

children becomes concentrated in large, tertiary paediatric intensive care units.<sup>1</sup> Training junior doctors in more than just the basic skills of resuscitation will be easier in centres with a high throughput of patients, and ultimately this will enable a higher standard of care to be delivered in local hospitals, where most of these doctors will eventually work.

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1 Impact of specialised paediatric retrieval teams [letters]. *BMJ* 1996;312:119-21. (13 January.)

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## Premature coronary deaths in Asians

EDITOR,—Sandeep Gupta and colleagues discuss ways in which premature coronary deaths in Asians in Britain might be avoided.<sup>1</sup> When cooking, many people in India and Pakistan use a semisolid fat obtained by partially hydrogenating vegetable oils. This product, called vanaspathi or vegetable ghee, contains high levels of *trans*-fatty acids, which adversely affect blood lipid concentrations and are thus likely to increase the risk of coronary heart disease.<sup>2</sup>

As part of a pilot investigation conducted at the National Institute of Cardiovascular Diseases in Karachi to assess the feasibility of a case-control study we collected specimens of subcutaneous fat from 48 subjects. The samples were collected by a modification of the technique described by Beynen and Katan,<sup>3</sup> stored at 70°C, and transported to the United States on dry ice. Fatty acids were extracted and analysed by capillary gas chromatography with a 100 m column. We found that the 14 subjects who used vegetable ghee for both cooking and frying had significantly higher percentages of *trans*-fatty acids and lower percentages of linoleic and linolenic acid in adipose tissue than the 21 subjects who used only non-hydrogenated vegetable oils (table 1). The adipose tissue of the remaining 13 subjects, who used a combination of different fats, had an intermediate composition.

These data indicate that consumption of vegetable ghee is associated with changes in the fatty acid composition of body fat that are likely to

increase the risk of coronary heart disease. Vegetable ghee is also consumed by south Asians who have settled overseas, and this may help explain their higher mortality from coronary heart disease.<sup>1,4,5</sup>

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## Information about prenatal testing does not necessarily increase uptake

EDITOR,—J G Thornton and colleagues report the effect of giving women extra, non-directive information about prenatal screening.<sup>1</sup> They found that ultrasound examination to look for structural abnormality in the fetus was almost universally accepted (99%) whereas screening for Down's syndrome was accepted by only about one third of the women.

In the first half of a normal pregnancy expectant women are usually offered a scan to enable them and their partner to see their baby, to check the baby's size, or to search for structural abnormality. A search for structural abnormality is not performed until 18-20 weeks, when most of the fetal organs can be assessed. If a woman would like to see her baby but considers abortion to be morally

wrong she can have a scan earlier in pregnancy. This is practical from 12-13 weeks, when the examination is brief and usually includes measurement of the baby's head, which may help the assessment of gestational age.<sup>2</sup> Additionally, the woman can choose to have a detailed ultrasound examination much later in pregnancy. If a structural abnormality is found at that stage she will be cared for jointly by a consultant obstetrician and a consultant neonatal paediatrician.

It is unclear if this information was available to the women in the authors' study before the first antenatal visit, an occasion when women face information overload.<sup>1</sup> Most women are aware of screening for Down's syndrome before they become pregnant and may have preconceived attitudes towards it; they are usually unaware of the scope of ultrasonography at different gestational ages in the first half of pregnancy.

I share the authors' suspicion that many women choose screening if to do so is perceived as normal. Experience has taught me, however, that uptake of screening for fetal structural abnormality at 18-20 weeks is less than 99% when women and their partners have had the opportunity to consider choices in ultrasonography before the first antenatal visit.

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## One and two view mammography in breast cancer

### Are carcinomas detected by one and two view mammography similar?

EDITOR,—Nicholas Wald and colleagues detected 24% more carcinomas with two view mammography than with one view mammography in the prevalence round of breast cancer screening, and they recommend that two view mammography should be standard practice.<sup>1</sup> They calculate the potential effect of this on mortality. Implicit in such calculations is the assumption that the behaviour of the carcinomas detected only by two view mammography is the same as that of the carcinomas detected by one view mammography.

The proportion of carcinomas that were invasive (rather than purely in situ) and 10 mm or less in diameter was similar in patients who had only one view mammography and patients who had only two view mammography. No comment is made about the pathology of carcinomas in patients who had two view mammography with one view interpreted by one radiologist and both views by another—which allows comparison of carcinomas detected only by two view mammography with the carcinomas detected by one view mammography.

For invasive carcinomas, standard pathological prognostic factors would be useful: tumour size, histological grade, histological type, and axillary nodal status. Although prognostic factors are less well defined for in situ carcinoma, the size, type, architecture, and grade or differentiation would be of interest. The study by Wald and colleagues has major implications for breast cancer screening. Ideally, carcinomas detected by one and by two view mammography would be compared with survival analysis, but this would require an enormous number of patients and long follow up. Pathology has been used as a surrogate marker in the assessment of breast cancer screening programmes. Full pathological details of all three

Table 1—Comparison of content of adipose tissue (expressed as percentages) in 48 subjects according to type of fat used for cooking and frying. \* Figures are means (SD)

	Type of fat		
	Vegetable ghee (n=14)	Non-hydrogenated vegetable oil (n=21)	P value (ttest)
Saturated fatty acids	26.89 (4.34)	26.34 (4.75)	0.73
Cis-monounsaturated fatty acids	43.99 (5.08)	40.86 (8.40)	0.22
Oleic	37.62 (3.53)	34.37 (8.66)	0.14
Cis-polyunsaturated fatty acids	16.03 (5.07)	21.61 (6.34)	0.01
Linoleic 18:2n-6	13.74 (4.90)	18.68 (5.65)	0.01
Linolenic 18:3n-3	0.60 (0.22)	1.07 (0.80)	0.02
Dihomogamma linolenic 18:3n-6	0.25 (0.08)	0.30 (0.11)	0.11
Arachidonic 20:4n-6	0.55 (0.30)	0.48 (0.19)	0.40
Long chain n-3 fatty acids	0.36 (0.11)	0.45 (0.20)	0.11
20:5	0.07 (0.06)	0.07 (0.05)	0.93
22:5	0.18 (0.07)	0.22 (0.09)	0.18
22:6	0.11 (0.06)	0.16 (0.09)	0.11
Total <i>trans</i> -fatty acids	4.99 (1.82)	3.41 (1.75)	0.01
Total 18:1 <i>trans</i>	3.92 (1.60)	2.65 (1.60)	0.03
Total 18:2 <i>trans</i>	0.96 (0.36)	0.63 (0.40)	0.02
<i>Trans, trans</i> 18:2n-6	0.13 (0.11)	0.13 (0.11)	0.83
<i>Cis-9, trans-12</i> 18:2n-6	0.59 (0.23)	0.33 (0.25)	0.005
<i>Trans-9, cis-12</i> 17:2n-6	0.24 (0.12)	0.17 (0.21)	0.26

\*Thirteen subjects used a combination of fats.