I would like to make the following points, which may benefit both the anaesthetist and the non-anaesthetist.

Correct placement of the tracheal tube must always be confirmed as any ensuing cyanosis may wrongly be ascribed to causes other than oesophageal intubation. Auscultation of the axillae, as recommended in the article, will certainly detect right bronchial intubation but will fail to detect 15% of accidental oesophageal intubations, whereas auscultation of the axillae and epigastrium will detect all cases.<sup>2</sup> The total reliability of the oesophageal detector described by Wee<sup>3</sup> in assessing the position of the tracheal tube has been confirmed.<sup>2</sup> When connected to a correctly placed tube this device, a 50 ml syringe or rubber bulb, allows free aspiration of air from the trachea; resistance to aspiration indicates oesophageal intubation. These two techniques should prevent undetected oesophageal intubation occurring during resuscitation.

The laryngeal mask airway has been used to resuscitate a patient in whom tracheal intubation was not feasible.<sup>4</sup> The mask airway provides an alternative to endotracheal intubation when the operator is inexperienced or abnormal anatomy exists. Insertion of the airway is generally easy. The laryngeal mask airway will not fully protect the tracheobronchial tree against aspiration as the cuff does not effect a complete seal. Its use, however, may save lives.

I therefore recommend that Wee's oesophageal detector device and the laryngeal mask airway become part of the standard resuscitation equipment available today.

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- 4 Calder I, Ordman AJ, Jackowski A, Crockard HA. The brain laryngeal mask airway. An alternative to emergency tracheal intubation. *Anaesthesia* 1990;45:137-9.