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We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Cryptorchidism: a renewed plea

SIR,—Most clinicians are well aware that the undescended testicle is prone to abnormal germ cell maturation, malignant transformation, torsion, and injury. It is usually associated with an inguinal hernia, although this is rarely the presenting feature. Furthermore, the psychological effects of an empty scrotum should not be underestimated.¹ Spontaneous descent can only occur up to the age of 1 year.² Beyond this age only a retractile testis can suddenly appear in the scrotum. Unfortunately, there is still much confusion about the optimal age at which a child should be treated. We believe that no testis should be left undescended after the age of 5 years, but there is evidence that this upper age limit should be reduced to the first year or two of life.³ As surgeons we can only deal with the problem as it presents to us and a review of 55 patients

presenting with cryptorchidism in our department in 1978 suggests that we still see the boys too late. The histogram shows the ages at which the boys were operated on. Less than half (24 patients) were under the age of 7, and only 9% under the age of 5 at the time of operation.

This limited but pertinent review is all the more disappointing when the patients have been referred from a well-defined catchment area with a high standard of primary medical care and close surveillance by the school medical services. The reasons for late referral may stem from a reluctance to promote the activities of surgeons who only wish to see normal anatomy when there is little evidence that fertility is improved or malignant potential decreased by orchidopexy. Indeed, maldescent may be one effect of a primary

dysplastic process which can even involve the scrotal testis in unilateral cases.⁴ However, we suspect that no such attitude of academic fastidiousness prevails. There may be a few who still believe that a truly undescended testis is capable of spontaneous descent up to the age of puberty; but it is also probable that many undescended testicles have not been

noticed by school doctors or by those performing the initial examination of the boy in infancy, when perhaps we may be uncharitable in assuming that less attention is paid to the examination of the infant's scrotum than to his hips or his heart.

It may be over-optimistic to expect that orchidopexy in infancy will promote the normal uncomplicated development of the majority of undescended testicles and perhaps even lessen the risks of malignancy. But we shall never have the opportunity of confirming this unless children are referred early.

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¹ Pinch, L, Aceto, T, and Meyer-Bahlburg, H F L, *Urological Clinics of North America*, 1974, 1, 573.

² Scorer, C G, *Archives of Disease in Childhood*, 1964, 39, 605.

³ Mancini, R E, Rosenberg, E, and Cullen, M, *et al*, *Journal of Clinical Endocrinology and Metabolism*, 1965, 25, 927.

⁴ Hecker, W C, and Hienz, H A, *Journal of Pediatric Surgery*, 1967, 2, 513.

Kielland's forceps

SIR,—Any article which defines a serious consequence of deficiencies in current management is worthwhile. In an era of "defensive obstetrics"¹ this is particularly true of perinatal medicine. We therefore read with interest the article on Kielland's forceps by Drs M L Chiswick and D K James (6 January, p 7): coming from a university maternity hospital which selectively admits high-risk patients it has particular authority. The message which we gained from it is that Kielland's forceps is a dangerous instrument, producing neonatal death from tentorial tears and abnormal neurological behaviour in an unacceptably large proportion of neonates. Such conclusions must lead to critical review of the instrument's use, but before we accept them unreservedly enlightenment on the following points is necessary.

(1) An analysis of who actually carried out the forceps delivery and of the senior doctor present at the delivery. The text mentions that the deliveries were by a registrar, consultant, or senior house officer. These are not interchangeable. Any forceps delivery may be traumatic if carried out by an unskilled operator; safe use of Kielland's forceps requires more instruction and experience than others. As "A Modern Epidemic" has shown, it is usually not the car which causes the accident but the driver.

(2) Intervention was required for a prolonged second stage or fetal asphyxia, or a combination of the two. It is likely that most were associated with deep transverse arrest of the fetal head or arrest in the occipitoposterior position. Kielland's forceps may be used in either situation. Again, these are not interchangeable for analysis. The application of these forceps is often straightforward in occipitoposterior presentations but may be difficult in deep transverse arrest, particularly the posterior blade if the sacrum is flat.

(3) The level of the fetal head in the pelvis when the forceps was applied is not mentioned. If the fetal head is not in mid-cavity—that is, if the biparietal diameter is above the level of the ischial spines—any application of forceps is

more hazardous for both fetus and mother. One assumes that all deliveries were made at full dilatation of the cervix, but this is not explicitly stated.

(4) Were Kielland's forceps applied electively in every case, or did some follow failed attempts at manual rotation? Were there cases of unsuccessful attempts at forceps delivery by junior members of the staff followed by "successful" vaginal delivery with forceps or caesarean section by a more senior member?

(5) In the section "Patients and methods" it is stated that delivery was under pudendal block or epidural anaesthesia. In the "Results" section, however, it is stated that 20% of the mothers had a general anaesthetic. It is also stated that two caesarean sections were carried out after failed forceps and that these babies had torn tentoria; but how many caesarean sections there were after failed forceps delivery is not mentioned. Kielland's forceps delivery is easier under a general anaesthetic, so that might have improved the neonatal results; but a general anaesthetic might have been given because a difficulty was expected or encountered. General anaesthetic would also increase problems in resuscitation.

(6) Cephalhaematoma is not normally taken to be a result of an abnormally traumatic birth. Facial palsy may be the result of pressure between the fetal head and the maternal pelvis, rather than a consequence of manipulated delivery. It is reasonable to consider both of these as birth trauma but hardly as indices of severe iatrogenic fetal damage. A torn tentorium, on the other hand, in these circumstances is almost certainly due to excessive traction or difficulty in manipulation.

(7) The study patients and controls were not matched for maternal height and fetal asphyxia. The increased neonatal morbidity and mortality in the study group might have been associated with Kielland's forceps only because of a concomitant association of low maternal height and fetal asphyxia. It is also true that birth trauma in the study group could have been exacerbated by a coagulation defect, which has been reported in hypoxic infants.²

Happiness is watching the "difficult" forceps delivery become less and less common. There would seem, however, to be a place for Kielland's instrument at least in malrotation due to inefficient uterine action or a relaxed pelvic floor. Complete definition of its place in current perinatal practice will require a large prospective survey.

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¹ *Lancet*, 1978, 2, 1349.

² Chadd, M A, *et al*, *British Medical Journal*, 1971, 4, 516.

SIR,—I read the two articles by Drs M L Chiswick and D K James (6 January, pp 7 and 10) with very great interest, but considerable disquiet, because they attribute the higher neonatal mortality and morbidity to Kielland's forceps, rather than to other factors such as fetal asphyxia associated with dystocia. I fear that this may lead to more frequent use of caesarean section for occipitoposterior presentation, with an increase, however

slight, in maternal risk. In my view this is unjustifiable as I believe that Kielland's forceps provide a safe and easy method of rotating the fetal head, provided the blades are correctly applied.

The authors comment on the higher incidence of epidural analgesia in these cases and recommend avoidance, but in my experience epidurals are invaluable because of the more painful labour and I believe that an epidural will usually allow a safe vaginal delivery rather than caesarean section.

The authors do not distinguish between rotation of a direct occipitoposterior and rotation of a head in deep transverse arrest, which is sometimes due to a contracted outlet. It would be interesting to know how many sections after failed forceps were due to failure to rotate the head (? inexperience) and how many were due to failure to deliver after successful rotation.

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SIR,—It would be unfortunate if the prominence given to the two papers related to the use of Kielland's forceps by Drs Malcolm L Chiswick and David K James (6 January, p 7 and 10) were to deter younger obstetricians from learning the correct use of what can be a most valuable instrument.

It is reassuring to read that when fetal asphyxia was excluded the use of Kielland's forceps was not associated with a significant increase in delayed onset of respiration or birth trauma, and isolation of the significance of fetal asphyxia is a helpful observation. Nevertheless, it is absurd for the authors to compare the outcome for babies delivered spontaneously with those born by rotation forceps and leave the impression that the differences are due to the use of these particular forceps themselves rather than the indications for which the intervention was required. The mortality and morbidity associated with malposition in the second stage are well known and it would have been a more useful exercise to compare babies delivered by Kielland's forceps with others arrested in malposition but delivered by manual rotation or caesarean section.

There are inconsistencies in the conclusions about the significance of maternal height and the rate of cervical dilatation, and a number of other debatable points. The mothers who required forceps had babies with relatively bigger heads (ratio of maternal height to head circumference); but there is no mention of the quality of uterine contractions, of the size of the pelvis, or of degrees of deflexion or asynclitism of the fetal head, all of which could contribute to cerebral irritation. Since epidural analgesia is associated with a higher incidence of rotation deliveries the authors conclude that epidurals should be avoided in short primigravidae already predisposed to malposition, but that would deny relatively pain-free labour to a group of women who most require help.

It is current teaching to undertake a "trial of easy forceps" in theatre with preparations for caesarean section when there is any doubt about the outcome of the operation. If as a consequence of these two papers and the recent Birmingham court decision¹ that policy were replaced by routine caesarean section for all patients with arrested malposition in the second stage, there would be a real risk of