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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.

Perinatal mortality rates

SIR,—In your leading article "Quality not quantity in babies" (9 February, p 347) the caution flag was again waved regarding possible over-optimism in the morbidity and mortality rates associated with newborn babies delivered weighing 750-1000 g. This editorial resurrected continuing questions which those of us involved in perinatal medicine must ask ourselves on a daily basis.

Perinatal mortality rates will continue to mould the future methodologies applied to perinatal care. Unfortunately, we exist at present in an environment which compares apples to oranges. The United States defines its perinatal mortality rate beginning with the 20th week of gestational age and continuing through to 28 days after birth. In Great Britain perinatal death encompasses stillbirths born after 28 weeks of gestation and neonatal deaths occurring within the first seven days of life. The remainder, neonatal deaths that occur up to the 28th day after birth, are excluded.

The problem arises, however, with those babies born alive prior to the 28th week deadline but subsequently succumbing within the first week of life. These obviously bias and confuse the figures and are open to different individual reporters' interpretations. As our proficiency improves with the survival of babies born at 26-30 weeks' gestational age, the predominant perinatal mortality will emanate from those fetuses delivered from 20 to 26 weeks.¹ Unfortunately, these deaths will not be recorded in the perinatal mortality rates of those countries that use the World Health Organisation criteria. On the other hand, a change from the currently accepted definition to one utilising birth weight, be it 500 g or 1000 g, instead of gestational age is fraught with numerous shortcomings.²

We again call for the utilisation of universally applied definitions. Authors must define their meaning of perinatal mortality in every article. It is most important that we should encourage

the production of literature which would rank and compare nations based on a universally accepted definition of perinatal mortality rates. As of today, that ranking is non-existent.

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¹ Knuppel RA, Cetrulo CL, Kappy KA, *et al.* *N Engl J Med* 1979;300:560-3.
² Goldstein H, Butler NR. *Lancet* 1977;i:1254.

Perinatal health services: an immodest proposal

SIR,—Making the French Connection is always tempting (22 March, p 843). Playing the French card is criticised as using crude mortality statistics to assess the quality of perinatal health care in different countries. Can the improvement in the French perinatal death rate and the French handicap rate be related to the pointers to better perinatal health services described in the article by Mr Iain Chalmers and others?

Certainly France is high up the European socioeconomic ladder, but France also has the problem of alcoholism (a problem not mentioned in the article). There is no reason to suspect that general stress is less of a problem in France than in other Western countries.

Has French organisation been more effective in ensuring that more women are delivered by trained personnel? Have the French been more prepared to accept the suggestion of J W Ballantyne quoted in the paper—have the French expectant, parturient, and puerperal patients received more emotional support within and outside the services? Does the act of giving financial incentives for

attendance at antenatal clinics as French national policy underline the importance of this group of women?

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Infant mortality in the USSR

SIR,—Dr Michael Ryan (1 March, p 624) states that there is widespread concern in the Soviet Union over the number of deaths of infants under 1 year of age. He quotes an infant mortality rate for the USSR as a whole of 22.9 for 1971 rising to 27.9 per 1000 live births in 1974. The data in the accompanying table,

Birth, death, and infant mortality rates per 1000 in the USSR

Year	Births	Deaths	Infant mortality
1913	45.5	29.1	268.6
1940	31.2	18.0	181.5
1950	26.7	9.7	80.7
1960	24.9	7.1	35.3
1970	17.4	8.2	24.7
1974	18.0	8.7	27.9

showing the striking fall in the infant mortality rate since 1913 may help to put these figures into perspective.

These figures are taken from the statistical yearbooks entitled *The People's Economy of the USSR* to which Michael Ryan refers. Unfortunately the infant mortality figure is not included in those numbers of the yearbook published after 1974. A relevant consideration in assessing recent trends in infant mortality may be the uneven fall in the birth rate within the USSR. This stood at 15.8 per 1000 population in Russia for 1977; but it was over twice this figure in Uzbekistan, Tajikistan, and Turkmenia, for example. It is, however, essential to have more recent data in order properly to assess whether there is in fact any