maternal intoxication and therefore the lack of maternal clinical hypervitaminosis has little relevance to the discussion of the teratogenic potential of vitamin A.¹ It is evident that the conclusion of Mrs. Wild and her colleagues that "it seems unlikely that women who conceive soon after discontinuing oral contraception run any teratogenic risk from increased vitamin A levels" may yet be more definite than is warranted by their data and should not be accepted as final. Further work is required.—I am, etc.,

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- ¹ Briggs, M., Briggs, M., and Bennum, M., *Contraception*, 1972, **6**, 276.
- ² Gal, I., Parkinson, C. E., and Craft, I., *British Medical Journal*, 1971, **2**, 436.
- ³ Gal, I., and Parkinson, C. E., *Contraception*, 1973, **8**, 13.
- ⁴ Bubb, F. A., *British Medical Journal*, 1974, **1**, 391.
- ⁵ Bodansky, O., Lewis, J. M., and Lillienfeld, M. C. C., *Journal of Clinical Investigation*, 1943, **22**, 643.
- ⁶ Lund, C. J., and Kimble, M. S., *American Journal of Obstetrics and Gynecology*, 1943, **46**, 207, 486.
- ⁷ Gal, I., and Parkinson, C. E., *International Journal for Vitamin and Nutrition Research*, 1972, **4**, 565.
- ⁸ Gal, I., Joint meeting of the Blair-Bell and Clinico-Pathological Societies, February 1972.

Complication of Proximal Gastric Vagotomy

SIR,—About a year ago a death following proximal gastric vagotomy was reported in your columns.¹ It appeared that the lesser curve of the stomach had sloughed. I am writing to describe a very similar case.

The patient was a lean, 64-year-old man with a 10-year history of peptic ulceration who had developed pyloric stenosis. On 7 March 1974 proximal gastric vagotomy and Heinecke-Mikulicz pyloroplasty were performed. In the initial postoperative phase there was delay in gastric emptying and a nasogastric tube was not removed till 11 March. On 13 March he suddenly collapsed with generalized peritonitis. At operation 45 minutes later it was found that the whole of the lesser curve of the stomach had sloughed between the two lines of ligatures placed on the blood vessels entering it. A 0.5-cm strip of adjacent mucosa was purple and obviously had a very poor blood supply. The peritoneal cavity was cleaned out and the defect in the stomach wall was closed with interrupted black silk. A Maurice Lee tube was inserted and the abdomen was closed with drainage to the lesser curve of the stomach. Leakage of gastric contents from the abdominal drain occurred on 25 March but gradually ceased and eventually the patient recovered completely.

The sequence of uneventful proximal gastric vagotomy, dissolution of the lesser curve on the sixth day, and recurrence of leakage 12 days later is exactly the same as in the previously reported case. I wonder whether there may have been other similar cases which have not been reported. If this is so surgeons may have to alter their impression that proximal gastric vagotomy is an operation almost completely free from undesirable sequelae.—I am, etc.,

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- ¹ Newcombe, J. F., *British Medical Journal*, 1973, **1**, 610.

Drugs for Gastric Ulceration

SIR,—Your leading article on gastric ulceration (27 April, p. 186) asks "Where is the clinician to turn when faced with this variety of drugs?" May I suggest that he

has very little to do with any of them. But, instead of trying to influence the "gastric acid secretory potential," tries relying instead on the natural neutralization of the gastric acid that occurs with natural foods and which is so seriously interfered with (especially by refining the carbohydrates) in our modern civilization.

Epidemiological evidence from all over the world and from prisoner-of-war camps in the last war shows the very close correlation between such interference and the incidence of gastric and duodenal ulceration¹ and has recently been much strengthened.² The striking absence of peptic ulceration in those peoples who do not consume refined carbohydrates and the closely related reduced buffering effects of these foods on the gastric acid merit the closest attention.—I am, etc.,

T. L. CLEAVE

Fareham, Hants

- ¹ Cleave, T. L., *Peptic Ulcer*. Bristol, Wright, 1962.
- ² Cleave, T. L., *The Saccharine Disease*. Bristol, Wright, 1974.

Pregnancy Associated with Copper-containing I.U.D.

SIR,—Pregnancy may occur in women with an intrauterine contraceptive device in situ.^{1 2} Usually the device stays embedded in the placenta or membranes and the thread tends to disappear as pregnancy advances. In one series,³ for instance, 33 patients using the Birnberg bow became pregnant. In only two cases the bow was expelled and in 31 it remained in situ. Out of 16 patients who became pregnant while using a Lippes loop the loop remained in situ in 13. In another series⁴ the contraceptive device was retained in utero in all 29 pregnant patients. However, in a study of an intrauterine contraceptive device containing copper wire (Copper-7, Searle) we noticed in 13 patients who became pregnant a feature that is uncommon with other devices. Twelve of the 13

patients had not expelled the device. In three of the 12 the Copper-7 remained in situ, as occurs with most devices, but in nine the device had descended and the stem lay with the tip just palpable within the external os.

Removal of a tailed intrauterine device has been reported to increase the abortion rate.⁵ In our limited experience, however, it would seem that when a Copper-7 device lies low in the cervical canal the placental site is not disturbed when the device is withdrawn. It is interesting to examine the possible reasons for this difference. One likelihood is that the shape of the device is such that it is pushed down by the conceptus instead of becoming trapped by it. The other possibility is that pregnancy occurs mainly when the device lies in such a way that much of the stem, which carried the copper, lies in the cervical canal. Though the exact mode of action of copper-containing devices is not fully understood the contraceptive action is probably effected by release of copper ions into the surrounding tissue fluids.⁶ The pregnancy rate is thus within certain limits dependent upon the surface area of the wire within the uterine cavity.⁷ It is therefore essential to ensure that when the device is inserted it lies right up against the fundus uteri.

We thank G. D. Searle & Co. for their help in this study.

—We are, etc.,

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- ¹ Tietze, C., and Lewit, S., *Intrauterine Contraception*. Amsterdam, Excerpta Medica, 1965.
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- ³ Bolognese, R. J., et al., *Fertility and Sterility*, 1968, **19**, 294.
- ⁴ Wajtraub, G., *Fertility and Sterility*, 1967, **18**, 570.
- ⁵ Lewit, S., *Contraception* (Los Altos), 1970, **2**, 47.
- ⁶ Oster, G. K., *Fertility and Sterility*, 1972, **23**, 18.
- ⁷ Zipper, J. A., et al., *American Journal of Obstetrics and Gynecology*, 1969, **105**, 1274.

Clinical Public Health Doctors

SIR,—I welcome your leading article (18 May, p. 348) in stressing the current uncertainty of the future of the clinical medical officers but join issue with the statements, "Worse still the isolation of the school health service is to be perpetuated, since it is to be put in the charge of the area specialist in community medicine (child health)" and later, "The appointment is not consistent with the concept of a district department of child health and furthermore is seen by many experienced child health principal medical officers as the imposition of another doctor above them, thus degrading their own position."

In the former large local authorities there was the medical officer of health and principal school medical officer in titular charge of the service, usually supported by a senior medical officer for school health responsible for the day-to-day administration. In the new service the area specialist in community medicine (child health) is responsible to the local education authority, not the area medical officer, so that one community physician is responsible for the school health service. I cannot see where there is the

imposition of another doctor—the situation is the reverse.

I cannot understand how you can justify your statement about the perpetuation of the isolation of the school health service from the document "Child Health Services (Including School Health Services)" (HRC (74)5). One of the main functions of the whole sphere of operation of the medical aspects of community child health. Nothing in HRC(74)5 precludes the future creation of district specialists to help to provide a comprehensive district child health service and I would agree that the main role of the area specialist should be co-ordination, epidemiology, and medical education.

However, I agree with the main theme of your article. There is a feeling among clinical medical officers that the majority of administrators at area and district levels have come from the hospital services and have little knowledge of community child health. No career structure has been agreed, and to await the Court Committee's findings, possibly late in 1975, shows a lack of realism regarding the work to be carried out now. Experienced staff are leaving the