of cardiac death. That would be, as Bassan writes, the height of folly. Instead we recommended further evaluation of patients in whom monitoring performed for clinical reasons shows abnormal findings (described in our paper). As we wrote, the benefit of managing silent ischaemia in elderly people is unclear. Nevertheless, if silent ischaemia is diagnosed it is clinically and ethically accepted, even in elderly patients, that risk factors should be controlled and treatment with aspirin and even β blockers considered. Specific treatment of the marker, arrhythmia, would be unwise and certainly ineffective. An important question is whether these markers are also valid in middle aged people.

Bassan argues that the markers were defined arbitrarily. This is not true. All clinically relevant arrhythmias shown by Holter monitoring were included in the analysis, and the cut off points for abnormal findings were based on the criteria used in other studies attempting to find prognostic markers.

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The persistent vegetative state

Task force's definition influences interpretation of outcome

EDITOR,—Robin S Howard and David H Miller's comments on the study by the American Multi-Society Task Force on the persistent vegetative state leaves two aspects of the prognosis that need to be clarified.¹ The adult mortality of 82% at three years and 95% at five years might suggest that more prolonged survival in a vegetative state is uncommon. Yet it is the prospect of long survival that promotes the debate about continuing treatment. The task force, however, defined a persistent vegetative state as being in a vegetative state at only one month after an acute cerebral insult; this would include some patients who had been vegetative for only a few days after a period in coma. Many such patients die in the next few months and some recover, leaving only 59%, 37%, and 24% of those vegetative at one month still alive and vegetative at three, six, and 12 months. Death rates reported for patients vegetative at three months in Japan^{2,3} and at six months in the Netherlands⁴ were much lower, while the death rate for those still vegetative at one year is quite low but not yet accurately documented.

With regard to recovery, the proportion of head injured adults who recover consciousness after three months in a vegetative state but who are severely disabled is more than half, not one fifth as Howard and Miller state.¹ Just how severely disabled they may be is evident from Andrews's report of 11 recoveries after four months or more in a vegetative state.⁵ Only four patients could speak, only four could feed themselves, and five still needed a gastrostomy.

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Report is unnecessarily negative

EDITOR,—Robin S Howard and David H Miller's editorial on the persistent vegetative state¹ is timely because several working parties are debating this condition, including the Royal College of Physicians; the European Union's biomedical and health research programme (BIOMED I) at the Centre of Medical Law and Ethics at King's College, London; and an international working party and conference on management of the condition held at the Royal College of Physicians in March. The editorial reviews the position of the Multi-Society Task Force.^{2,3} Considerable concern has been expressed, particularly among consultants in rehabilitation, that the task force's report is unnecessarily negative.

The international working party was set up because of concern that insufficient attention was being given to the treatment, especially the rehabilitation, of patients in a persistent vegetative state. It will debate the concern about the terminology used; the classification of patients into various levels of persistent vegetative state and states of low awareness; the need for more sensitive measurement scales; the effectiveness of treatment programmes; and the relevance of rehabilitation for medical, legal, and social policy. Concern must be expressed at the assumption made by many people that severe disability is not worth achieving. This has implications for the treatment not only of people with severe brain damage but also of those with other chronically disabling disorders.

The persistent vegetative state is so rare that it is difficult, even in specialist units such as the Persistent Vegetative State Rehabilitation Unit in Putney, to build up sufficient research data to provide answers to many of the questions required to make reasonable clinical, legal, and social decisions on behalf of such unfortunate patients and their families.

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Eclampsia in the United Kingdom

More information is required

EDITOR,—K A Douglas and C W G Redman have produced an invaluable 70 year landmark report on the state of eclampsia in the United Kingdom.¹ Hopefully, more information will follow as some aspects are not discussed in detail in their paper.

What of the 138 (26%) women who were not included in the survey, having originally seemed to fit the criteria? What did these women with pseudoeclampsia have? Five of the 64 who had a fit while receiving community based care had hypertension and albuminuria, but how many had one or the other and how many had been seen in the week preceding the fit? The 356 singleton pregnancies had a fetal loss of 84/1000, but the 55 babies in the 27 multiple pregnancies survived. Was the eclampsia different in these two groups—

for example, in the incidence of major maternal complications? Roughly a quarter of the patients were multiparous, which suggests that primiparous women are more susceptible to the condition. To what extent is the different incidence of eclampsia in teenagers accounted for by the effect of parity? What are the relative risks of eclampsia in primigravidae and multigravidae? Was there any information about the multigravidae—for example, did they have new partners?

We find it difficult to understand the results under the heading "antenatal care." If one follows the standard antenatal care described in the article, 42 of the last 112 days of pregnancy are more than seven days away from the last visit—that is, 38%—so one would expect to find that 62% of these patients had been seen in the week before their eclamptic fit. In fact, 325 (85%) had been seen. This is despite a quarter of the patients having either no or less than standard antenatal care. Had these patients been brought back early because, at the previous visit, they had had hypertension or proteinuria or some other cause for concern? Antenatal care as described so dramatically in the classic paper by Hamlin remains the cornerstone of prevention of eclampsia.² Altogether 89% of these patients had warning signs. We desperately need a test for "dangerous" toxemia.

Finally, was there any difference in postpartum eclampsia between vaginal delivery and caesarean section? Probably none of the women who had a caesarean section would have been given ergometrine, and they would have been the more severe cases. It would not surprise us, however, if the incidence of postpartum eclampsia was higher in patients who had few signs of toxemia and had been given ergometrine.

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Better standards of care will reduce morbidity and mortality

EDITOR,—Traditional teaching is that eclampsia reflects poor standards in obstetric practice, and K A Douglas and C W G Redman's paper provides further evidence of this.¹ Of the 383 women with eclampsia, 294 were inpatients when eclampsia occurred and only 36 had no recorded hypertension or proteinuria in the week before the first fit.

Successive confidential inquiries into maternal mortality have highlighted the seriousness of this condition, identifying important substandard care in 88% of deaths.² It is disappointing to learn that 23% of the women with eclampsia in this study had less than standard antenatal care and that biochemical tests were so poorly used: only 54% of the women had their plasma creatinine concentration measured and only 30% had their transaminase concentration measured. The most recent confidential inquiry noted that ergometrine had been given to five of 27 women dying of hypertension disorders of pregnancy.² We would be interested to hear from the authors whether similar inappropriate use of ergometrine was an important factor in postpartum eclampsia in their study.

The authors found that in those women whose blood pressure was recorded within an hour of the onset of convulsions the mean diastolic pressure was 97 mm Hg. We wonder whether they found any difference in blood pressure between the women who had eclampsia antenatally and those