trials of antihypertensive treatment (which included many type 2 diabetic patients) has been published with similar results, such as the SHEP study (low dose diuretics plus β blockers and reserpine),¹⁵ the HOT study (various drugs or combinations added to calcium channel blockers),¹⁶ and the SYSTEUR study (calcium channel blockers with angiotension converting enzyme inhibitors and diuretics as reserves).¹⁷ The ABCD study showed a larger reduction in non-fatal myocardial infarction with angiotensin converting enzyme inhibitors than with calcium channel blockers in hypertensive diabetes and resulted in controversy.¹² No J shaped curves were noted in any of the studies. The blood pressure in the intensive treatment group in the UK prospective diabetes study was reduced to a mean of 144/82 mm Hg—a reduction of 10 mm Hg in systolic and 5 mm Hg in diastolic blood pressure. This level of reduction is comparable to that in other studies, except for the HOT study, where blood pressure was reduced even further, the reduction in diastolic pressure ranging from 20 to 24 mm Hg. The actual goal in clinical management is probably a level of around 140/85 mm Hg, or even lower—as in essential hypertension trials⁸—since the correlation between blood pressure and cardiovascular disease is likely to be curvilinear, with no threshold. The goal for glycosylated haemoglobin is 7% or lower, taking into account the condition of the patient. Any reduction of glycosylated hameoglobin from a high value is important, as shown in the in the diabetes control and complications trial.⁵

The “bad companions” of diabetes also include dyslipidaemia, and the 4S study showed that secondary prevention in diabetic patients was effective.¹⁸ An important subject for further research is primary prevention, and a trial of this is now in progress in the UK prospective diabetes study. Research into effective antismoking campaigns in diabetes is similarly important. Increasingly, the evidence suggests that an intensified multifactorial intervention strategy is warranted in type 2 diabetes, possibly including aspirin treatment.¹⁶ The UK prospective diabetes study combines both clinical and basic research, and progress in patient care must be soundly founded on research in both fields. The lesson of this week’s papers, however, is that focusing only on isolated vascular biology without also paying close attention to overall clinical management,

in particular blood pressure control, may not be enough.

Carl Erik Mogensen *Professor of medicine*

Medical Department M (Diabetes and Endocrinology), Aarhus Kommunehospital, DK-8000 Aarhus C, Denmark

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First trimester ultrasound screening

Carries ethical and psychological implications

Ultrasonnd scanning has been an integral part of antenatal care in industrialised countries for some time,¹ but until recently detection of fetal abnormalities by this method has been possible only in the second trimester. High resolution scanning during the first trimester is now possible and is routine in some units. Not only chromosomal abnormalities but also structural anomalies can be diagnosed by this

means,² and the advent of such a capability raises both ethical and psychological issues.

While healthcare professionals in maternity services are good at giving some sorts of information to patients—for example, on nutrition during pregnancy—they may fail to consider the issues of informed consent raised by the use of such a powerful diagnostic tool during routine antenatal care.^{3 4} Most

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women being offered these scans are at low risk of fetal abnormality and the scan constitutes their first visual encounter with their baby. They may believe that it will provide information only about gestational age and be unaware of the range of abnormalities that can be detected. Recent research suggests that many women are not told beforehand of the first scan's potential to detect fetal anomalies,⁴ and several letters in this week's issue add further evidence (p 748). Many women whose pregnancies may have naturally ended in spontaneous perinatal loss are thus being faced with having to make an active decision about whether to continue with their pregnancy. If the implications of this technology are not fully explained to patients they may be unprepared for bad news or a period of uncertainty about the outcome of their pregnancy.

Not all women will want to know if their baby is abnormal and not all women will choose to terminate their pregnancy if it is. Women at high risk who are undergoing more invasive antenatal screening, such as amniocentesis or chorionic villous sampling, usually have had time to think about the decision to take up screening and about the implications of testing. Women routinely having an early high resolution scan may have less opportunity for such thinking. It is important that the possible outcome is discussed with all patients, including those at low risk, before the procedure.

Several recommendations have been made to improve clinical practice in prenatal testing.⁵ While these are primarily aimed at services for the high risk group, they are relevant to all women receiving routine antenatal care. Staff training in providing clear and accurate information is paramount. All women should receive a clear explanation of the purposes of all antenatal testing, including ultrasound scanning, the information that may be discovered, and the degree of certainty about the information. Specific discussion should take place about false positive and false negative diagnoses. The attending clinician should explore a woman's views about screening and ensure that she understands that she can choose not to have investigations that may lead to the discovery of abnormality. The implications of finding a fetal abnormality should be discussed. For women known to be at risk of chromosomal abnormalities or inherited conditions counselling constitutes a routine part of antenatal care. In first trimester ultrasound screening counselling may be reserved for women at high risk and those where a fetal abnormality has been detected.

Psychological support has been defined as an objective of scanning for fetal abnormality,⁶ so it is important that mental health professionals play their part in determining the psychological implications of new developments in this area. When first trimester scanning does detect an abnormality there may be pressure for the decision to terminate to be made quickly to facilitate a suction termination. Some women may feel that they have been given insufficient information and time to consider the issues. Their emotional resources may be limited even if personal and professional support is available. Research on first trimester termination has largely focused on those having terminations for psychosocial reasons, after which psychological morbidity is low.⁷ Women

with a fetal abnormality, however, are often faced with the decision to terminate a planned and wanted pregnancy. Termination is thus likely to have different meanings for the two groups and research findings should not be generalised from one group to another.

The incidence of psychological morbidity after termination for fetal abnormality in the second trimester is similar to that after spontaneous perinatal loss—about 25%.⁸ There may also be effects on the parents' relationships with older siblings of the aborted child and subsequent children.⁹ Though the risks to physical health are reduced by earlier termination,¹⁰ the effects on psychological morbidity are unclear. As yet there is no firm evidence that early termination is psychologically advantageous to women who undergo this procedure for fetal abnormality. In relatively late losses, where there is labour and delivery, the fetus is more likely to be experienced as a real baby, and the process of naming and holding and getting to know the baby may facilitate grieving.¹¹

Our own clinical impression is that uptake of counselling services is low after termination for fetal abnormality, even among those who report continuing distress. Careful consideration may need to be given to the way psychological support is offered in order to improve take up rates. It is critical that the psychological morbidity associated with early and late termination for fetal abnormality are determined. These findings should be taken into account when considering the timing of screening for fetal abnormality and the way in which women and their partners are prepared for these investigations. Such preparation should include the accurate presentation of all available information before screening to ensure that consent is truly informed.

Anne McFadyen *Senior lecturer*

Julia Gledhill *Honorary research fellow*

Leopold Muller Department of Child and Family Mental Health

Barry Whitlow *Clinical research fellow*

Demetrios Economides *Senior lecturer*

University Department of Obstetrics and Gynaecology, Royal Free Campus, Royal Free and University College Medical School, London NW3 2PF

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