White also states that, from a new analysis of a limited number of studies, he has established that the minimum all cause mortality for men occurs at a consumption below 21 units a week, with the implication that this might invalidate the government's new sensible drinking levels. The analysis of data carried out in *Sensible Drinking*—which does not, as White suggests, take a disproportionate account of any particular studies—examined all the studies that are referenced. This analysis, which incorporated White's own statistical advice, found that it was difficult to arrive at a categorical absolute point at which the minimum all cause mortality occurred on the basis of mathematical analysis of all the studies. Because of the relatively shallow base of the J shaped curve for all cause mortality, however, the report was able to conclude "that for men of all ages there is a band of minimal mortality associated with a weekly consumption between about 7 and 28 units a week." White's new point of minimum all cause mortality falls within this band and does not affect the report's recommendations. Thus the report tried to reflect a range of similar all cause mortalities in defining the new daily benchmarks rather than a categorical weekly amount: a range of consumption with similar risk seems more accurately to reflect the scientific facts.

Although the new daily benchmarks have been perceived by some people as an "effective increase in sensible drinking levels," others have noted that if drinkers in Britain complied with them then many individuals would probably reduce their overall weekly consumption.³

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Home visiting and child injury

Consider measurement issues

EDITOR,—Ian Roberts and colleagues' systematic review of home visiting programmes and the prevention of child injury and child abuse neglects a key methodological issue in the discussion.¹ The authors fail to describe the overlap between childhood injury and abuse: many injuries to children are the result of poor parenting or inadequate supervision. Injuries, particularly in young children, are sometimes the result of physical abuse or neglect but go unrecognised as such. The authors emphasise the difficulty in using reported abuse as a valid outcome measure, yet they do not discuss the importance of considering other health outcomes (such as emergency room visits or injuries) as proxy measures of abuse. In a recent review of home visitation programmes, Olds and Kitzman used data from multiple sources to highlight the importance of assessing programmes' impact on maltreatment of children.¹ Measurement of children's encounters with the health care system can be an important proxy measure of caregiving problems.

In addition, the authors claim that no other review of randomised trials has examined the effect of home visitation programmes on child abuse by using methodologic criteria proposed for scientific overviews. However, we carried out a systematic overview of the prevention of physical abuse and neglect and reached a different conclusion about home visitation.¹ In this, the

scores for methodological quality of trials were considered in reaching conclusions and a range of outcomes was reviewed in determining effectiveness of the prevention programmes. In the review by Roberts and colleagues, studies were rated on methodological rigour, but these ratings do not seem to have been taken into account in drawing conclusions. Our group concluded that home visitation can prevent physical abuse and neglect of children in high risk families.

Roberts and colleagues have carried out a careful overview of an important topic; nevertheless, failure to consider measurement issues in evaluating effectiveness of child abuse prevention programmes can lead to faulty conclusions about effectiveness.

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Author's reply

EDITOR,—In emphasising the absence of a clear distinction between child injury and child abuse, MacMillan and Offord make a very important point. The idea that childhood injuries can be neatly divided on the basis of intent is neither sensible nor sensitive and should probably be relegated to medical mythology. It is precisely because child abuse was so difficult to diagnose, and so prone to reporting bias, that we elected not to calculate pooled estimates for child abuse. With this decision made, the methodological quality of the primary trials was irrelevant. It seemed far more appropriate to consider the effect of supportive home visiting on injury occurrence irrespective of intent, as we did.

We were wrong to claim that no previous review of randomised trials of home visitation in the prevention of child abuse satisfies the methodological criteria for scientific overviews, and we are grateful to the correspondents for drawing our attention to the excellent review which concluded that home visitation can prevent child abuse.¹ However, the correspondents claim that our review reached a different conclusion. This may be the case, but we certainly did not conclude that home visitation was ineffective. Our conclusion might best be described as an open verdict. To argue, in the absence of valid evidence, that home visitation was ineffective would have been entirely inappropriate. In this regard, we were interested to note that the correspondents' statement that "many injuries to children are the result of poor parenting or inadequate supervision" was not supported by any references. Could this be another medical myth?²

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Lactate dehydrogenase should be used as marker in testicular tumours

EDITOR,—We wish to emphasise the importance of tumour markers in the management of testicular tumours and not merely in "deciding the course of the disease."¹ β Human chorionic gonadotrophin and α fetoprotein concentrations are of proved value in diagnosis, staging, the prediction of tumour behaviour, and the monitoring of treatment and recurrence of disease.² Nevertheless, an appreciable number of patients with testicular tumours, particularly those with seminomas, have normal concentrations of these two markers. Thus additional markers are needed to help in diagnosis and the selection of treatment.

We suggest that it may be useful to measure lactate dehydrogenase. Skinner and Scardino found that a raised lactate dehydrogenase level may be the sole biochemical abnormality in as many as a tenth of patients with persistent or recurrent non-seminomatous tumours.³ The lactate dehydrogenase level may be even more helpful in patients with seminoma, as only a tenth have a raised β human chorionic gonadotrophin concentration but half have a raised lactate dehydrogenase value.² This variable is valuable as a marker in the surveillance of patients with advanced seminomas, in whom it is an indicator of tumour bulk.⁴ It can also provide some prognostic information: three multivariate analyses have shown it to be a significant prognostic factor independent of β human chorionic gonadotrophin or α fetoprotein concentration in both seminomas and teratomas.⁵ We therefore believe that lactate dehydrogenase should be measured routinely both preoperatively and in the follow up of patients with testicular germ cell tumours.

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Rates of triplet pregnancies in Western Australia may be beginning to fall

EDITOR,—We have previously reported twinning and triplet rates to 1989 in a study of cerebral palsy in multiple births in Western Australia.¹ The steep rise in triplet pregnancies was particularly worrying because, although actual numbers were small, the risk of having a child with cerebral palsy was 47 times greater in a triplet than a singleton pregnancy. The main contributor to the widely reported rise in multiple births during the 1980s is thought to have been the increasing use of fertility treatments.² We continued to monitor these trends and can now report twin and triplet rates to 1994; we used data to 1993 from the maternal and child health research database³ and data for 1994 from the midwives' notification of births.⁴