However, it seems relevant to refer now to the incidence of vomiting in paracetamol poisoning.

In total, we have records of 392 patients who ingested analgesic overdoses which included paracetamol; 120 took paracetamol alone, 44 took Distalgesic (dextropropoxyphene and paracetamol) alone, 157 took paracetamol combined with other drugs, and 71 took Distalgesic combined with other drugs. Among these patients only 46 (11·7%) had vomited or were vomiting at the time of admission; and of the 63 who were treated with oral methionine, vomiting occurred in only 13. Further examination of these cases shows that all vomited before the treatment began but that this symptom did not persist during treatment.

Obviously further analysis of these data is required, but it is already apparent that the difference in the incidence of vomiting with this type of poisoning as reported from Edinburgh (77%)[1] and London (16%)[2] cannot be explained simply by the fact that many of the latter data are collected indirectly through the Poisons Information Service inquiries.

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[1] Prescott LF, Illingworth RN, Critchley JAJH, Proudfoot AT. *Br Med J* 1980;**280**:46-7.
[2] Vale JA, Meredith TM, Crome P, *et al. Br Med J* 1979;ii:1435.

Antenatal care and high-risk babies

SIR,—Regular antenatal assessment is important in the interests of fetal and maternal health. However, as your leading article "Quality not quantity in babies" (9 February, p 347) points out, the fall in British perinatal mortality has occurred before there has been a chance to introduce incentives for mothers to attend antenatal clinics. But the idea is being spread through the media—presumably because of the misinformed opinion of certain professional health workers—that failure of pregnant women to avail themselves of antenatal check-ups is a leading cause of death, illness, and subsequent handicap in newborn babies. The implication is that the mother is at fault.

About 70% of deaths in the first week occur in low-birthweight babies, and many—perhaps most—weigh less than 1·5 kg. In the light of present knowledge it is difficult to see how regular antenatal assessment might prevent this happening. Certainly most of the ill low-birthweight babies cared for in our own newborn intensive care unit are born to women who book early at the antenatal clinic and receive regular and skilled antenatal care. They suffer from complications such as premature rupture of membranes, spontaneous premature onset of labour, hypertensive disease of pregnancy, antepartum bleeding, and fetal growth retardation. We know very little about the causes of these conditions and we know even less about their treatment. Regular antenatal supervision might lead to their prompt diagnosis—but then what? That there is still an ill or high-risk neonate to be cared for is a measure of the success of the obstetrician in preventing the death of the unborn baby. In many respects there is a positive correlation between the quantity and quality of antenatal care and the paediatric resources needed. The problem is that in many of our maternity hospitals technological advances in monitoring the health of the fetus have outstripped the availability of resources required to care for the resultant high-risk baby after birth.

Firstly, we must stop laying the blame for things we do not understand at the feet of our patients. Failure to do so merely magnifies the guilt that women are already burdened with when their baby dies so soon after birth. Secondly, if we want women to book early and attend the antenatal clinic so that they and their unborn babies may benefit from obstetric services, we must also ensure that delivery units and special care baby units have the proper staff and facilities to look after those same babies after birth. The message is simple—regular antenatal care won't make ill babies go away.

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Quality not quantity in babies

SIR,—In your leading article (9 February, p 347) you discuss an "amniocentesis programme to detect fetuses with lethal central nervous system abnormalities." I think I am right in saying that amniocentesis will detect *open* central nervous system lesions, but cannot distinguish between those of varying severity, let alone indicate which are lethal.

There is a similar widespread but mistaken belief that open myelomeningocele in the neonate is lethal unless operation is done. This is, of course, untrue—unless steps are taken to *ensure* that they all die—for example, by heavy sedation and inadequate feeding.

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Cephalopelvic disproportion and caesarean section

SIR,—Barbara Culliton and Mr Wallace Waterfall (8 December, p 1488) comment that the caesarean section rate in the United States has doubled over the last decade and I believe that many obstetricians are worried lest a similar trend occurs in this country. Dr Marion Hall (2 February, p 333) incriminates intrapartum fetal monitoring and refutes the explanation, given by these authors, that the rise is due to an increase in cephalopelvic disproportion.

While the incidence of absolute disproportion may not have changed, perhaps the diagnosis of relative cephalopelvic disproportion has. The use of partograms highlights slow progress during labour,[1] while it has been reported that slow progress after dilatation of 7 cm may be associated with a difficult forceps delivery.[2] The clinician may now be more likely to anticipate such a delivery and, either in the best interests of the baby or for medicolegal reasons (17 March 1979, p 763), opt for caesarean section earlier than he would have done some years ago.

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[1] Philpott RH, *Br Med J* 1972;iv:163-5.
[2] Davidson AC, Weaver JB, Davies P, Pearson JF. *Br J Obstet Gynaecol* 1976;**83**:279-83.

Herpes zoster in pregnancy

SIR,—The letters by Drs Veronique Moens and K M Huntington (6 October, p 870) which followed Professor A P Waterson's interesting review of virus infections during pregnancy (8 September, p 566) suggest that zoster may be commoner than the 13 cases found by Brazin *et al* in their review of the literature.[1] However, in 33 years of detailed surveillance of zoster cases in a practice of 3800 patients, Dr R E Hope-Simpson (personal communication) has not seen a case in pregnancy, and none occurred in 87 cases of zoster reported from a Glasgow general practice.[2]

I wish to report three more cases of zoster in pregnancy. They have occurred within four months, during an epidemic of varicella, in a practice of 7800 with approximately 100 deliveries a year. None of the patients give a history of recent contact with varicella zoster virus, nor did they meet at antenatal clinics.

Case 1—A 25-year-old woman, gravida 2. Expected date of delivery assessed as 19 August 1979 by ultrasound scan, which gave a maturity of 19 weeks on 29 month. Rubella immune. Zoster rash appeared on 9 August (38 weeks' gestation), left T8 dermatome. She had a normal delivery on 25 August at the general practitioner maternity home, and returned to her own home four hours later. The baby appeared normal and healthy and has remained so. Complement-fixation test: 1/160 against varicella zoster virus on cord blood. The Epidemiology Research Laboratory, Colindale, was consulted antenatally and advised that zoster immune globulin was unnecessary. The patient had had a severe attack of varicella in childhood at an unknown age.

Case 2—A 31-year-old woman, gravida 3. Rubella immune. Last menstrual period 29 August 1979. Expected date of delivery 5 June. Zoster rash appeared 26 November (12 weeks' gestation) with right L1 distribution. Complement-fixation test: 1/≫ 320 for varicella zoster virus. Severe varicella at age 2 years 9 months. Pregnancy appears normal.

Case 3—A 25-year-old woman, primigravida. Rubella non-immune. Last menstrual period 7 October 1979. Expected date of delivery 14 July. Zoster rash on 26 November (seven week's gestation), left T10 dermatome. Complement-fixation test 1/≫ 320. The patient had severe varicella aged 5 years. The patient is booked for confinement in the specialist unit as she is a primigravida and 150 cm (4 ft 11 in) tall.

Zoster is less common in women aged under 30 years than in older people (6·4% and 9·6% of two series[2 3]) but may be underreported in pregnancy as it seems probable that the fetus is rarely infected.

The two normal cases reported to your journal by Drs Moens and Huntington, the 13 cases reviewed by Brazin *et al*,[1] and my first case total 16. Eleven babies were reported