BRITISH MEDICAL JOURNAL

SATURDAY 20 SEPTEMBER 1986

LEADING ARTICLES

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

MEDICAL PRACTICE

NO 6549 BRITISH MEDICAL JOURNAL 1986 VOLUME 293 709-768
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.

WEEKLY. ISSN 0267-0623
AS IM CODEN: BMJOAE 293 (6549) 709-768 (1986)

CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Is skimping on care of the newborn false economy?

SIR,—Dr Brian D Speidel's leading article (6 September, p 575) was a passionate plea from a paediatrician, but will it or should it convince the managers of the health service to divert scarce resources to neonatal intensive care? Another report in the same issue (p 638) hinted at the central problem—the need to evaluate outcome, perhaps by using quality adjusted life years (QALYs).

The weakness of the leading article is highlighted in the sentence "Further expert neonatal intensive care *seems* to reduce not only mortality but also long term morbidity" (my italics). It really is important to show the benefit and the cost benefit of a service before expecting to receive substantial additional sums of money which would otherwise be spent on some other part of the NHS.

There is some American evidence that neonatal intensive care units are effective and show a positive cost benefit in the treatment of babies over 1250 g but a loss for infants weighing 500 to 909 g.[1] This work needs to be repeated here, where the costs and benefits may be very different.

Once we have identified the types of babies which should be in neonatal intensive care units the next step is to ensure that all units are of reasonable standard. Probably the best way of ensuring that is to set up regional teams to visit and assess all neonatal intensive care units in the region (along the lines of the perinatal monitoring group set up by the South East Thames region). Units which are below standard cannot be assumed to produce benefits comparable to the best units, and some will need to be closed or given appropriate support.

Having laid down criteria for those small babies which should be admitted one hopes that constantly improving techniques will ensure that babies excluded from the initial scheme will ultimately be included. These excluded babies must be the subject of meticulous research and the outcome properly evaluated in special units. They should not be treated in every neonatal intensive care unit.

Some of the benefits of neonatal intensive care units will be by saving the costs of managing handicapped children outside the health service—in schools, in special hostels, and the like. These savings would be a strong reason for expecting additional money from outside the NHS. Indeed, I believe the way to unlock additional finance for many parts of the NHS is to show convincingly that the benefit in cost terms to the community exceeds the cost of the service.

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1 Boyle MH, Torrance GW, Sinclair JC, Horwood SP. Economic evaluation of neonatal intensive care of very low birth weight infants. *N Engl J Med* 1983;**308**:1330-7.

Obstetric anaesthetic services

SIR,—Dr Felicity Reynolds presents a good case for greater availability and use of epidural analgesia in labour (16 August, p 403), a cause with which I strongly sympathise. However, she does that cause a disservice by claiming that there is "no overall increase" in the forceps delivery rate in women who have epidurals "with correct management of the second stage of labour." She should know better since she has herself shown an increased instrumental delivery rate in patients given epidural analgesia,[1] but she does not cite that report.

Instead, she refers to three earlier publications to support her statement, but each of these, too, clearly showed an increased rate of instrumental delivery in association with epidural analgesia. Considering primigravidas, one of her sources claims that the introduction of an "epidural service" caused only a modest rise in the instrumental delivery rate from 24·3% to 29·4%.[2] But 24·3% is quite a high starting point and an assisted delivery rate of 29·4% would unquestionably be considered high if epidurals had not been implicated (it is also noteworthy that the caesarean section rate increased from 7·9% to 11·1% and that fewer than half the primigravidas actually had an epidural).

In another of her sources the "proper" management of the second stage of labour with epidural analgesia in primigravidas involved routine use of an oxytocin infusion to induce "regular, strong uterine contractions" if the fetal head was above the ischial spines at full dilatation.[3] When the head was below the ischial spines, either the epidural was allowed to wear off and the mother started to push when she felt the urge to do so or she was asked to start pushing while analgesia was maintained throughout the second stage, but because epidural analgesia using bupivacaine cannot be made to wear off rapidly there may not have been much difference between these two subgroups. The forceps delivery rates were 43% and 25% respectively (not significantly different), or 34% "overall."

In a third source women receiving epidural analgesia who delayed pushing until, on average, two hours after onset of the second stage had an increased spontaneous delivery rate compared with women who began pushing sooner, but the forceps rate remained high at 44% (of which one in four were rotational forceps deliveries).[4]

Does it matter if epidurals cause more forceps deliveries? It could be argued that epidural anal-