life table rate per 100 woman-years, in which this problem of interpretation does not arise.

(3) The risk factors which predispose to ectopic pregnancy vary from population to population and may vary between users of different contraceptive methods. Unless this variability is taken into account bias may be introduced. Future studies should be designed to ensure that such bias is excluded.

(4) All published studies of ectopic pregnancy rates have, so far as can be determined, failed to state the criteria for the diagnosis of ectopic pregnancy, leading perhaps to an overestimate of its incidence. If ectopic pregnancy is thought to have occurred in test or control patients in any clinical trial of an IUD all material removed from the peritoneal cavity should be examined. Fluid, blood clots, and curettings, if taken, should be studied macroscopically. Clots should be sieved or fixed and sliced for gross examination and all suspicious areas examined microscopically. The aim of the verification of the diagnosis of ectopic pregnancy is to improve the accuracy of incidence data in IUD studies. For this purpose it is considered essential for the diagnosis that fetal parts (identified grossly or microscopically) and/or trophoblast are identified. Decidual reaction and/or blood in the Fallopian tube is not sufficient to establish the diagnosis. This definition does not preclude a presumptive diagnosis made for clinical purposes, based for example on tubal disruption, decidual change in Fallopian tube or endometrium, gross blood in the peritoneal cavity, or other suggestive operative findings.

(5) Because of the limited data available and the difficulties of comparisons between studies it is not possible to state that the Progestasert IUD users are at higher risk of ectopic pregnancy than other IUD users. Ectopic pregnancy rates for Lippes Loop and copper-carrying IUD users quoted by Dr Snowden, 0.06 and 0.05/100 woman-years respectively, are much lower than those cited by Vessey *et al.*,² 0.121/100 woman-years for a variety of IUDs. Dr Snowden compares UK data with world-wide data for the Progestasert IUD, a comparison which is felt to be invalid.

At the present time it is not possible to make a valid comparison of the ectopic pregnancy rates for different IUDs.

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C L BERRY	E PIZARRO
I D COOKE	P J ROWE
A CUADROS	S T SHAW, jun
R GRAY	T WAGATSUMA
G P McNICOL	F WEBB
	E WILSON

Geneva

¹ Tatum, H J, and Schmidt, F H, *Fertility and Sterility*, 1977, **28**, 407.

² Vessey, M P, *et al*, *Journal of Biosocial Science*, 1976, Suppl 11.

How not to apply for an appointment

SIR,—Among the large number of applications received in response to a recent advertisement in the *BMJ* for a vacancy in this department many were from overseas graduates. Most were handwritten and several were scarcely legible. One spelt the addressee's name incorrectly. In other cases the carbon copy of a standard letter of application was sent with amendments and additional information in ballpoint. Typed curricula vitae, when these were sent, were generally set out badly and often contained spelling mistakes. One applicant requested the return of his curriculum vitae after "we had finished with it."

The immediate reaction on receiving applications such as these is to dismiss them as being so carelessly prepared that they indicate little real desire to be considered seriously for the vacancy. However, having

made the effort to read each of them, it became clear that several of the applicants were of high quality. It is regrettable, therefore, that partly out of a poor knowledge of English and partly out of ignorance of the high value (perhaps much too high a value) placed in our culture upon neatness and etiquette in matters of this kind many doctors do not do themselves justice and risk repeated disappointments over not being short-listed.

I would like to suggest that those whom overseas graduates request to be a referee might offer their help over composing letters of application and curricula vitae. Since nearly all overseas graduates spend some time in hospital appointments, should not the consultants for whom they work make sure that their protégés have mastered the rules of this procedure, which is one of such importance to them in their future career?

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"Baby and Child"

SIR,—When I read Dr Penelope Leach's letter (25 February, p 506) I felt some initial anxiety lest I had misread certain sections of her book. However, your readers will find if they will refer to the book that I have nowhere misquoted it.

D P ADDY

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Stiff-neck syndrome

SIR,—I was most interested to read the letter from Dr J Shafar describing a stiff-neck syndrome (25 February, p 511). About four years ago I witnessed a similar incident. Three nurses working in the theatres at one hospital where I worked and one auxiliary working in the theatres of another all complained of stiff neck at about the same time. I was also affected as was my sister with whom I lived.

Although I was not concerned with treating any of the nursing staff, the clinical picture relating to my sister and myself was as described by Dr Shafar. The close association of cases in time seemed to be more than coincidence and an infective origin the most likely explanation.

M DUCROW

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Plasma urate changes in pre-eclampsia

SIR,—Dr C W G Redman and his colleagues (25 February, p 467) are to be commended for attempting to establish the sequence of events leading to pre-eclampsia. However, in using plasma urate concentration to define incipient pre-eclampsia they may have underestimated the variations which occur in normal pregnancy.

Previous publications^{1,2} from Oxford have made use of a critical value (350 $\mu\text{mol/l}$ (6 mg/100 ml)) above which patients might be classified as having significant pre-eclampsia. The justification for such a classification is to be found in an epidemiological study³ in which the same authors demonstrated

a significant increase in perinatal mortality in hypertensive patients with a plasma urate concentration above this value. Their recent paper, however, makes use of incremental changes in plasma urate concentration without reference to this critical value. We are not shown the epidemiological justification for this new method of defining disease severity.

Our own data would suggest that the rise of 30 $\mu\text{mol/l}$ (0.5 mg/100 ml) used by the authors to categorise "borderline" pre-eclampsia may be physiological in normotensive pregnancy, during which a gradual increase in plasma urate concentration is to be anticipated.⁴ We have found that (1) between 16 and 36 weeks' gestation in normal pregnancy an increase in plasma urate concentration of 30 $\mu\text{mol/l}$ or more occurred in 13 out of 24 healthy patients,⁵ while eight patients in fact showed a rise of more than 60 $\mu\text{mol/l}$ (1 mg/100 ml); and (2) throughout the course of a single 24-h period in the third trimester of normal pregnancy a diurnal variation of 30 $\mu\text{mol/l}$ or more occurred in 10 out of 14 healthy patients.⁶ (One subject showed a maximum variation of 61 $\mu\text{mol/l}$.)

In the recent study by Dr Redman and his colleagues, the groups of patients showing a "borderline increase" and "no increase" in plasma urate did not differ appreciably in terms of mean blood pressure, proteinuria, gestational age at delivery, mean birth weight, and perinatal mortality. This seems to strengthen our suggestion that an increase in plasma urate concentration of 30 $\mu\text{mol/l}$ should not be regarded as abnormal.

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¹ Redman, C W G, *et al*, *British Journal of Obstetrics and Gynaecology*, 1977, **84**, 904.

² Redman, C W G, *et al*, *Lancet*, 1977, **2**, 1249.

³ Redman, C W G, *et al*, *Lancet*, 1976, **1**, 1370.

⁴ Boyle, J A, *et al*, *Journal of Clinical Pathology*, 1966, **19**, 501.

⁵ Dunlop, W, and Davison, J M, *British Journal of Obstetrics and Gynaecology*, 1977, **84**, 13.

⁶ Hill, L M, Furness, C, and Dunlop, W, *British Medical Journal*, 1977, **2**, 1520.

Osteoporosis and osteomalacia

SIR,—Dr T C B Stamp (25 February, p 511), discussing a paper by Dr R G Long and others on the treatment of hepatic osteomalacia (14 January, p 75), comments that the x-rays in the latter study "indicated osteoporosis and not osteomalacia." Apart from numerous fractures the radiological skeletal survey in all four patients showed bone thinning but no evidence of osteitis fibrosa cystica or periosteal reactions.

In 56 consecutive cases of thinning of the upper cortex of the clavicle in adults aged 42-91 idiopathic osteoporosis was present in 44, but osteomalacia was present in 4.¹ In elderly patients it is uncertain whether cortical thinning is due to osteomalacia, as there may be a concomitant osteoporosis due to aging. For this reason I followed up all cases of clavicular cortical thinning (1.5 mm or less) in adults over 45. There were 18 such patients in a 10-year period. Chronic renal failure accounted for eight, coeliac disease seven, steroid therapy two, and Cushing's syndrome one. All the patients with coeliac disease had biochemical osteomalacia. Pseudofractures were common but were absent in one case,

cortical thinning being the only radiological sign of osteomalacia. Thus true osteoporosis was responsible for the cortical thinning in only the cases of steroid therapy and Cushing's syndrome—three out of 18 cases. The other 15 were due to hyperparathyroidism and osteomalacia.

Cortical thinning cannot therefore be regarded as synonymous with osteoporosis.

H C ANTON

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¹ Anton, H C, *British Medical Journal*, 1969, 1, 409.

Antacid and sodium content of Gaviscon

SIR,—We were interested to read the paper by Dr R E Barry and Mr J Ford (18 February, p 413) referring to the sodium content and neutralising capacity of some commonly used antacids.

We would like to correct an apparent misconception in the paper and point out that the action of Gaviscon in the management of dyspeptic symptoms depends on the formation of an alginate raft for the suppression of gastric reflux and not upon neutralisation of gastric acid. The antacid component in liquid Gaviscon is present to aid the formation of the alginate raft.

The sodium content of the Gaviscon range has been clearly stated in our literature and our data sheets since 1971 and cautionary warnings about the use of the products in conditions in which sodium intake needs to be controlled have also been made.

A W HARCUS
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Hot foot syndrome

SIR,—I was most interested to read the report of a case of unilateral lumbar sympathectomy due to retroperitoneal tumour by Dr R C Brown and others (18 February, p 410). The combination of a hot foot, ankle oedema, and pain associated with recurrent retroperitoneal tumour has become known as the "hot foot syndrome," first described at a clinical meeting by Dr R J Evans, head of the Eleanor Smythe Pain Clinic, Toronto General Hospital, who has since collected many cases. An article from him is currently in press detailing the findings of his cases. Since I first learnt of this syndrome from him I have collected six cases and have found the hot foot sign to be a very valuable indicator which may precede all other evidence of tumour recurrence. One of these patients underwent a laminectomy on the basis of a diagnosis of disc protrusion before the recurrence of her ovarian carcinoma became obvious.

Thermography is obviously a useful investigation in these cases and has shown that the main temperature difference occurs at the feet but a much smaller difference is detected along the lower leg. One very recent case was of an inoperable carcinoma of the rectum in which the temperature difference between the feet was very marked indeed, this being confirmed by several independent examiners. However, by the time the patient attended the

radiotherapy centre for treatment the difference could not be detected by either palpation or thermography and could not be elicited by making the legs dependent or by exercise. It is interesting to note also that this patient did not have any pain whatsoever, although pain does usually accompany this sign.

Hot foot sign should clearly be regarded as a very valuable physical finding for tumours which may recur in the retroperitoneal space and I would echo Dr Brown's comment that a deliberate search should be made for this sign in all suitable cases.

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Cost of outpatient chemotherapy

SIR,—I would like to add to the interesting article (25 February, p 493) by Professor K C Calman and others. Having been an outpatient myself for chemotherapy for over a year the largest saving of all was the continuing ability to stay at work throughout treatment. Being a teaching hospital representative with ICI and a district councillor means that I have plenty to do. I found eventually that even on the days I received intravenous therapy I would be fit enough to attend council meetings in the evening. My results at work remained above average, as did my income, this point being especially important to our children, now in final years at school and university.

The greatest impact of outpatient therapy has been on my friends and people in general. People are learning that it is possible to live with cancer for eight years, go as an outpatient and return to one's own family each day, and usually get to work the next day, and still be able to give to life.

DAVID O R S THOMSON

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Snap-happy parents

SIR,—I was most interested to read the letter from Drs J A Sills and J E Handley (11 February, p 368) and thought your readers might be interested to know how I adopted the same practice of providing a clear photograph to all mothers who are separated from their babies in my special care baby unit. About 18 months ago a father asked me if he could take a Polaroid picture of his newly born premature baby who had been transferred 30 miles from another hospital where there were no facilities for coping with such babies. This was a new idea to me, and when I saw the resulting "instant" picture, which contained a minuscule baby surrounded by the paraphernalia of incubator, oxygen analyser, etc, I decided to ask our hospital photographer to provide a larger picture instead. As a routine now she takes a 10 × 6 in black and white picture of the nude baby only, so that the mother can see all the features of the baby clearly. This picture is then sent to any separated mother immediately to encourage "bonding" and because of the importance of this first critical 36-h period in this respect.

I have interviewed several of these mothers subsequently and all have been very enthusiastic in expressing how much that photo-

graph meant to them when they had to remain in another hospital surrounded by other mothers who had their own babies near them. I intend carrying out a survey of all the mothers who have received such photographs, to include developmental progress of their children and the occurrence of any subsequent disturbed behaviour or poor mother-child relationship as compared with a similar group of premature babies whose mothers did not receive photographs in past years.

Following that initial inspiration of seeing the father use his Polaroid camera I discovered that it was also standard practice in such hospitals as Mill Road, Cambridge, and Queen Charlotte's and King's College, London, so that any aspirations to originality rapidly vanished.

I might add finally that we always try to take the photograph before inserting umbilical and other catheters, nasal cannulae, ECG electrodes, etc, which might otherwise present a frightening appearance to the mother. I think the practice of introducing an explanatory leaflet about the special care unit, explaining the purpose of these items of equipment, is an admirable one and this was something else that I learnt was used in the Cambridge unit and will shortly be introduced here.

ALAN GOODWIN

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Help for parents after stillbirth

SIR,—So far in the correspondence about stillbirth there has been no mention of any kind of planned management being carried out in hospitals. Although it is only in its initial stages and will need to be co-ordinated with what happens in the delivery room and on the wards following the delivery of a still-born baby, a deliberate approach has been adopted by the social work department at this hospital. We are automatically informed of all deliveries in the hospital and are almost always able to talk to mothers of stillborn babies before they are discharged—usually within 48 h of delivery. The greatest value of this first interview is not so much the opportunity it offers of giving these mothers the information they always request (in the main they require explanation and reassurance from doctors at this time); rather it lies in enabling us to follow up these mothers after they return home.

For many mothers the time spent in hospital is remembered as a prolonged nightmare. However, as long as they are in hospital they can continue to see themselves as mothers, albeit bereaved mothers. After discharge from the hospital they rapidly have to adjust and are often pushed by family and friends into denial of ever having been expectant mothers. It is during this time that feelings of depression, guilt, and resentment are strongest and also during this time that a continued link with the hospital can be of great value.

We maintain contact with these mothers by telephone after discharge and see them again at home after the district midwives have stopped going in. Whether or not follow-up continues depends on whether the parents are agreeable to it, on the reaction the mother has to stillbirth, and on the help she has received from family and friends.

Such follow-up takes a lot of time but its value is immense. Firstly, it gives immediate support to parents of stillborn babies. Mothers