is therefore the normal position of choice; a pillow placed under the patient's buttocks gives the surgeon maximum room to manoeuvre without his being hampered by the edge of the couch. Under anaesthetic the left lateral position remains the position of choice unless sigmoidoscopy precedes a minor anal procedure about to be performed in the lithotomy position.

No mention is made of inspection of the anal canal prior to instrumentation. This is particularly important in relation to the diagnosis of a fissure, as any subsequent examination in these patients will be extremely uncomfortable and is better left until the patient is admitted for definitive treatment under anaesthetic. Sigmoidoscopy should always be performed prior to proctoscopy; this is stated at the end of the article but your title and layout suggest that proctoscopy comes before sigmoidoscopy.

The choice of instrument is obviously the prerogative of the surgeon but in a busy rectal clinic the standard stainless steel instrument is probably more practical than the disposable instrument; a fiberoptic light source is essential.

The presence of blood in the lumen is very important; but it should be stressed that blood seen on the way up is more important than blood seen on the way down, which may be secondary to instrument trauma.

I feel that it should also have been stressed that a negative digital examination merely means that nothing has been felt, not that there is no lesion; and it is also important to point out that sigmoidoscopy should always be performed prior to requesting a barium enema. Hopefully this sigmoidoscopy will be to 25 cm—that is, past the rectosigmoid junction. Failure to visualise the lower sigmoid will require a sigmoidoscopy under anaesthetic, or flexible sigmoidoscopy, if the barium enema is negative and symptoms are suggestive of a lesion in the lower sigmoid colon. The rectosigmoid junction is a blind area to the radiologists and tumours will be missed by the surgeon if he does not visualise the sigmoid colon between 15 and 25 cm from the anal margin.

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SIR,—With respect, the surgical instrument manufacturers have always considered a trocar to be a sharp pointed instrument for piercing a cavity wall in paracentesis.

The trade description of the component used for introducing a proctoscope tube into the anal canal (9 August, p 437) is surely the obturator.

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Sudden infant death syndrome and ventilatory control

SIR,—The hypothesis that impaired chemoreceptor ventilatory drive is partly responsible for the sudden infant death syndrome, as outlined in your leading article (2 August, p 337), may be supported by two further observations.

Firstly, the common anaemia of infancy reaches its nadir between the second and fourth month of life,¹ when the majority of sudden infant deaths occur.² Haemoglobin accounts for only a third of the buffering

power of the blood, but is of great importance in disturbance of acid-base balance of respiratory cause.³ This fall in haemoglobin tends to be more profound where prematurity and adverse social circumstances exist, factors which are also associated with the sudden infant death syndrome.^{2,4}

Secondly, metabolic acidosis is recognised in premature infants and has been found to occur in apparently healthy full-term infants.⁵ It is more common among bottle-fed infants,⁵ as is the sudden infant death syndrome.²

Infants with impaired chemoreceptor ventilatory drive are prone to develop hypoxia and hypercapnia. If these infants also became anaemic and acidotic, they would have little reserve to withstand a combined respiratory and metabolic acidosis in the course of a respiratory infection.

Monitoring capillary blood gases and haemoglobin levels in high-risk groups⁴ might prove to be a simpler means of averting some cases of sudden infant death than monitoring ventilation.

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¹ Matoth Y, Zaizov R, Varsano I. *Acta Paediatr Scand* 1971;60:317-23.

² Carpenter RG, Shaddick CW. *Br J Prev Soc Med* 1965;19:1-7.

³ Zilva JF, Pannall PR. In: *Clinical chemistry in diagnosis and treatment*. London: Lloyd-Luke (Medical Books) Ltd 1971:65.

⁴ Carpenter RG, Gardner A, McWeeny PM, et al. *Arch Dis Child* 1977;52:606-12.

⁵ Moore A, Ansell C, Barrie H. *Br Med J* 1977;i:129-31.

Perinatal and neonatal mortality

SIR,—Your leading article welcomed the report of the Parliamentary Social Services Committee on Perinatal and Neonatal Mortality (26 July, p 255). Of particular interest were its views on the thorny problem of the best place for delivery. The committee felt that an unresolvable dilemma existed in that many women still wish to be delivered in maternity units which do not have the facilities to ensure the lower possible perinatal and neonatal mortality. We have been particularly concerned with this dilemma recently in South Teesside and we wish to report our attempts at solving it.

The heavily industrialised and socially deprived South Tees Health District has a population in excess of 300 000. Middlesbrough, administratively the "centre" of the district, is situated geographically in the north-western corner and so there are several substantial pockets of population more than 20 miles away from the hospital centres or, more relevantly perhaps, 90 minutes away by public transport. This combination of unfavourable social and environmental factors has resulted in a delivery rate outside the consultant units of almost 30%. In 1978, out of 4332 deliveries, 1223 (28.2%) occurred in one of these isolated general practitioner units. This contrasts with a rate of 5.9% for England and Wales as a whole. These factors are, not surprisingly, associated with a relatively unfavourable perinatal death rate (19.9 compared with 15.5 per 1000 nationally).

In response to these problems a plan has been evolved, the central feature of which is the gradual concentration of deliveries into the consultant unit. As a first phase in this process the most isolated of these units was closed. The unit was housed in an old converted house, with inadequate facilities and services. It was more than 15 miles from emergency consultant help. Despite the obvious disadvantages it was well loved by some of the community it served and by the GPs and midwives who staffed it. The protests provoked by its closure were of such intensity that reverberations were felt as far away as the Elephant and Castle

and the Minister of State himself came to survey the scene.

It had been recognised that the closure of this unit would cause inconvenience and additional expense to the patients and their relatives. To minimise their effects, a new consultant antenatal clinic was established in the area and the existing clinics in adjacent areas were expanded. By taking the "consultant mountain" to the "patient Mohammed" the patients' travelling time has been greatly reduced and so their acceptance of care and attendances have been increased. There have been other less obvious benefits. Both hospital and district staff have benefited from the closer working relationships established. With this closer co-operation it has been possible to produce a more selective and appropriate early discharge policy after delivery. It is planned to improve further on this policy by establishing postnatal beds in the community hospitals. When these beds are available we hope to operate a "delivery only" policy at the central unit for suitable cases. The patient will then be transferred back to her own community and caring team within a few hours.

We believe that this policy should ensure the maximum acceptance by patients living in these outlying areas of intensive central hospital facilities for the vital hours of labour and delivery, while preserving as much as possible the homely local unit atmosphere for antenatal care. Perhaps these proposals represent one partial solution to the Parliamentary Social Services Committee's "unresolvable dilemma."

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Progesterone, fluid, and electrolytes in premenstrual syndrome

SIR,—We take strong issue with the conclusions drawn from the paper by Mr P M S O'Brien and others (10 May, p 1161) that progesterone deficiency is probably not the cause of premenstrual syndrome and that treatment with progesterone is illogical unless a deficiency is detected.

The subjects in this study consisted of the same population used in a previous investigation,¹ in which spironolactone was compared with placebo. The group consisted of volunteers from the hospital environment, who may have had prior knowledge of symptoms; and the method of assessment is a further problem as only a full Moos menstrual distress questionnaire has been considered as really reliable.² Estimation of premenstrual mood index (PMI) was made when the subjects were on placebo and is a most unsatisfactory way to define groups for further comparison, as inevitably both contain a mixture of "symptomatic" and "asymptomatic" patients. There are two reasons for this: firstly, symptomatic patients may be included in the asymptomatic group because of a placebo effect and, secondly, asymptomatic subjects have a one in four chance of being included in the symptomatic group, since the probability of randomly obtaining two positive PMI scores in two placebo cycles is one-quarter. In addition, the whole validity of the subsequent conclusions is called into question on account of the small and unequal groups of subjects—namely, 18 and 10.

With regard to the progesterone levels, only four estimations were made—on days 4, 12, 18, and 24 of the menstrual cycle—which obviously bear no relation to ovulation or menstruation unless every subject had an identical 28-day cycle. Two blood levels, therefore, at some stage of the luteal phase is scant evidence on which to base a strong claim. Furthermore, the authors have taken the individual