acceptable" must be rejected. Any method of delivery that increases perinatal morbidity is open to challenge, particularly when that method is directly responsible for a perinatal mortality rate of 35 per 1000.

In their second paper Drs Chiswick and James ignore the role of the active management of labour in avoiding the type of complications leading up to Kielland's delivery. Several papers have been published which conclusively demonstrate that these problems are avoidable.³⁻⁵

None of the correspondents appear to recognise the essential difference between intracranial haemorrhage due to trauma and that due to asphyxia. Tentorial tears, which cause subdural haemorrhage, have been shown to be 11 times more common when forceps have been applied, with or without intrapartum hypoxia,⁶ and virtually all cases of gross intracranial haemorrhage occurring during labour are due to trauma.⁷ In contrast, asphyxial intracranial haemorrhage in the mature infant is characteristically sub-arachnoid and petechial.

Finally, in the broader context of the role of Kielland's forceps in modern obstetrics my experience convinces me that they have no place. This personal experience is based on exposure to about 12 000 deliveries where labour was actively managed and Kielland's forceps unavailable (at the National Maternity Hospital, Dublin). The papers from Drs Chiswick and James support this conviction.

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¹ Beard, R W, et al, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1971, **78**, 865.

² Edington, P T, Sibanda, J, and Beard, R W, *British Medical Journal*, 1975, **3**, 341.

³ O'Driscoll, K, Jackson, R J A, and Gallagher, J T, *British Medical Journal*, 1969, **2**, 477.

⁴ O'Driscoll, K, Jackson, R J A, and Gallagher, J T, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1970, **77**, 385.

⁵ O'Driscoll, K, and Stronge, J M, *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 1975, **15**, 1.

⁶ Butler, N R, and Bonham, D G, *Perinatal Mortality*. Edinburgh, Livingstone, 1963.

⁷ Potter, E L, and Craig, J M, *Pathology of the Fetus and the Infant*. 3rd edn. London, Lloyd-Luke, 1976.

SIR,—We were interested to read Drs Malcolm L Chiswick and David K James's articles on Kielland's forceps (6 January, pp 7 and 10). Their study comprised a group of 86 cases; we have examined the notes of 75 cases of delivery by Kielland's forceps carried out in this unit in the last 24 months. None of our patients had epidurals. We found certain interesting differences in the results and perhaps in our conclusions.

We detected no difference in the delayed onset of respiration (allowing for epidural) or the subsequent finding of transient irritability in the child. However, we were rather surprised that in their study the incidence of injury (facial or brachial palsy or cephalohaematoma) was 15.1% of patients, whereas in our study the incidence was only 6.7%. There were no stillbirths or neonatal deaths in our study whereas there were three in theirs.

In view of the indications for using Kielland's forceps, the complications in our study are acceptable. It would be unfortunate if Kielland's forceps were to develop a bad reputation for the second time in their life. Carefully used with the correct indications, with adequate safeguards so that the obstetrician can change his mind and carry out

a caesarean section where necessary, these instruments remain of considerable value.

Perhaps in these litigious times we should be using trial forceps in theatre much more frequently than in the past.

MICHAEL BURKE
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Retinal haemorrhages in infancy

SIR,—Last year you reported an innocent cause of extensive retinal haemorrhages in infancy, after a 2-month-old baby had been discovered as a near-miss case of cot death (4 February 1978, p 281). The problem was to decide if these haemorrhages were caused by hypoxia or the trauma of resuscitation, as such lesions normally provide important evidence of child abuse.

Since then I have looked for retinal haemorrhages in cases of sudden unexpected death in infancy before the necropsy. Such haemorrhages are frequently visible, provided that the cornea has not become too opaque. In all the cases in which they have been observed subsequent examination has shown the typical distribution of petechiae in the thoracic organs. No evidence has been found of the rare viral encephalitis which can produce retinal haemorrhages.¹

This work was funded by the DHSS.

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¹ Holzel, A, and Tobin, J O'H, *Lancet*, 1967, **2**, 723.

Cryptorchidism: a renewed plea

SIR,—Most surgeons with a paediatric practice will agree with Mr M C Bishop and Mr R H Whitaker (10 February, p 407) that too many boys present late for orchidopexy and that our aim should be to place both testicles in the scrotum by the time a boy starts school. I would make two practical suggestions.

Firstly, the true undescended testicle will not be in the scrotum at birth so a careful postnatal examination will identify all children requiring supervision. Just as discovery of a clicking hip leads to an appointment with the orthopaedic surgeon, so discovery of a testicle outwith the scrotum should lead to an appointment with the surgeon who would, in the course of time, be responsible for orchidopexy should it be required. The importance of the finding should be explained to the parents and an appointment given to them for the surgical clinic in six to nine months' time. This policy would not result in any major increase of work load in outpatients and should lead to a sharp improvement in quality of care.

The postnatal examination is an opportunity not to be missed because the next time that all children are examined is at school, in their 6th year, and it is clear, as Mr Bishop and Mr Whitaker point out, that all boys with true maldescent are not then directed to a surgeon. Only 21% of our patients have an orchidopexy before 5 years of age, and 32% have the operation between 5 and 7. This still leaves 47% who have their orchidopexy between their 7th and 13th birthdays, which is much too late. There seems to be a case for a specific

examination of the time and method of referral of boys in whom maldescent is found at the school examination.

Secondly, operative technique can make a contribution to earlier operation. It is not easy by the standard Bevan approach to mobilise an impalpable incompletely descended testicle from around the deep abdominal ring of a boy of 2 or 3 years and place it in a good position in the scrotum, so there is a natural tendency to defer this operation until the boy is older. Using the abdominal extraperitoneal approach, however, which has recently been described,¹ the separation of the hernial sac from the testicular vessels and the vas becomes comparatively easy, and a greater length of the testicular vessels can readily be freed. Thus we have operated on boys aged 4, 5, 8, 10, 12, and 16 weeks with troublesome inguinal herniae as well as maldescent, and the operation proved to be simple and was successful both immediately and on review at one year. I believe this approach can make a useful contribution to earlier operation.

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¹ Jones, P F, and Bagley, F H, *British Journal of Surgery*, 1979, **66**, 14.

SIR,—May I strongly support the plea which Mr M C Bishop and Mr R H Whitaker make (10 February, p 407)? There is no evidence that any significant descent occurs after about 3 months of age in the full-term baby boy. The diagnosis of the deformity should be made in the first three months of life and is therefore within the province of the general practitioner and the paediatrician.

Parents are usually anxious to co-operate and if an operation to bring the testis into the scrotum is not done between the 3rd and 6th months (possible in some 30% of cases) a yearly visit to the surgeon should be made. He can then plan to operate before the age of 5 years.

The importance of a recorded diagnosis made in infancy is that it eliminates the endless confusion of trying to make an accurate diagnosis in a boy aged 5 to 12 years, when spontaneous retraction of one or both testes is so common. If it is known that both testes were in the bottom of the scrotum at birth then the high testis in later years must be retracted even though the examiner's fingers cannot draw it down. It will "drop" as puberty approaches.

C G SCORER

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Guar crispbread in the diabetic diet

SIR,—Professor David J A Jenkins and others (23-30 December, p 1744) have again demonstrated reduction in glycosuria and a small but significant reduction in fasting blood sugar when guar gum was added to the diets of diabetic patients over a five-day period. The long-term effects of such supplementation are, however, less clear cut and, although a reduction in insulin dosage and glycosuria occurred over an eight-week period, there was no change in body weight and blood glucose concentrations were apparently not estimated.

In a study which we have just concluded (to be reported in full elsewhere) we studied the effect of adding either guar gum, bran, or