the exclusion of one pair in which the control had breech labour from the analyses including birthweight, and the exclusion of two additional pairs in which the case had breech labour from the analyses including gestation. For those pairs included in the analyses the unadjusted relative risk estimate associated with breech labour was 9·0 (9/1) for the birthweight analyses and 7·0 (7/1) for those involving gestational age. These contrast with the relative risk of 4·5 (9/2) in the analysis involving all pairs. These differences emphasise the small numbers of breech labours on which our risk estimates are based. Nonetheless, as shown in the table, adjustment for either of these factors did not have a substantial effect on the estimate of relative risk associated with breech labour.

Whether it is appropriate to thus apply statistical adjustments for birthweight and gestation to calculations of the risk of cryptorchidism associated with breech labour depends upon the mechanism(s) of any association of low birthweight with risk of cryptorchidism persisting beyond infancy, and these mechanism(s) are not yet known clearly.

A SWERDLOW
P G SMITH

Epidemiology and measures of disablement

SIR—Recently I have read a short, lucid, and comprehensive new book introducing community medicine[1] and new editions of two outstanding and widely read textbooks.[2 3] The authors are to be congratulated, but I was disappointed at the lack of emphasis given to the assessment of disablement in these books. Disablement should be viewed alongside mortality and morbidity as one of the dimensions in the assessment of "community health", and it should be a component of outcome measures used in clinical audit and the monitoring and evaluation of health services. Diagnostic labels, for example, cerebral haemorrhage, multiple sclerosis, rheumatoid arthritis, diabetes, do not convey the degree of associated disablement. Survival, restoration to normal physiological and biochemical values, changes in the clinical condition, and return to paid employment are insufficient measures of the outcome of many of today's treatments (eg, renal dialysis, amputations in the elderly, use of anti-rheumatic and cytotoxic drugs) and of physiotherapy and other rehabilitation activities. Certainly there are many difficulties in the measurement of disablement, not least those arising from the complex interplay of impairment, personality, and the social and physical environment. Nevertheless students should be introduced to the concepts of impairment, disability, and handicap,[4 5] and to the various approaches (and the shortcomings) that are available to assess their presence and severity.[6 7]

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Consumption of trans acids in relation to heart disease

SIR—The Institute of Shortening and Edible Oils would like to comment on the recent articles by Thomas *et al.*[1 2] The authors report a higher proportion of "lower" *trans* acids (16:1 and 18:1) in adipose tissue taken post mortem from 136 people who died of heart disease (cases) compared with 95 individuals who died of unrelated causes (controls). Noting that "lower" *trans* acids are more abundant in commercially hydrogenated fats than in ruminant-animal fats, the authors conclude that "the cases consumed a higher amount of hydrogenated fat relative to ruminant-animal fat than did the controls". The authors conclude further that "those hydrogenated fats having higher content of lower *trans* acids will present the greater risk and in this respect it is possible that some hydrogenated vegetable oils may well be more harmful than hydrogenated marine oils". This is sheer speculation without basis in fact.

Thomas *et al* clearly are speculating and do not provide convincing evidence that the heart disease in their cases was directly related to consumption of *trans* acids. The authors claim that the difference in lower *trans* acid levels (16:1 plus 18:1, designated as "T_L") between cases and controls is statistically significant. However, the absolute difference is small and the variability is high. In table 1,[1] the authors present mean T_L values for cases and controls for 10 regions of the UK but do not present overall mean values. From these data I calculated overall (unweighted) mean T_L values to be 3·31% (of total adipose tissue lipid) for cases and 3·08% for controls.

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