risk in patients receiving long-term phenobarbitone or phenytoin therapy.

Exposure to enzyme-inducing agents such as drugs, industrial and agricultural chemicals, pesticides, food additives, etc, is a hazard of living in the more highly developed countries. It is tempting to speculate that the differences in serum cholesterol between such populations and those of less affluent countries, which have never been fully explained by differences in dietary intakes of animal fat,^{8,9} may in part be due to differences in their degree of enzyme induction.

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Use and effectiveness of IUDs

SIR,—The Family Planning Research Unit in the University of Exeter has for some years been collecting data on the use and effectiveness of IUDs. Data from 25 000 fittings, with 8000 additional fittings each year, are processed and evaluated to give detailed information on a number of IUD models. Part of our work is the follow-up of women who have become pregnant when wearing an IUD.

The table¹ shows that the incidence of ectopic pregnancy is far lower than was suggested in your leading article (31 May, p 458). Your rate of one ectopic pregnancy in every five pregnancies is clearly an error, for the studies you cite in evidence give a crude rate of 1 in 25 pregnancies. Our data give a comparable ectopic pregnancy rate of 1 in 29 IUD pregnancies. The paper by Mr A K Thomas (27 September, p 747) rightly draws attention to the need to study all IUDs in relation to septic abortion. Our experience suggests that the incidence of spontaneous abortion is high among pregnant women wearing IUDs irrespective of the IUD model worn (see table). I am unaware of any deaths

in Britain attributable to the wearing of an IUD. However, two among the 317 pregnancies reported to our unit ended in septic spontaneous abortion during the mid trimester.

I agree with Mr Thomas that pregnancy associated with an IUD is a potentially serious condition, but I believe that a registry system for all IUD fittings would be a cumbersome, complicated, and probably unworkable system for identifying low-incidence medical complications such as he describes. More useful, perhaps, is a system which can quickly adapt to selected problems as they arise. Such a system requires a careful follow-up of a large number of IUD fittings in various parts of the country. It is this follow-up system that differentiates a prospective, flexible approach to problems as they arise from the retrospective, more rigid approach of a registry system on all IUD fittings.

Our unit systematically collects data from 20 IUD fitting centres situated in England, Scotland, and Wales and, in collaboration with these centres, has developed procedures for the follow-up of IUD fittings. As a result we can respond to requests for information at relatively short notice. This was the case when the FDA requested information during their hearings on the Dalkon shield last year. Low-incidence complications will continue to arise, especially as the number of IUD fittings is increasing. What we need is a large scale but flexible follow-up system in selected fitting centres which will assist in identifying such complications as soon as possible after they appear.

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Stereotaxic neurosurgery for cerebral palsy

SIR,—I was interested to read your recent leading article on this subject (20 September, p 665) especially as it mentions the experience in my own group. I would contest, however, the last paragraph, in which you suggest that stereotaxic surgery is unlikely to be widely undertaken on children with cerebral palsy because of the need to perform the operation under general anaesthesia, making accurate localisation impossible. The cases reported,¹ however, had the passage of the probe and its final placement monitored using electro-physiological recording from cerebellar cortex, white matter, and deep nuclei, an essential aid in placing accurate lesions. The use of depth recording and

stimulation in increasing stereotaxic accuracy has been known for many years and has been reported extensively.²⁻⁴ For this reason I think it is likely that stereotaxic procedures will be increasingly performed on children with cerebral palsy as the results of such treatment become increasingly successful.

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Diazepam withdrawal symptoms

SIR,—I was interested in Drs Indira Vyas and M W P Carney's letter (4 October, p 44) describing a case of withdrawal fits following prolonged medication with diazepam. I recently had two patients who developed withdrawal phenomena on stopping taking diazepam despite the fact that they had been immediately changed to another benzodiazepine tranquilliser, oxazepam.

A young woman had a severe long-standing anxiety neurosis partially controlled on diazepam 10 mg three times a day, which she had been receiving for about a year. She felt that the drug had lost its efficacy and requested a change. She was started on oxazepam 30 mg three times a day but within 48 hours of the changeover she developed marked shaking. She put herself back on to the former dose of diazepam and over the next few days the shaking subsided.

A middle-aged woman with an obsessive compulsive neurosis had been receiving diazepam 10 mg three times a day for two years. She was changed to oxazepam 30 mg three times a day at her request and within 48 hours of the changeover developed severe limb shaking and became unable to stand. Intravenous diazepam dramatically alleviated the symptoms, but over the next few hours they gradually returned. She was restarted on oral diazepam 10 mg three times a day and the shaking subsided within a few days.

These two patients were unknown to each other and had no psychological dependence on diazepam as it was changed at their request. It is most likely, therefore, that they had both developed a physical dependence on diazepam, which is more markedly sedative and muscle-relaxant than the oxazepam to which they were changed. It is suggested that some degree of physical dependence occurs on diazepam when given in large doses for long periods of time.

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Outcome of pregnancy in 317 women who completed a pregnancy when wearing an IUD

"Completed" pregnancies	All IUDs		Dalkon shield		Gravigard		Lippes loop		"M" Device		Antigon		Other IUDs	
	No 317	Rate	No 149	Rate	No 64	Rate	No 43	Rate	No 24	Rate	No 23	Rate	No 14	Rate
Full-term births	66	(1:5)	31	(1:5)	14	(1:5)	12	(1:4)	2	(1:12)	4	(1:6)	2	(1:7)
Spontaneous abortion*	104	(1:3)	50	(1:3)	11	(1:6)	18	(1:3)	15	(1:2)	9	(1:3)	1	(1:14)
Induced abortion*	109	(1:3)	49	(1:3)	32	(1:2)	8	(1:5)	5	(1:5)	8	(1:3)	7	(1:2)
Uterine perforation followed by pregnancy	2	(1:159)	0	(—)	0	(—)	2	(1:27)	0	(—)	0	(—)	0	(—)
Ectopic pregnancy	11	(1:29)	5	(1:30)	0	(—)	3	(1:14)	0	(—)	2	(1:12)	1	(1:14)
Pregnancy outcome not known (but not now pregnant)	25	(1:13)	14	(1:11)	7	(1:9)	0	(—)	2	(1:12)	0	(—)	2	(1:7)

*As stated by doctor reporting on the pregnancy.