

explicable by Guus A de Jonge and Adele C Engelberts's comments on secondary sleeping position, since the proportion of boys among infants found in the prone position was 53/77 (69%) in the cases and 28/45 (62%) in the controls, in the side position 22/43 (51%) and 41/92 (45%) respectively, and in the supine position 36/67 (54%) and 311/618 (50%) respectively. Thus among the babies who died more boys than girls rolled from their side to prone during the final sleep.

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Recorded consultations for children under 5 have increased considerably in general practice

EDITOR.—Suspecting that parents' concerns about the health of their children might be a reliable indicator of public expectations of the NHS and demands on it, I went through the medical records of the first five years of life of all patients registered with the practice who were born in 1947, 1950, 1960, 1970, 1980, and 1990 and noted the number of general practice consultations for each child. I discounted all incomplete medical records and consultations for immunisations and, more recently, for child health surveillance.

I found that there has been a sharp increase in the recorded number of consultations for children in the first five years of life (table 1). This could, of course, reflect an increasing awareness by family doctors of the importance of keeping proper medical records. It could also, however, indicate a lamentable reluctance by parents to initiate home remedies before seeking medical advice.

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Ambulatory monitoring of blood pressure should be restricted to scientific research

EDITOR.—Frank W Beltman and colleagues report the predictive value of seated and ambulatory blood pressure after the withdrawal of anti-hypertensive drugs.¹ Their conclusion that seated blood pressure (defined as two measurements obtained during one visit) is a worse predictor of blood pressure in the long term than ambulatory blood pressure (multiple measurements obtained during one day) is not surprising.

The limited accuracy of blood pressure measured during a single visit was described almost 20 years ago.² For that reason, the British Hypertension Society recommends that seated blood pressure should be measured at least twice at each visit on up to four separate occasions before drug treatment is started (or restarted).³ Given the large within person variability in blood pressure, the potential "white coat effect," random measurement errors, and regression to the mean, the Dutch College of General Practitioners even proposes that at least five duplicate repeat measurements should be obtained in patients with initial diastolic pressures of between 95 and 105 mm Hg.⁴ Comparison of the ambulatory blood pressure with a series of measurements of blood pressure obtained in the clinic, as recommended by international guidelines, would show better predictive values of seated blood pressure measured by a doctor. The equivalence of multiple measurements of blood pressure in the clinic and ambulatory measurement as a predictor of left ventricular mass has been described by Fagard *et al.*⁵

I hope that in a future double blind, placebo controlled study (as called for by Beltman and colleagues) the internationally recommended number of clinic measurements would be used. For the time being, the use of ambulatory monitoring should be restricted to scientific research.

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Intracytoplasmic sperm injection

Karyotyping should be done before treatment

EDITOR.—Concern has been expressed about the genetic consequences of intracytoplasmic sperm injection for the treatment of male factor infertility.^{1,2} We wish to report the early results of our chromosomal screening programme for this procedure. The programme was introduced after earlier reports of increased chromosomal abnormalities in pregnancies resulting from treatment with intracytoplasmic sperm injection (M Bondulle *et al.*, proceedings of the 4th international workshop on assisted fertilisation by intracytoplasmic injection of epididymal and testicular sperm, European Society for Human Reproduction and Embryology, Brussels, 1994).³

To date, 33 patients with varying degrees of oligospermia and asthenospermia have been screened with karyotyping of peripheral blood cells; four abnormal karyotypes have been detected. Two of the abnormal karyotypes were Klinefelter mosaics (47XXY/46XY); in one case four of the 28 cells examined exhibited XXY, and in the other case one of the 20 cells examined exhibited XXY. The two other karyotypic abnormalities were pericentric inversions, one involving autosomes (46,XY,inv(3)(p21q13.2)) and the other involving the Y chromosome (46X,inv(Y)(p11.3q11.2)).

These initial results suggest higher rates of chromosomal abnormality than have been reported previously⁴ and do not take into consideration more subtle abnormalities which may be confined to the germ cells. This increased rate is probably attributable to the fact that we screen only patients with more severe abnormalities of sperm function.

On the basis of these early results, and in the light of current concerns, we would recommend that chromosomal screening should be mandatory for all patients before treatment with intracytoplasmic sperm injection, to reduce the risk of chromosomally abnormal fetuses.

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Illustration of sperm may show attachment of potentially pathogenic micro-organisms

EDITOR.—Susan Mayor reports possible risks associated with intracytoplasmic sperm injection.¹ The figure with her article (reproduced here (fig 1 (left)) shows sperm, with the legend "Sperm selected for infertility treatment should be mobile and morphologically normal."

During the 1980s a pilot study from this department identified a high yield of IgM D-K antibodies to chlamydia in serum from sperm donors.² Personal discussion with Dr Simon Fishel (then of Park Hospital's in vitro fertilisation/embryo replacement unit, Nottingham) raised the possibility that small nodules immediately below the head of sperm may indicate micro-organisms

Table 1—Number of consultations recorded in general practice records for children in first five years of life

Year of birth	Total No of patients	No (%) eligible	No of consultations over 5 years	Mean No of consultations/child
1947	181	71 (39)	226	3.18
1950	153	50 (33)	130	2.60
1960	121	73 (60)	272	3.73
1970	99	72 (73)	655	9.10
1980	132	102 (77)	1366	13.4
1990	115	103 (90)	1773	17.2