antibody (>40%) in November 1989, thus giving additional evidence that infection had occurred at least some months before conception.⁴ It might be considered that the risk of fetal infection was therefore minimal in this case and would be outweighed by the risk to the fetus of the invasive investigation.

The case described underlines the importance of reference laboratories investigating cases of suspected toxoplasma infection in pregnancy, not only because of the additional technical skill and the range of investigations that they offer but also to allow discussion between the obstetrician, the microbiologist and the patient at the referring hospital, and the microbiologist at the reference laboratory. This permits a coordinated approach to investigation and a management plan tailor made to the circumstances of the patient,⁶ including the use of invasive investigations if indicated. Four cases of toxoplasmosis acquired during or shortly before pregnancy were identified and managed in this way, with satisfactory outcomes, in the Southampton district during 1989-90.

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Epidural analgesia and maternal satisfaction

SIR,—Dr J D Murphy and colleagues doubled the rate of spontaneous delivery in their group of primiparous women given epidural analgesia in labour by using epidural fentanyl with a lower dose of bupivacaine rather than epidural bupivacaine alone.¹ Mr D P Keane suggests that their rate of spontaneous delivery of 35% is unacceptable and quotes the overall rates of non-elective caesarean section and forceps deliveries in primiparous women at the National Maternity Hospital in Dublin, but he fails to relate these to the use of epidural analgesia.²

In North West Thames each of the 15 maternity units has collected standardised data on all pregnancies since 1988, using the St Mary's maternity information system. The database for 1988-9 includes data on 29 688 primiparous mothers with a vertex presentation at term (table). The spontaneous delivery rate was 48% in women who received epidural analgesia during labour compared with 82% in those who did not. Thus most primiparous women in North West Thames who receive epidural analgesia have an operative

Method of delivery for 29 688 primiparous women with vertex presentation at term, North West Thames, 1988-9

	No (%) not given epidural analgesia	No (%) given epidural analgesia	% Overall
Caesarean section	992 (4.8)	1 438 (15.8)	8.2
Forceps	2 771 (13.5)	3 302 (36.2)	20.5
Spontaneous	16 803 (81.7)	4 382 (48.0)	71.4
Total	20 566 (69.3)	9 122 (30.7)	

delivery. Figures nearer to those in Dublin are found when all primiparous women are considered, suggesting that Mr Keane's criticism is unsupported. Any measure that tends to improve the spontaneous delivery rate is to be welcomed.

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Support for mothers of twins

SIR,—The finding of Dr Karen Thorpe and colleagues of a higher prevalence of depression in mothers of twins is no surprise.¹ Many people fail to appreciate that these families need not only practical help but emotional support.

Introductions to other families through local twins clubs can be invaluable. Professionals wanting more information about the needs of these families should contact the Multiple Births Foundation, which runs regular prenatal meetings for parents and grandparents as well as twins clinics.

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Multiple pregnancies resulting from assisted conception: burden on neonatal units

SIR,—Dr Alison Walker has reported on the proposed new code of practice drawn up by the Human Fertilisation and Embryology Authority.¹ Attention has recently been drawn to the effect of assisted conception techniques that result in multiple pregnancies on the workload of neonatal intensive care units.²

In our unit during 1990, 10 infants were admitted as a consequence of four such pregnancies (two triplet and two twin pregnancies). Two of the pregnancies had resulted from in vitro fertilisation and two from administration of gonadotrophin. All these infants were below 28 weeks' gestation, and their mean birth weight was 798 g; they represented 23% of all infants admitted before 28 weeks. Seven died, representing 35% of all deaths of infants of less than 28 weeks' gestation. All required ventilation, and their collective ventilatory requirements was 220 "ventilator days," representing 17% of the total number of ventilator days for all infants in the unit for the year.

Our experience supports the view that assisted conception results in a disproportionately heavy burden on overstretched neonatal units. Levene concentrated on the problems created by increasing numbers of triplet and higher order births.³ We believe that the effect of all multiple births resulting from assisted conception must be monitored carefully if neonatal services are not to become saturated.

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Preventing needlestick injuries

SIR,—Professor D C Anderson and colleagues argue the case for resheathing needles but in so doing advocate a procedure that, far from preventing injury, puts the operator at unnecessary risk for unproved gains.¹ The only way to eliminate needlestick injuries is safe and efficient disposal of sharps and their subsequent incineration. The container should be sufficient for its purpose and conform to British safety standards BS 7320. The practice of resheathing needles serves merely to delay their appropriate disposal while putting the operator at risk of self injury.

Intuitively, many people believe that a resheathed needle is safer, but when they are faced with a sharps box, a needle, and a sheath they cannot explain satisfactorily why it is safer to resheath the needle before putting it in the sharps box. This is elementary safety at work practice, and all medical and nursing practitioners owe it to themselves and their colleagues to take appropriate precautions to minimise hazards. Instruction at the beginning of clinical training to dispose of used needles promptly and efficiently will do most to minimise the hazard of needlestick injuries.

We can see no benefit in resheathing needles and view recommendations that are claimed to make this practice safer as a retrograde step.

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- 1 Anderson DC, Blower AL, Packer JMV, Ganguli LA. Preventing needlestick injuries. *BMJ* 1991;302:769-70. (30 March.)

Jarman index

SIR,—The recent correspondence on the place of the Jarman score in determining the distribution of NHS support for the care of patients in deprived areas raised two important issues.^{1,2} Firstly, Dr Roy Carr-Hill and Mr Trevor Sheldon hinted at the conceptual problems of using indices comprising multiple measures based on limited census data³; and Drs Joy A Main and Paul G N Main pointed to the practical problems of using aggregated data, which can lead to areas of particular deprivation within electoral wards being overlooked.² Secondly, Dr Carr-Hill and Mr Sheldon questioned the need to use complex indices when simpler measures that correlate with health service utilisation are known.

The preferred way to develop the policy for allocating any "deprivation allowance" must surely be through using simple measures of disadvantage easily accessible within general practices. With the recent evolution of information systems for general practices it is now feasible for proxy information on social deprivation to be held alongside an age-sex register.

Analysis of data collected in a recent survey of people attending general practice enabled us to compare the ability of several measures of disadvantage to predict scores on the Nottingham health profile,⁴ a standardised measure of perceived distress which comprises six subscales of distress. Scores on the profile have been shown to predict use of the health service.⁴ We used eight measures of disadvantage in our analysis: home ownership; recent unemployment; having had further education; car ownership; registrar general's social class; Jarman score of patient's area of residence; age; and presence of a long term physical health problem.