average factors from standard food tables rather than by direct chemical analysis of the specific items concerned. The same is true, however, for almost all nutritional surveys.

(5) As a result of limitations (3) and (4), and because each family takes part in the survey for only seven days, the National Food Survey can say nothing about the nutrient intake or eating behaviour of individual household members or indeed of individual households. It can only reasonably provide estimates for fairly broad groups of households; but the recommendations of the DHSS are framed in similar terms. Furthermore, the food consumption of any family or individual during a single week, no matter how accurately measured, is unlikely to be directly reflected in their later morbidity or mortality. Epidemiological studies are therefore usually concerned with group averages.

The main strength of the National Food Survey is that it provides continuous information on food and nutrient intakes now spanning more than 30 years, not only for Britain as a whole but also for many subgroups within the population. Though constrained by financial and practical considerations, it remains an up to date, readily accessible, and comparatively cheap means of monitoring trends in household food consumption and of assessing a major aspect of nutritional state

for epidemiologists to compare with any similar temporal or cross sectional data on morbidity and mortality.

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Necessary safeguards when prescribing opioid drugs to addicts: experience of drug dependence clinics in London

P H CONNELL, M MITCHESON

The management and treatment of opiate addiction comprise a range of different approaches. Although not the most important element of treatment, prescribing a reducing or maintenance dose of drugs may be highly controversial and is undoubtedly a decision which should not be taken lightly or before careful review of the individual patient. We describe safeguards based on procedures that have been developed by the special drug dependence clinics in London over 15 years and been generally agreed in mutual discussion.

Background

The growing problem of heroin abuse by young adults during the 1960s led to the setting up of special clinics for the treatment of drug dependence. The approach at that time included the concept outlined in the United Kingdom by the Rolleston committee in 1926 that it was reasonable medical practice to maintain patients with a regular dose of prescribed opioids, who would then be stable and able to lead a normal and useful life.¹ This practice was first set out as a response to middle aged and elderly patients who had become dependent on drugs in the course of medical treatment. The pre-

scribing of large amounts of heroin to the younger drug taker of the 1960s by a limited number of independent practitioners was identified by the second Brain committee as contributing to the oversupply of drugs.² In order to control the supply—but without cutting off legal supplies altogether—the committee modified the previous practice in part by recommending the restriction of the power to prescribe heroin and cocaine for addicts to doctors in receipt of a special licence. The shift in tone and content from the earlier Rolleston to the Brain committee reports suggested a change of emphasis from helping an individual to continue in a stable and socially productive lifestyle to one of controlling the supply of drugs and restricting the criminal activity associated with drug use. In the same period the United States was moving from a strictly law enforcement attitude which included compulsory hospital treatment to maintenance with oral methadone in special clinics for the management and treatment of heroin addicts. Maintenance treatment with this drug was later controlled under federal and state legislation.

When the clinics were set up in 1968 to implement the Brain committee recommendations there was little knowledge or experience among consultants, junior doctors, or other staff to help them. Most clinics were in London, the major area of heroin availability and addiction. The Department of Health convened regular meetings of the staff of these clinics, where information was shared regarding policies and experience. These meetings have continued in various forms, the clinics taking over the responsibility for organisation. It has never been possible to obtain agreement that might result in the imposition of a uniform clinical approach with formal agreed procedures for the management of all patients; nor, indeed, in the view of the majority of members, is this even desirable. There has, however, been substantial agreement on styles of treatment and it has been possible to ensure that for almost anyone living within the boundaries of Greater London (with the exception of two or three boroughs) a clinic has been identified which will accept responsibility for providing a service; much valuable information has been shared regarding changes in the favoured substance of abuse, new fads, and dangerous side effects. Nevertheless, each consultant operates as an independent doctor, with the right to treat patients as

Drug Dependence Clinical Research and Treatment Unit, The Maudsley Hospital, London SE5 8AZ

P H CONNELL, FRCP, FRCPsych, director

Drug Dependence Clinic, University College Hospital, London WC1E 6AU

M MITCHESON, MRCPsych, DPM, consultant in charge

Correspondence to: Dr P H Connell, 21 Wimpole Street, London W1M 7AD.

he or she thinks fit, and also there are basic differences of opinions concerning treatment policies; hence a variety of different styles continues to operate at different clinics.

During the past two to three years a more concerted effort has been made to arrive at certain agreed guidelines for practice. These incorporate the experience of the special clinics and form the basis of this report. We also draw attention to certain practical implications arising from what clinics would regard as the basic requirements. The present, very serious escalation in numbers of drug dependent people in Britain has several complex causes. These include the organised illegal distribution of relatively cheap heroin—first from Iran and subsequently from Pakistan—with the result that the price in actual and real terms has fallen over the past five years; a breakdown of social constraints on drug use in various cultural groups (related in part to cocaine consumption and possibly also to the movement of younger persons from cannabis to a wider range of drugs, such as solvents, sedatives, and tranquillisers); and the availability of a wider range of synthetic opioids. Plainly there is an urgent need for interim measures to treat or support the handicapped individuals who make up a large proportion of the addict population, and “cost effectiveness” is clearly a practical reality and not merely a political cliché. While careful consideration should be paid to the cost of proper ethical medical procedures, the question arises about the extent to which the National Health Service is in a position to take appropriate precautions before embarking on what may be an indefinite and expensive maintenance prescription.

Both the Rolleston and Brain committees emphasised that decisions concerning the prescribing of opioid drugs should not be taken by a doctor in isolation and that a second medical opinion should be obtained. In modern practice this advice may be more appropriately implemented by a multiprofessional team approach which leads to a discussion of issues and a team decision on action. This serves to protect the individual doctor from pressures that patients can apply when seeing a doctor on his own in order to obtain larger supplies of drugs—and which are often couched in terms of “help,” which caring, sensitive doctors may find difficult to resist, leading to excessive prescribing. It should also be noted that the Rolleston committee’s somewhat reluctant support for maintenance prescribing took note of the difficulties of effecting withdrawal in the conditions operating in private practice. The same problem affects many clinics that are not generously staffed and which have no back up inpatient resources. The economics of a proper service cannot be ignored.

Agreed guidelines of London clinics

ASSESSMENT

It is agreed that for a patient dependent on opioids proper assessment in relation to prescribing opioids on a withdrawal or maintenance basis cannot be completed at a single outpatient session.

Before considering maintenance prescribing at least two urine samples showing positive results for an opioid should be obtained. Delay is inevitable in receiving the laboratory findings, so that at least a third attendance is required to communicate the decision to the patient. Facilities for testing urine for drugs should be available to any doctor undertaking the assessment of opioid (and other) drug abuse. Such facilities are expensive and are not available throughout Britain.

Experience shows that a commitment to the maintenance prescribing of opioids should never be entered into at an emergency consultation at the first outpatient visit. Physical examination should be undertaken in all cases before deciding whether to prescribe controlled or other drugs of dependence. Thus medical examination and clinical rooms are mandatory facilities. Information from a previous prescribing doctor should be obtained in all cases before prescribing to a new patient—this is a safeguard to which the clinics have long subscribed but which is frequently ignored in independent practice.

Adequate secretarial and nursing staff are essential. Secretarial staff play a key part in the organisation of the clinic, and thus senior grades of clerical staff are required with training and continued professional support.

PRESCRIBING

The prescription of opioid drugs to outpatients, whether as maintenance or withdrawal treatment, should be in the form of either

methadone mixture DTF (Drug Tariff Formula) or in rare exceptions alternative liquid preparations for oral use. In rare instances where injectable opioids are to be used freeze dried ampoules of heroin or ampoules of methadone should be used. Very few clinics now maintain new patients with injectable drugs.

It is highly undesirable to prescribe tablets of Diconal (dipipanone-cyclizine), Palfium (dextromoramide), Physeptone (methadone), or any other opioid. These are apt to be dissolved and injected intravenously by addicts whatever the adverse consequences. Rare exceptions would be therapeutic addicts such as haemophiliacs who show no evidence of self injection. Drug dependence clinics find, however, that even these patients require careful control of prescriptions, including daily collection of the drug and frequent review of the need for continued prescribing; often they resemble non-therapeutic addicts more closely than short term patients requiring analgesics, and the physical condition may have become a rationalisation for obtaining a drug of dependence which is no longer required for physical illness.

When a decision is made to include maintenance or withdrawal prescribing as part of treatment arrangements should be made by the clinic (with the agreement of the pharmacist and the participation of the patient, who should approach a chosen pharmacy) with a specific pharmacy to undertake the supply of the drug as prescribed by the clinic doctor. Patients should be distributed among pharmacies so that none has an excessive number of patients, thereby minimising the development of pharmacy based drug subcultures.

Counselling and social work help should be available for all patients, though this may not necessarily be required by all patients at the same time.

Many clinics now require that patients should attend the clinic on time and regularly if they are to receive a prescription and find that even “chaotic” patients are able to comply.

When behaviour or urine testing shows that other drugs have been taken, or the drug prescribed has not been taken, a review of treatment including the prescription is indicated. All clinics require (or should require) regular provision of supervised urine samples for analysis for drugs as a condition for prescription.

An increasing number of clinics operate a “contract” system, in which patients agree to define goals or objectives as part of treatment to include a prescription, either for maintenance or on a reducing withdrawal basis.

In order to avoid an implied commitment to lifelong prescribing most, if not all, clinics set a clear limit to the duration of the initial prescribing period, whether it be of injectable drugs, oral drugs, or injectable and oral in combination. Clinics very rarely prescribe central nervous system stimulants or sedatives (such as amphetamine, cocaine, methylphenidate, chlormethiazole, barbiturates, and benzodiazepines) as maintenance treatment to addicts to these drugs.

General comments

These guidelines are mainly confined to the prescribing of opioids, since these drugs cause the greatest concern. Prescribing, however, is only one aspect of treatment, and a wide range of therapeutic approaches may be used, including individual therapy, group therapy, counselling, behaviour therapy, occupational therapy, family therapy, and so on.

Many patients are best treated as inpatients in a special drug dependence unit, though many who require this treatment do not want it and the shortage of facilities means that many who request such treatment cannot receive it immediately. There is also a range of residential rehabilitation programmes in “non-statutory” therapeutic communities which depend in large measure on public funds. Most of these programmes have a waiting list. Information on these may be obtained from established drug clinics or through the Standing Conference on Drug Abuse. (SCODA, Kingsbury House, London NW6 1XA.)

Treatment clinics are severely overstretched and the quality of their work is limited by understaffing at all levels and inadequacy of technical resources. It will clearly take some considerable time to increase treatment facilities along the lines recommended by the Advisory Council on the Misuse of Drugs.³ Since the number of drug dependent individuals is increasing rapidly and drugs are becoming increasingly available and at a lower price in the illicit market the question arises of

what can be done before more extensive specialist services can be provided. In this respect the role of general practitioners and private practice doctors has recently been canvassed. There has been much criticism both of the liberality of prescribing by independent doctors on the one hand and of the reluctance to prescribe by special clinics. This debate has been reflected in journals and the media and needs to be examined very carefully. The combined experience of the special drug dependence clinics as put forward here requires serious consideration. Overprescribing is widely accepted as harmful. The singlehanded doctor, whether general practitioner or consultant in the NHS or private practice, who has little or no experience of addicts is a vulnerable target for the drug seeker. So have been consultants and juniors in special treatment clinics where a team approach is not used.

The substance of this communication has been agreed by those working in London drug dependence clinics. They consider that their experience will be helpful to those ad-

ministrators (medical and otherwise) who are faced with responding urgently to the rapid increase in the addict population—and who are required to implement the recommendations of expert bodies such as the Advisory Council on the Misuse of Drugs—and the increasing political and public pressures surrounding this problem.

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Personal Paper

Kiellands forceps delivery

SHEILA SHEERIN

The recent reviews and correspondence on the use of Kielland's forceps prompt me to write an account of my own experience of the procedure as a patient. I make a token apology for inflicting my views on others, but on the whole I think that there is advantage to obstetricians in feedback from a patient.

In June 1982 I presented to the labour ward of the maternity hospital for the delivery of my fourth child, the first three having been uneventful vaginal deliveries. The membranes had ruptured spontaneously and full dilatation had been achieved. The baby's head was in an occipitoposterior position, and I felt continuous back pain. Because of the severity of this pain I was unaware of any contractions or impulse to bear down but continued for over an hour to push when urged to do so. The head seemed to me too high to push out.

At the end of this time the fetal heart rate was normal, but I was becoming somewhat distressed. The position of the head was between left occipitoposterior and transverse, mid-cavity and poorly flexed. A pudendal block was performed, the Kielland's forceps were applied, and attempts were made to rotate the head. This resulted in very severe pain in the left buttock and down the back of the left thigh. Attempts to rotate the head were then abandoned, an episiotomy was performed, and the baby was delivered face to pubes with Kielland's forceps. This was also extremely painful because of a pelvic tearing sensation.

The baby, a 3700 g boy, had Apgar scores of 8, 9, and 10 at

one, five, and 10 minutes and his development to date (15 months) has been normal.

In the weeks after delivery I developed numerous symptoms including incontinence of faeces, numbness in the left posterior perineum, difficulty in sitting for any length of time because of a tender and painful coccyx, a feeling of heaviness in the perineum especially with any jarring movement, and occasional pain in the left buttock and back of the thigh. The pain in the buttock and thigh became worse when I returned to work 12 weeks after delivery. Examination at 15 weeks after delivery showed an indurated tender area in the left perineum with maximum tenderness in the left ischioanal fossa. The perineal numbness had been replaced by paraesthesiae and a stabbing rectal pain, presumably caused by inferior rectal nerve damage.

Six months after delivery I noticed a positive Trendelenburg sign on the left, indicating some weakness of the left gluteus medius. It also seemed to me that I limped when tired or when carrying a heavy weight. The neurological damage was presumed to be intrapelvic. Adequate pain relief was obtained for the first time in March 1983 when I was fitted with a transcutaneous stimulator. I took up jogging to improve the strength of the left leg, but in July the pain became worse and the limp more pronounced, and the left ankle jerk was absent. A myelogram showed herniation of the disc between L5 and S1, and at operation a complete prolapse of the disc was found. There has been considerable pain relief since laminectomy.

Obstetric textbooks affirm that injury to pelvic nerves in labour is comparatively rare and that nerve injuries may occur after spontaneous delivery but are more often the result of a difficult forceps delivery. The classic obstetric paralysis—that is, painless foot drop—was previously thought to be caused by damage to the lumbosacral cord, but now it has been suggested that the injury is the result of sudden prolapse of an intervertebral disc.

As a result of my experience and a search of the published

Princes Risborough, Bucks

SHEILA SHEERIN, MRCPATH, part time senior registrar

Correspondence to: 32 Manor Park Avenue, Princes Risborough, Bucks HP17 9AS.