toxic nodules treated with 500 MBq (13·5 mCi) of ^{131}I and have found no cases of hypothyroidism.[3]

Nevertheless, after treatment with a single standard dose of ^{131}I some patients will remain thyrotoxic and require a second dose to render them permanently euthyroid. We regard this as entirely acceptable when compared with thyroidectomy, which carries a small but well documented complication rate even in expert hands, results in a scar, requires hospital admission, and is very much more expensive than ^{131}I therapy.

M N MAISEY
I FOGELMAN
S G COOKE
G E RATCLIFFE

Department of Nuclear Medicine,
Guy's Hospital,
London SE1 9RT

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Triumph over terror

SIR,—Professor Derek Russell Davis's leading article (16 November, p 1369) discussed the treatment of recurrent nightmares. In such cases it is important to discriminate between nightmares and sleep terrors. The former occur in rapid eye movement sleep and are vivid and terrifying dreams.

Sleep terrors are initiated in deep slow wave sleep. They consist of a feeling of impending doom (typically a sensation of crushing) and terror and are marked by screaming and activities such as rushing from the bed. They are not dreams, and vivid visual imagery is not present. These attacks are thought to represent a fault in slow wave sleep and occur with sudden arousal to a state of dissociated wakefulness.

The behavioural treatments of nightmares discussed in the article took place in wakefulness. Hartmann has hypothesised that the dream is the mechanism by which more complex psychological systems are repaired after waking use.[1] Presumably the recurrent nightmare represents a failure of repair and integration of affect laden or frightening events and memories.

Waking rehearsal of a nightmare with a more satisfactory ending may improve the repair function or provide an alternative system of integration. Change in the actual structure of the frightening dream may occur.[2]

A more active treatment may be to attempt to change the dream directly by inducing the subject to dream lucidly. A lucid dream is one in which the dreamer is aware that he is dreaming. In such a situation it is possible for the dreamer consciously to control and alter the content of the dream.[3] Various techniques including rehearsal of memories[4] and electrical stimulation during rapid eye movement sleep to arouse the sleeper slightly[5] have been used.

Such techniques could be used in patients with recurrent nightmares. They also have potential in the investigation of the phenomena of dreams and insomniacs. The lucid dream offers potential new approaches to the treatment of neurotic and personality disorders. In future, will we be training our patients to confront their fears in their dreams?

B MATTHEWS
M OAKEY

Sleep Laboratory,
Atkinson Morley's Hospital,
London SW20

1 Hartmann EL. *The functions of sleep*. New Haven and London: Yale University Press, 1973.
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Risk of booking for a home birth

SIR,—I was pleased to read Dr J M L Shearer's paper (23 November, p 1478). He shows that there is no evidence of an increased risk associated with home confinements in a series of 202 women booked in his Essex practice. His survey did not include primigravidas. It seems to be generally assumed that booking to have a first baby at home is dangerous. Our experience has not shown any evidence of increased risk.

We have been supervising home confinements in our inner London practice since 1961. In 228 consecutive home bookings since 1977 our findings have been very similar to Dr Shearer's—that is, 10% of women in their second or subsequent pregnancies were transferred to hospital either during pregnancy or in labour. There have been no tragedies attributable to home booking. Since 1977 we have booked 75 primigravidas for home confinement. This is because there are an increasing number of women in our area requesting home confinement, and we feel, as does the Maternity Services Advisory Committee, that the choice of a home booking should be available to those who seem to be in low risk category.[1] With very careful selection and supervision we have found no evidence to suggest any increased risk to mother and baby.

The transfer rate among primigravidas was predictably high. It used to be 25% until 1983 but including all cases up to December 1985 it is 32% (24 mothers). Five transfers were for antenatal complications requiring specialist care (twins, breach presentation, premature labour) and the rest (19) because of failure to progress in either the first or second stage of labour and the need for assistance in hospital. The final outcome was successful in every case. The remaining women delivered their babies safely at home.

Our experience with primiparas has shown that a trial of labour at home does not carry any increased risk to mother or baby. After all, the dramatic emergencies such as postpartum haemorrhage or a baby needing resuscitation are as common, or in the case of postpartum haemorrhage more common, in multiparas than primiparas.

O G FRANKLIN
S R ILIFFE

London NW6 6RY

1 Maternity Services Advisory Committee to the Secretaries of State for Social Services and for Wales. *Maternity care in action part II: care during childbirth*. London: HMSO, 1984.

Progress in in vitro fertilisation?

SIR,—We agree with most of Mr D R Bromham's sentiments (7 December, p 1643) about the availability of infertility services in general and in vitro fertilisation in particular. Most of the recommendations made by the Warnock committee have been ignored in public debate, in particular their comments on the need for funding to collect statistics about the scope of the infertility problem.

With the birth of the first NHS "test tube" baby in October 1984 the vast number of referrals to the regional in vitro fertilisation unit at St Mary's Hospital forced us to limit the cases that could be included on our waiting list. We decided to concentrate our efforts on helping childless couples and will no longer list any couple who have children living with them, even if they are the product of a previous marriage or are adopted. In addition, although in vitro fertilisation is a recognised effective form of treatment for oligozoospermia, we do not accept couples in whom a male factor accounts entirely for their infertility. Despite these restrictions, patients on the waiting list can expect to wait for about four years before they can be seen in the clinic, let alone offered courses of treatment. We therefore feel it is unrealistic to accept any patients who do not live in the area covered by the North West Regional Health Authority even though we appreciate that there is no NHS funded servce available in their own region.

There are currently 680 patients on the waiting list for a clinic appointment; 283 couples were referred to the unit this year. The table shows the number of patients who could not be included on the waiting list despite meeting the other criteria of suitability for treatment by in vitro fertilisation.

Referrals to in vitro fertilisation unit January-November 1985

	No
No unsuitable for waiting list	227
Referral from outside region	87
Child living with couple, but not product of that union	79
Woman aged ≥36 years	32
Infertility due to oligozoospermia	18
Medically unsuitable	11
No referred and listed	283
Total referrals	510

Obviously this is merely the tip of the iceberg as most clinicians who refer patients to the unit are aware of our criteria for acceptance. Indeed, it has recently been estimated that the number of cases suitable for treatment by in vitro fertilisation in the catchment area of the North West region is 1250 a year (I Leck, personal communication).

While we accept that there are many pressures on the scarce resources of the NHS, infertility is not rare, and each health authority should look again at the provision of infertility services, accepting the view of the Warnock committee that "medicine is no longer exclusively concerned with the preservation of life, but with remedying the malfunctions of the human body." There is also a great need for parliament to debate the entire contents of the Warnock committee report and act accordingly. In vitro fertilisation is no longer an experimental but an established form of treatment and should be available at regional centres throughout the United Kingdom.

DIANA J FOTHERGILL
PAMELA BUCK

Regional In Vitro Fertilisation Unit,
St Mary's Hospital,
Manchester M13 0JH

SIR,—While accepting the development of in vitro fertilisation as a major breakthrough in the treatment of infertility, I am puzzled by the figures quoted by Mr D R Bromham (7 December, p 1643). He states that "the proportion of infertile couples in our population may now be considerably greater than conventional estimates of 10% . . . perhaps some 20% of those will be afflicted with surgically irremediable tubal blockage. . . . 6-16% of the adult population may eventually find in vitro fertilisation of benefit." Each statement is qualified with a "may," a