able amounts of blood loss. The total length of menstrual bleeding and the amount (number of tampons used) was reduced in all cases. One patient noted some intermenstrual spotting, but this was acceptable.

The first two patients have been followed up for 11 and 16 months respectively and are alive and well, still with regular menstrual cycles and acceptable blood loss. The third patient was followed up for seven months and during this time had regular cycles with no side effects; four months after insertion she had a kidney transplant and three months later died from a massive gastrointestinal haemorrhage. The fourth patient was seen for nine months after IUD insertion; after five months she also had a kidney transplant and four months later died from pneumococcal pneumonia. These two deaths were not related to the IUD use.

We conclude from this small series that the progesterone IUD offers definite advantages for patients undergoing haemodialysis who have heavy periods. In contrast to the use of systemic steroids intrauterine progesterone produces regular cycles with acceptable menstrual blood loss.

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[1] Pharriss, B B, *et al*, *Fertility and Sterility*, 1974, **25**, 915.
[2] Martinez-Manatou, J, *et al*, *Fertility and Sterility*, 1974, **25**, 922.
[3] Rosado, A, *et al*, *Contraception*, 1974, **9**, 39.

Laparoscopic removal of IUDs from the abdomen

SIR,—Perforation of the uterine wall by intrauterine contraceptive devices (IUDs) is an uncommon but not rare occurrence. With the increasing popularity of the IUD the incidence of this complication will quite possibly increase.

We have recently seen two such cases. Both presented with diffuse acute low abdominal pain which had started three or four days after insertion of an IUD (Lippes loop, size C, in one and Copper-7 (Gravigard) in the other) by an experienced general practitioner. The pain had gradually become more severe over five or six days until admission. Both patients were multiparous and apparently had normal pelvic anatomy at insertion of the IUD. On examination there was generalised lower abdominal tenderness and marked cervical excitation. The thread of the IUD could be neither seen nor felt in the cervix.

Removal was by laparoscope, using a method basically similar to that described by Steptoe,[1] under general anaesthesia. The thread attached to the IUD was in both cases visualised by manipulation of the uterus by means of Hulka forceps in the cervix. The thread was then grasped with Palmer forceps passed into the abdomen through a trocar inserted at the junction of the medial third and the lateral two-thirds of a line joining the umbilicus and right anterior superior iliac spine. The forceps and trocar were then withdrawn together, and the IUD, still grasped by its thread with the forceps, was manipulated through the tiny incision made by insertion of the trocar. In both cases the site on the posterior aspect of the uterus at which perforation had occurred was scarcely noticeable. The only other pathological finding in the abdomen was a pool of "old" blood, about 20-30 ml in volume, in the pouch of Douglas. In both cases the patient was able to be discharged the following day.

These cases illustrate the use of laparoscopy as a therapeutic as well as diagnostic process and also emphasise the importance of checking the position of the IUD in patients presenting with low abdominal pain who have had one of these devices fitted.

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[1] Steptoe, P C, *Laparascopy in Gynaecology*, 2nd edn. Edinburgh, Livingstone, 1975.

IUDs and fibrinolysis

SIR,—In your leading article (7 February, p 304) you suggest that the mechanism of the tendency of intrauterine contraceptive devices (IUDs) to cause heavy periods might not be completely separable from the mechanism of the device's contraceptive action.

We examined fertilised rat ova histochemically for their fibrinolytic activity.[1] Activity was found during tubal passage but disappeared at implantation. Simultaneously the fibrinolytic activity of the endometrium disappeared. It is well known that inhibition of fibrinolysis in organ and cell culture on clotted substrates promotes adhesion and growth.[2] Absence of fibrinolytic activity might thus be a prerequisite for implantation of the zygote. In the light of these observations it is of interest to note that IUDs raise the fibrinolytic activity in the endometrium, which, in contrast to that of non-users, is localised to the superficial cell layer.[3]

The disappearance of endometrial fibrinolytic activity at the time of decidualisation prompted us to study the human decidua in tissue culture for inhibitors of fibrinolysis. We used a method in which tissue explants are cultured in the presence of, but not in contact with, a preformed standard plasminogen-contaminated fibrin clot. Urokinase added to the culture medium degrades the fibrin with consequent accumulation of stable fibrin degradation products (FDP) in the medium. The amount of FDP is assessed immunochemically. When inhibitors are released from the cultured explants they will inhibit the formation of FDP.[4] The results are given in the table.

Inhibition of urokinase by decidua in organ culture. Mean value of two cultures. Each value denotes FDP content in μg/l of Parker medium

	Days of culture		
	1	2	3
Urokinase 3·0 U/ml alone ..	153	228	448
Urokinase 3·0 U/ml + decidua	15	69	120
Urokinase 1·5 U/ml alone ..	27	87	195
Urokinase 1·5 U/ml + decidua	7	22	38
Urokinase 0·75 U/ml alone ..	1·5	15	60
Urokinase 0·75 U/ml + decidua	0	0	5
Decidua alone	0	0	1·5

We also examined decidua cultures for their influence on the fibrinolytic activity of rat ova. When rat ova were incubated on fibrin slides without culture medium or with addition of fresh medium the mean lytic area was found to be 90×10^3 μm². On the slides to which human or rat decidua culture medium had been added to the fibrin film the lytic area never exceeded the area of the ovum—that is, $< 18 \times 10^3$ μm².

IUDs medicated with inhibitors of fibrinolysis have been claimed to decrease the incidence of intermenstrual bleeding as well as heavy periods. However, the possible interference of such treatment with the contraceptive effect of the device should be borne in mind.

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[1] Liedholm, P, and Åstedt, B, *International Journal of Fertility*, 1975, **20**, 24.
[2] Ingemanson-Nordqvist, B, and Källén, B, *Experimental Cell Research*, 1961, **21**, 232.
[3] Larsson, B, Liedholm, P, and Åstedt, B, *International Journal of Fertility*, 1975, **20**, 77.
[4] Åstedt, B, Pandolfi, M, and Nilsson, I M, *Proceedings of the Society for Experimental Biology and Medicine*, 1972, **139**, 1421.

Supervision of repeat prescribing

SIR,—As director of the research centre from which the paper by Mrs S M Shaw and Mr L J Opit comes I am naturally distressed at the astonishment, hilarity, and anger of the practitioners involved (20 March, p 713). The authors themselves are, of course, responsible for the views expressed in the paper and I would not wish to speak for them, but I think I must in fairness reply on behalf of a number of other loyal and hardworking collaborators and say how much I regret unwarranted public castigation of their work.

I appreciate that these comments arise from the hot sense of injustice which the partners feel, and this partly from their failure to receive their transcript of the paper. We suppose this error must have occurred in this office and must accept responsibility, although we are now unable to trace events because of a burglary with much destruction and subsequent disorganisation. Absence of acknowledgements in the paper was due to the partners' request for non-identification following their perusal and commentary upon earlier accounts of the work and not to any intended slight.

There is one other point I must put straight. It is possible to read one of the sentences in the partners' letter to imply that Mrs Shaw changed the treatment of one of the patients. This was raised in discussion between ourselves and the practice, when I was present, and it was explained that a locum doctor changed the treatment when informed of the situation. This was not doubted by the partners at the time and I hope they are not doubting it now. Perhaps I am over-sensitive in treating a bit of ambiguous English as something which could be seen as an innuendo.

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Disposable bacteriological loops and vaginal discharge

SIR,—The investigation of a vaginal discharge involves sample taking from the urethra, cervix, and vagina for Gram staining, culture, and wet-film microscopy. The standard bacteriological swab has certain drawbacks. It is too big to enter the urethra without pain and may be too big to enter the cervical canal. Any Gram films made may be obscured by carbon particles if a charcoal-coated swab is used. A common alternative is the platinum

loop. This has to be sterilised in a flame before each use. It upsets many patients if they see the flaming, as they are liable to do if it is done on the ward. Moreover, the metal tends to cut into the solid medium of the plates inoculated, which renders isolation of any growth difficult.

A highly acceptable improvement is the presterilised plastic disposable bacteriological loop. In South Glamorgan 10-μl capacity loops (made by Nunc Ltd.) are bought in bulk, packed singly, and sterilised in 15% ethylene oxide in carbon dioxide mixture for three hours in the central sterile services department. These loops easily enter the urethra and do not traumatise patient or bacteriological medium. Vaginal wet films are easily taken for direct microscopic examination for *Trichomonas vaginalis*.

Decreasing the difficulties in specimen-taking increases the motivation of the medical staff to perform adequate investigation and may be one factor in the 29% isolation rate for *Neisseria gonorrhoeae* in salpingitis patients in this area.[1]

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[1] Sparks, R A, and Davies, A J, *British Journal of Venereal Diseases*. In press.

Otitis media

SIR,—I disagree with the opinion expressed by Mr J F Birell in his original article (21 February, p 443) and subsequent letter (3 April, p 836).

I have on numerous occasions seen children complaining of severe unilateral earache with a temperature and signs of an upper respiratory infection in whom there was soft, beige-yellow wax in the affected ear. On the occasions I have removed this wax—either by syringing or with a probe—an inflamed red drum behind the wax has been revealed. I no longer do this, principally because it is too painful in such a situation. I regard the presence of such wax as diagnostic and therefore needing appropriate antibiotic therapy.

Occasionally the mother will say there has been a discharge from the ear, sometimes describing it as "bloody." I have assumed that the temperature of the inflamed middle ear has melted the wax, causing some of it to run and subsequently the colour to change.

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SIR,—In his article Mr J F Birrell (21 February, p 443) did not mention myringotomy in the treatment of acute otitis media. However, surgical drainage is one of the basic principles in the treatment of empyema. In otitis media the functioning of the congested Eustachian tube and the clearing activity of the middle ear epithelial cilia are impaired and this occasions the accumulation and stagnation of inflammatory exudate in the middle ear—a situation resembling empyema. The accumulated exudate can then corrode its way through the drum causing necrotic perforation, which takes much longer to heal than a small myringotomy hole made through a "healthy" drum. Thus early paracentesis can in many cases prevent spontaneous necrotic perforation and its consequences. On the other hand stagnation of exudate in the middle ear lengthens the course of infection. Friedmann,[1] in his experimental studies, found proliferation of mucous elements and formation of glands in the middle ear mucosa even after only two weeks of inflammatory process. Thus a prolonged course of infection probably plays an important role in the development of secretory otitis media, a process that is characterised by the proliferation of the secretory elements of the middle ear mucosa. Our finding[2] of the dominance of lymphocytes and neutrophils in smears made of 137 glue-ear secretions and the finding of bacteria in one-third of those smears further support the infectious aetiology of the disease. Consequently I consider the performance of myringotomy to be of the utmost importance in bringing about environmental conditions that are as advantageous as possible for the resolution of the infection.

Fluid in the middle ear impedes mobility of the drum, the appearance of which can sometimes be misleading. With the aid of a pneumatic speculum the movements of the drum can be visualized. If fluid is suspected myringotomy under local or general anesthesia must be performed, the incision of the drum always being followed by aspiration of the fluid from the middle ear.

As Mr Birrell states, pain is the principal symptom in acute otitis media. Myringotomy gives immediate relief from pain. Since, at the same time, myringotomy provides reliable information on the nature of the middle ear process and also creates as favourable conditions for rapid healing as are possible under the circumstances there seems no justification for not using this widely advocated[3] procedure.

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[1] Friedmann, I, *Journal of Laryngology and Otology*, 1955, **69**, 588.
[2] Palva, T, Holopainen, E, and Karma, P, *Annals of Otology, Rhinology and Laryngology*. In press.
[3] Taylor, L, in *Scott-Brown's Diseases of the Ear, Nose and Throat*, ed J Ballantyne and J Groves, vol 2, p 101. London, Butterworths, 1971.

Psychosurgery on television

SIR,—This unit has more experience of contemporary stereotactic psychosurgical operations (and we do not refer to the obsolete earlier leucotomies) than any other department in Britain and probably in the world.

On the basis of this experience we were most disturbed to see a programme on Independent Television on 30 March. This showed a patient who had a psychosurgical operation apparently because of abnormally aggressive behaviour. The indications for psychosurgery in this case would have proved controversial in any medical conference and many would have grave doubts about the type of operation performed. It seems to us, therefore, to be quite irresponsible to present, and in some lurid detail, such an extremely unusual clinical problem for popular consumption.

It is generally realised that the use of psychosurgery for abnormally aggressive behaviour presents especially difficult ethical and clinical problems and such operations are very rare in Britain. As a result of the television programme, which lasted an hour, the public will confuse the controversial case shown to them with the increasingly accepted type of psychosurgery carried out both at this unit and at the Atkinson Morley Hospital for certain severe psychiatric illnesses which have been described by us in several publications.[1-3]

Is it not possible for some kind of control to be exerted on the mass media or are we to allow their presentations to be solely dictated by a need for the dramatic and the extreme?

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[1] Bridges, P K, and Bartlett, J R, *Postgraduate Medical Journal*, 1973, **49**, 855.
[2] Göktepe, E O, Young, L B, and Bridges, P K, *British Journal of Psychiatry*, 1975, **126**, 270.
[3] Ström-Olsen, R, and Carlisle, S, *British Journal of Psychiatry*, 1971, **118**, 141.

An eye-pad hazard

SIR,—While the obvious lesson to be derived from Dr R Wall's account of inflammable eye pads (27 March, p 772) is that they should be made non-inflammable, might one also stress the equally important but less obvious lesson—was this and indeed any other eye pad strictly necessary?

For a long while it has become increasingly clear that in very many cases the traditional use of eye pads—for example, after outpatient procedures, the incision of meibomian cysts, and even tonometries—is not only totally unnecessary and a source of considerable discomfort to patients but may additionally be actively harmful as the cause of pad abrasions. It is to be hoped that the non-ophthalmological doctor and nurse will take due notice of the very marked changes that have taken place in accepted and advised practice in this matter.

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SIR,—My recent letter concerning the inflammability of eye pads (27 March, p 772) contained a reference to John Dickinson and Co Ltd. I have since been informed that this company is responsible only for the packaging of the eye pads in question, which they neither manufacture nor supply. I wish to apologise for any embarrassment that they have suffered.

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Specialties within community medicine

SIR,—As a trainee in community medicine I write to endorse Dr A S St Leger's views (20 March, p 709). We are being trained rather than educated and the syllabus embodies many of the epistemological mistakes that have hindered progress for so long. Sociology and administrative theory are full of untestable hypotheses and, as Dr St Leger says, our study of the other topics is so limited that the worth in them is not fully appreciated.

It is obvious that community medicine is becoming committee medicine and that community physicians are dealing with Health