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Schoolgirl mothers

Over 1200 girls under 16 become mothers each year in England and Wales. The incidence has not increased in recent years, but, in contrast, 4000 schoolgirls had abortions in 1983, nearly twice as many as in 1977. Mortality among the children of young mothers is higher than that among those with older mothers, as are rates of prematurity, low birth weight, stunted growth and intellect, and child abuse.^{1 2} It may be, however, that these adverse outcomes are the result of the general disadvantages of poverty and low social class common to this group rather than specifically of young maternal age. But what are the difficulties for these mothers—parents while still only children themselves?

There are pervasive effects of early motherhood on their physical and mental health, education, economic independence, and social relationships.^{1 3 4} A recent in depth study of 30 schoolgirls who kept their babies portrayed the experience through the eyes of the girls themselves; most were from broken homes with unemployed parents, and school had held little satisfaction.³ Ironically, the luckier mothers found that the special education provided because of their condition had improved their motivation to learn as well as placing them with a peer group, which made them feel less ostracised. They had delayed seeking antenatal care and found attending clinics and classes with older women difficult and sometimes humiliating. When arrangements had been made for group attendance or more individual care attendance had improved. They were very anxious about money.

Most of the girls became pregnant by their first and only partner, who was often no older or more advantaged than they were, and few had plans to marry. They had known about contraceptives but had only a hazy idea about how to obtain them and had unfounded beliefs about the safety of unprotected intercourse. All had moral objections to abortion and adoption. As the researchers concluded, they do not understand the "social reality of under 16 pregnancy and motherhood; do not adequately appreciate the potential results of sexual activity . . . ; do not realise that biological maturity does not license activating this capacity at will [and] . . . that once the baby is born, it takes precedence over its mother . . . and at the same time the mother loses her own privileged status as a child."³

What should be provided for the small but steady numbers of schoolgirl mothers? Many people worry that providing services may imply approval, but not providing services leads to the accumulation of even more disadvantage and contributes to the intergenerational "cycle of deprivation." Intervention programmes should first identify adolescents at risk of precocious pregnancy and provide them with counselling

and birth control services.¹ Next, easy access to termination of unwanted pregnancies should be provided, and, finally, the consequences of pregnancy to mother and child should be minimised by providing medical, social, and educational help, including postnatal contraceptive counselling. One programme showed that return to education was more important in preventing subsequent pregnancy than providing contraceptives.⁵

Special antenatal clinics for pregnant schoolgirls are feasible only in large cities,⁶ but that is where most cases will be found. Should not each university hospital provide one? Should not each education authority ensure that it provides special continuing education for pregnant girls and schoolgirl mothers? Should not the state provide adequate, uniform, and ungrudging financial help? The cost of all these—because of the low numbers—would be minuscule. The benefits to these most disadvantaged child parents and their babies would outweigh the costs.³

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Angioplasty for intermittent claudication

Percutaneous transluminal angioplasty is now an established treatment for peripheral vascular disease. Under radiological control a balloon catheter is introduced over a guide wire, usually through the femoral artery in the groin. Inflation of the balloon within arterial stenoses or occlusions restores the lumen by cracking the inner diseased layers of the arterial wall and redistributing atheromatous material.^{1 2} Ideal lesions for treatment are short iliac stenoses and stenoses or short occlusions of the superficial femoral artery. More extensive and more distal lesions can be dealt with successfully, but the chances of the artery staying open are poorer.

As many as two fifths of patients presenting with lower limb arterial disease may be suitable for angioplasty,³ and more patients with peripheral arterial disease are now being investigated and treated because of this technique.^{4 5} Compared with reconstructive surgery the hospital stay is shorter and the cost for each patient substantially lower.^{3 6} Angioplasty offers new possibilities for simple treatment of patients with severe and mild disease: unfit patients with severe ischaemia⁷ and a much larger number of patients with intermittent claudication insufficiently severe to justify reconstructive surgery.^{8 9} Yet if those patients with mild claudication are to be investigated by arteriography with a view to angioplasty the potential benefits and risks must be considered before offering the treatment on a widespread scale.

Selection of patients depends on consultation between vascular surgeons and radiologists. Success rates after two to

three years have been reported to be around 90% for iliac angioplasty¹⁰⁻¹³ and 75% for femoropopliteal angioplasty,^{10-12, 14} although complete long term follow up has not always been achieved and both measurement protocols and "success" have sometimes been poorly defined. Indeed, 12 centres cooperating with Zeitler and Gruntzig could furnish follow up data on only 35-40% of cases.¹⁵ Stringent objective follow up of a large series of patients has been reported by Johnston and colleagues from Toronto,¹⁶ showing cumulative success after two years in only 66% of iliac and 48% of femoropopliteal angioplasties. These carefully monitored results contrast with more optimistic reports, particularly because most of the patients treated had claudication and thus a prognosis after angioplasty better than those with more severe ischaemia. Another important consideration is the effect of experience, and units beginning or performing few procedures have poorer results.¹⁷⁻²¹ The complication rates of those with modest experience also differ from the figures of less than 5% claimed by larger units.

These points need to be considered before offering angioplasty to the patient with less severe symptoms than would normally justify surgery. The typical patient presenting with signs of a superficial femoral artery occlusion has a good prognosis and may improve or remain stable over many years. To see whether this disease is amenable to angioplasty will require an arteriogram, and even if a suitable lesion is present angioplasty may also give rise to complications and has a lower success rate than bypass grafting. Failure of angioplasty rarely, however, makes a patient worse than before,²² and the possibilities of a repeat angioplasty or of surgical reconstruction remain.

The increasing use of angioplasty has implications both for vascular surgery and for the National Health Service. It may delay or avoid amputation in some unfit patients with critical ischaemia, and many more patients with modest disability can now be treated. There are, however, no controlled data comparing the long term results of angioplasty with those of non-intervention. A multicentre study has been started, but until this and other studies can provide guidance vascular surgeons and radiologists will need to balance their own success and complication rates against the benign clinical course of intermittent claudication.

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A practical guide to prescribing hypnotic benzodiazepines

Insomniacs complain of lying awake for long periods before falling sleep, waking during the nights and not falling asleep again quickly, or waking early. As a consequence they feel tired during the day. The tradition of prescribing sleeping pills has led to the widespread use of today's favourites, the benzodiazepines. These drugs have their problems, however, and guidelines are needed for the practical prescriber.

He needs to know three things about the pharmacokinetics of the benzodiazepines¹: firstly, that their rate of absorption determines the speed of their onset of action; secondly, that some benzodiazepines—such as diazepam and to a lesser extent temazepam—are redistributed quickly, which limits the duration of their action; and, thirdly, that the speed of their elimination usually determines their duration of action. Hypnotics with rapid onset and offset are useful in those who cannot get to sleep but not in those who wake early; drugs with slower onset will not help the patient fall asleep quickly.

The next day the patient may have subjective feelings of sedation and show objective evidence of psychological impairment.^{2,3} In general these residual effects occur more often after long acting drugs (such as nitrazepam or flurazepam) than after intermediate (temazepam) or short acting ones (triazolam). But dosage is very important: thus 5 mg of nitrazepam produces few effects compared with 10 mg³; similarly, large doses (over 0.5 mg) of triazolam produce definite hangover effects.⁴ Furthermore, accumulation of long acting benzodiazepines is inevitable and particularly troublesome when high doses are used.

When benzodiazepines are stopped patients may experience transient insomnia⁵ or anxiety,⁶ and they may thus be led to restart their drugs. Rebound effects are particularly likely to occur if the drug is short acting, given in high dosage, and withdrawn abruptly. Conversely, very long acting hypnotics (such as flurazepam or quazepam) show milder and less consistent rebound effects.

There are four main groupings of insomnia. Firstly, some patients sleep poorly because of pain, dyspnoea, and pruritus, and the primary condition should be treated. Secondly, many patients suffer from anxiety or depression, or both, and again the primary emotional disturbance should be treated. Anxiolytic or antidepressant drugs may be given at night. Next, many patients complain chronically of poor sleep without definite associated psychiatric syndromes, but the insomnia may reflect otherwise subclinical anxiety and depression. Finally, some normal sleepers may experience transient insomnia because of acute stress or short term insomnia associated with a longer term stress often related to