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CORRESPONDENCE

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters must be signed personally by all their authors.

Inadequate prenatal diagnosis of Down's syndrome

SIR,—This letter is written because a local 40-year-old trained nurse has recently been delivered at term of a liveborn infant with Down's syndrome even though she had early amniocentesis at 16 weeks' gestation. Culture failure due to poor laboratory conditions and excessive work load can be blamed. This is not an isolated example and similar ones will occur in the future because demand from women informed and alarmed by the media threatens to swamp available resources. Ultrasonic scanning facilities are overloaded (Dr B M Gompels, 3 June, p 1487) and there are relatively few obstetricians in a position to perform amniocentesis, while amniotic cell chromosome analysis is time consuming so that trained cytogeneticists cannot cope with more than 150-200 cultures per year.

Ferguson-Smith[1] and others have commented on the high frequency of chromosomally abnormal fetuses at the time of early amniocentesis in older women, perhaps an accurate reflection of an unexplained increase in the frequency of Down's syndrome among the newborn.[2] Chromosome aberrations are found in 0·6-1·5% of fetuses at maternal age 35-39 and in at least 5% of women of 40 and over. Thus, prenatal screening for Down's syndrome with termination of affected pregnancies becomes increasingly cost effective with maternal age, the break-even point being about 35 years.[3] Other indications for early amniocentesis include a previous pregnancy involving Down's syndrome or neural tube defect and a persistently high maternal serum α-fetoprotein concentration in the present pregnancy. With due allowance for women who wish to opt out, obstetricians should be able to offer prenatal diagnosis at least to women with these high risks, whereas at present many have to be turned away. When facilities are available only the highest clinical and laboratory standards are acceptable since the choice of abortion in a *wanted* pregnancy already advanced to 20 weeks is a life-and-death decision unique in medicine, while the avoidable birth of a child with Down's syndrome or open crippling spina bifida is an obvious and distressing event. Sadly, within some centres resources may not be available to allow such high standards, although this problem may be obscured by a lack of follow-up of pregnancies submitted for prenatal diagnosis and pronounced normal, so that "false-negative" laboratory errors may be missed. Further, if amniocentesis does cause some increase in fetal loss and of perinatal problems this will not be apparent unless follow-up at a local level is a routine procedure. Regrettably, preamniocentesis counselling may not always be adequate and an individual woman may not be given sufficient comprehensible information to decide for herself whether the rewards of amniocentesis are commensurate with the risk. Finally, support from health visitors and others is essential during this difficult phase of a woman's life.

For both humane and economic reasons adequate moneys should be made available to properly designated regional genetic centres associated with expert obstetrics and sonar for amniocentesis. Some means must also be found to circumvent the present doctrine of devolution within the Health Service, since regional services sometimes compete un-