References

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Authors' reply

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EDITOR—The questions about costs raised by Venn-Treloar, Whittle, and Reynolds were addressed in the full text version of the report on bmj.com, with further details in the technical report (www.ich.ucl.ac.uk/srtu/frampubs.htm).**1** We included the costs of counselling before amniocentesis, chorionic villus sampling, or termination, but we assumed that screening options were discussed with all women at booking. As all women were assumed to have had a dating ultrasound scan, the cost of the nuchal fold translucency test relates to the additional time to take measurements, explain the results, and train ultrasonographers.

Reynolds seems to have missed the section in the methods that explains that the nuchal fold measurement was adjusted for verification bias. Howe makes the case for a modelling exercise. Differences between our detection rates and those from studies based on routine care will be strongly affected by uptake rates, referral practices, and verification bias. Modelling takes account of these factors to allow comparison of test performance and would still be required even if trials were feasible.

Finally, Reynolds raises an important point about the poor precision of the detection rate. One approach is to look for consistency of the characteristics of test performance. Meta-analyses of the results for biochemical markers produce comparatively precise results, which are consistent with the characteristics used in the analysis. But to take account of the correlation between markers we used test characteristics from a single large, archived dataset. Other archived datasets have given similar results.**2** We believe that this approach gives the best estimates of test performance but accept that random error is not represented.

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Ratio of femoral length to tibial length needs to be evaluated extensively

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EDITOR—Gilbert et al and Howe et al in their articles rely heavily on maternal age to screen for Down's syndrome. **1** **2** But maternal age is not so useful in India and other countries where early marriage is the norm and the social pressures for early motherhood are enormous. In our series, which included 3000 deliveries and seven babies with Down's syndrome, we saw that all babies with the syndrome were born to mothers younger 35 years.

We reported in the *American Journal of Perinatology* our finding that the ratio of femoral length to tibial length remains remarkably constant around 1.15 (range 1.13-1.19) in fetuses after 13 weeks' gestation.**3** Fetuses with Down's syndrome had this ratio greater than 1.2 (standard deviation 4.5) compared with norms. The youngest fetus with Down's syndrome in our sample was 22 weeks old at the time of measuring. We hope that this ratio will be evaluated more extensively and earlier in