same issue (p 656); D, the incidence of morbid events, corresponds to a negative utility function. The ratio R expresses the benefit in treating a true positive as a multiple of the loss in treating a false positive; such loss must include the limited nature of resources and inconvenience involved were all pregnancies to be monitored intensively as from 34 to 36 weeks of gestation. Dr Klipstein's formula (4) can be taken a little further: T_2 is better if $R > 7.3$, apparently, though rounding errors demand that such calculations be performed on the original data rather than on summary statistics. In the same way, the low value of R, 5/3, in Card's example led to a preference for medical rather than surgical treatment.

Two further points warrant mentioning. The discrepancies of the false-positive rates from the expected 10% are nothing but artefacts of the smoothing process. The false-positive rates for all the potential screening variables could be standardised at, say, 44/438 by moving each 10th percentile line parallel to itself until exactly 44 of the points representing infants of normal growth lay below it. Such adjustment for the product of crown-rump length and trunk area in the paper of Dr Neilson and colleagues (17 May, p 1205) would be in a downwards direction and would thus almost certainly add two further false negatives, making 4/36 (11%) instead of 2/36 (6%) and matching the false-negative rate of the product with the circumference. The moral is that with only 36 positives these two screening criteria are indistinguishable in performance.

Furthermore, it is asserted that fetal-head measurements proved to be the least sensitive indicators of growth retardation. We are concerned, however, about growth retardation not for its own sake but as a marker for mortality, morbidity, and potential need for intervention. The 56-59% of growth-retarded neonates whose heads were small and in whom perhaps "brain sparing" has been less effective may well fare considerably worse than the corresponding "false negatives" and on clinical grounds may be a more appropriate group to identify.

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Perinatal practice and compensation for handicap

SIR,—Mr P Mitchell and Mr I G Chalmers (27 September, p 868) have done a public service in pointing out the risk that defensive attitudes will inevitably affect perinatal practice unless the Government brushes aside the objection of some lawyers and assumes both the responsibility for compensating handicapped children and the right to sue those responsible for the recovery of the costs involved. Such a ruling would put suer and sued on more equal terms than are likely to obtain when an individual parent tries to recover damages from a powerful international company, and would also obviate the temptation for parents to sue individual doctors and nurses for alleged mistakes of judgment made in good faith in the exercise of their duties.

The present situation is highly unsatisfactory, cases of real negligence being settled out of court without publicity while defensible cases are heard in public, thus exposing

often innocent parties to professional denigration based on the natural sympathy that the public feel for handicapped children and their assumption that someone must be to blame as an alternative to accepting that we live in a difficult and dangerous universe. Our slogan should be "to each according to his need and from each according to his liability" and this can be achieved only if the State acts as broker and parents abrogate their right to sue in exchange for adequate assistance in rearing their handicapped child—assistance which is more likely to be appropriately directed than the residue left after the deduction of legal expenses when damages are awarded to the child for administration by his guardian.

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Taking blood and putting up a drip in young children

SIR,—In that it dismisses the external jugular, internal jugular, and femoral veins as sites for venepuncture, I assume that the article by Drs Andrew Whitelaw and Bernard Valman on how to take blood in babies (30 August, p 602) excluded the seriously ill baby where the peripheral circulation is compromised. On the assumption that the patient is well perfused, I cannot condone the routine use of butterfly needles for taking blood. This is a tendency which is creeping in among junior paediatricians and it is entirely unnecessary and expensive.

One butterfly needle costs 50p whereas the standard No 1 (green) needle costs 2p. If blood is taken from a hand, foot, or scalp vein, the needle can be inserted without a syringe and the blood allowed to drip into the collecting tube—unaesthetic maybe, but effective and cheap. If, as usual, the antecubital veins are used, then with experience an ordinary syringe and needle are perfectly adequate

for whatever technique the individual has developed. I find the one-handed technique shown in the figure helpful, as the thumb of the other (supporting) hand can be used to steady the needle and even vary its position in the vein.

In summary, there are indications for using butterfly needles for taking blood—for example, for taking large quantities or perhaps

arterial puncture—but on the whole I think that the expense involved should discourage their routine use.

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SIR,—I also read with interest the article about taking blood in young children (30 August, p 602), and the reply by Dr C G Peters (27 September, p 870). His use of a fiberoptic cold light source to transilluminate the patient's hand or foot to demonstrate vessels is a good idea. However, I would like to draw attention to a report in the annual report of the Medical Defence Union¹ of a case in which such a cold light source was used, and four partial or full-thickness burns resulted. The following day the procedure was repeated on the other arm, this time with a protector, with a gap of 2 cm between the light and the skin; and further burns occurred. The doctor then tested the light source on his own finger and burnt it. The instrument, intended for endoscopy, is thought to reach a temperature of 70° or 80°C. The incident was investigated; the instrument was not found to be defective, but its use had been unorthodox.

I would like to agree that I have found these light sources becoming very hot, and that doctors using them to demonstrate vessels should show extreme caution in order to protect the child's skin from burns.

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¹ Medical Defence Union. *Annual report*. London: MDU, 1980:22.

* * * Other readers have written on this point and we thank them for their letters.—Ed, *BMJ*.

Progesterone, fluid, and electrolytes in premenstrual syndrome

SIR,—Dr Anthony Clare (20 September, p 410) has great difficulty in comprehending the definition of true premenstrual syndrome. Reading the chapter "Definition and diagnosis" in my book *Premenstrual Syndrome and Progesterone Therapy*¹ and a glance at figure 2.1 showing the common timing of symptoms should resolve his confusion. For simplicity's sake, premenstrual syndrome could be defined as "the recurrence of symptoms on or after ovulation, increasing during the premenstruum and subsiding during menstruation, with complete absence of symptoms from the end of menstruation to ovulation." A carefully recorded three-month calendar will enable him to decide the diagnosis in "the woman whose diary reveals symptoms occurring intermittently during the cycle." There are no characteristic symptoms of premenstrual syndrome, although there are common symptoms. The diagnosis can never be made on the presence of symptoms alone.

A strict definition of premenstrual syndrome is of practical as opposed to theoretical importance, because of the aetiological significance and the therapeutic response to progesterone. In her controlled trials of progesterone Sampson² was using patients with menstrual distress and, as stated in my letter to the *British Journal of Psychiatry*,³ the correct title would have been: "Menstrual