Council in 1975). It is equally simplistic to suggest that voluntary organisations could be given seats on district health authorities; they would surely run very quickly into identity problems—would they be the managers of the full range of services, or champions of their own client group's interests (a legitimate role for them on community health councils)?

Professor Klein's remarks on the monitoring of services and the alternative options open ignores completely the role of community health councils in influencing positively and progressively the development of local health services. The long-term influence of the community health council through the planning process and otherwise on the type and emphasis of evolving health services is surely its most important function. Yet Professor Klein talks loosely of an inspectorate and of community health councils as if the two were interchangeable, whereas the two functions have practically nothing in common.

To be positive, Professor Klein does acknowledge that the direct cost of community health councils is trivial as a proportion of total NHS expenditure. Not only is it trivial, but it is money which stimulates many times its worth in voluntary effort, both deliberative and practical, in support of the NHS. During the last five years community health councils have provided a users' commentary on services which has been of value to management, and that they have acted as a springboard for new voluntary activity in many localities is well documented.

"Patients first" without community health councils does not offer the key to balancing central control and local responsiveness. Both organisationally and financially the pressure will be for district health authorities to cover large populations, in many instances the same as the areas of today. And with fewer members, less non-NHS representation, and the job of management to do it is idle to pretend that the district health authorities can or will effectively "represent the interests of the users of the service."

There is still a need for community health councils.

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SIR,—Professor Rudolf Klein (9 February, p 420) contemplates abolition of community health councils in favour of a proposal "which should, surely, be eagerly seized on and welcomed" for monitoring services at district level—that is, by an advisory group of experienced NHS officers who would report to the district health authorities, professionals, including economists, reporting to professionals; the model exists in the Health Advisory Service.

The NHS has seen two expensive adventures in the last 30 years: the construction of massive district general hospitals, which the DHSS admits it would not build again, and now reorganisation of the 1974 reorganisation. These decisions have not been costed but a modest estimate could be thousands of millions of pounds. Reorganisation in 1974 was recommended by Professor Klein's professionals—that is, senior medical, nursing and administrative staff, aided by management consultants.

The consultative document *Patients First* is not supporting its own doctrine when it questions the need for community health councils; were not these established not only

to provide community representation but also to allow patients to seek information on the use of the service? A good working relationship between officers of community health councils and the NHS can provide awareness of its limitations yet be constructive in approach and able to dispel public ignorance of what is and what is not possible with limited resources.

Health Advisory Service officers arrive from afar and have not the intimate knowledge of local problems, often seemingly trivial but none the less vital to the public (car parking at our local district general hospital is a current one) and which cannot always be known to them, as is possible with day-to-day public contact with community health councils.

It is not only district health authorities who will be responsible for health care problems. Local authorities are increasingly concerned with community care concepts and community health councils provide an independent yet co-operative link both with health authorities and with voluntary organisations generally. Community health councils are acknowledged by Professor Klein as trivial. Can the "public voice" caution against "eagerly seized" enthusiasms, past and present?

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Phenobarbitone and epilepsy

SIR,—I would like to support in the strongest possible terms, the letter from Dr Alan Richens and Dr Jolyon Oxley (16 February, p 482) concerning the proposed legislation on disubstituted barbiturates.

While I agree that the widespread use of phenobarbitone in epilepsy has been superseded by more modern antiepileptic drugs, there are still an appreciable number of patients with epilepsy who are well controlled without side effects by phenobarbitone, and in whom attempts to reduce or remove phenobarbitone lead to breakdown in the control of the epilepsy. Once this breakdown has occurred it can be difficult to regain control. I think this is particularly true in the more severe epilepsies such as one sees at a special centre. I have had considerable difficulty in some patients in withdrawing phenobarbitone for a number of reasons, both here at the David Lewis Centre and also in outpatient practice at the university departments of neurology in Manchester. I think that there is a very real danger to certain patients with epilepsy if phenobarbitone is included in the Misuse of Drugs Act, for the reasons given by Drs Richens and Oxley.

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Plasma concentrations of paracetamol

SIR,—Recently we have received inquiries from hospital departments of clinical chemistry about the need to provide, at short notice and throughout the 24 hours, facilities to measure plasma levels of paracetamol. In the recent letters in your columns by Dr J A Vale and others (1 December, p 1435) and by Dr L F Prescott and others (5 January, p 46) about the mode of treatment for this type of poisoning this question has been overlooked.

From our point of view clinicians seem to be

divided into three camps in their attitude to the treatment of paracetamol overdose. There are (i) those who turn immediately to oral methionine and are content with this so long as the patient does not vomit; (ii) those who regard intravenous *N*-acetylcysteine as the treatment of choice; and (iii) those who have not yet made up their minds but are considering ease of administration, therapeutic efficacy, and economy.

In a hospital where the first of these policies is adopted there is no need for an emergency laboratory service to estimate plasma paracetamol concentrations. Provided that no more than 10 hours have elapsed since ingestion, there is confidence that even in patients who present with very high levels the oral antidote will be effective. On the other hand, if the overdose is not in this dangerous category, no harm will be done by the methionine and a negligible sum of money will be wasted in unnecessary treatment.

In cases where vomiting is troublesome, the physician may well turn to *N*-acetylcysteine without waiting for a plasma paracetamol assay. However, the course of the infusion extends in total over 20 hours and the cost is by no means insignificant. A plasma paracetamol measurement obtained as soon as possible could therefore indicate whether this intravenous therapy needs to be continued for a full course. The same reasoning applies in hospitals where there is a forthright preference for intravenous *N*-acetylcysteine.

When clinical indecision prevails, this will not in itself be resolved by turning to the laboratory in the first place and so losing valuable time. It is suggested, therefore, that in such circumstances the physicians discuss the problem with those in charge of the clinical chemistry department to settle on course of action (i) or (ii) and so have the plasma assay facilities organised accordingly. Alternatively, it would seem reasonable to administer methionine immediately in the knowledge that it is an effective treatment, while allowing time for the laboratory to measure the blood paracetamol concentrations. At this stage the physician will have the fullest possible indication of the potential risk to his patient without having delayed treatment. He can then, bearing in mind such factors as cost, convenience, and the lack of overwhelming evidence in favour of either treatment, decide on his course of action.

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SIR,—Dr L F Prescott and his colleagues (5 January, p 46) quite reasonably question the low incidence of vomiting (16%) reported to the National Poisons Information Service as the result of telephone inquiries. We are aware that such reporting may well be biased in several ways and in particular that the information on the presenting symptoms may not be complete. For this reason we formed a group to undertake a prospective survey of the presentation and management of all cases of analgesic poisoning admitted to our several hospitals. The information on each case was collected on a standard questionnaire, which was in turn sent to the National Poisons Information Service for checking and processing by computer. That study is now completed and we are in the process of writing a full report, which we hope to publish later.

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 Distalgesc (dextropropoxyphene and paracetamol) alone, 157 took paracetamol combined with other drugs, and 71 took Distalgesc 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 intra-partum 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 dispro-

portion 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 under-reported 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