such monitoring could not be better achieved by direct fetal ECG monitoring after rupture of the membranes. Their suggestion that low-risk cases do not need monitoring under such circumstances must also be questioned.

While prostaglandin given vaginally is undoubtedly effective in achieving cervical softening, be it by the effect of circulating oestradiol or, as we are currently assessing in this unit, by an effect on collagenase activity in the cervix, the response to such treatment is widely regarded as very variable—as noted in this series, where a number of patients laboured after a single administration and some failed to respond to two such administrations of prostaglandin E_2 . Its blanket use in a fixed-dose regimen must be questionable under such circumstances and it must be only a matter of time before the hypertonus already reported recurs with more serious consequences.

The transfer of a patient in labour starting after the administration of prostaglandin E_2 vaginally on the antenatal ward may not be always as rapid and smooth as is necessary if monitoring is to be instituted sufficiently early in labour to avoid occasional fetal asphyxia. A routine induction policy must carry with it some risk and I would be concerned to see it generally applied without the recognition of this problem.

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Thromboembolism in pregnancy

SIR,—In your leading article (23 June, p 1661) the comment is made that "... oral anticoagulants are probably best avoided in the puerperium if the mother is breast-feeding." The most widely used oral anticoagulant in this country is warfarin; we have clearly demonstrated that warfarin is not excreted in human breast milk.¹ Using sensitive and specific analytical techniques, less than 10 ng/ml warfarin was found in breast milk and in the plasma of breast-fed infants. This concentration of warfarin is at least ten times less than that usually required to produce any change in the prothrombin time. Further, no prolongation of prothrombin time was found in those infants breast-fed by mothers taking warfarin. Earlier reports of warfarin being present in breast milk utilised non-specific warfarin assay methods, which monitored inactive warfarin metabolites in breast milk.

Mothers are being encouraged now to breast-feed their infants whenever possible. There is no need to deny this on the basis of outdated and inaccurate information to women taking warfarin.

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¹ Orme, ML'E, et al, *British Medical Journal*, 1979, 1, 1564.

Luteal function in patients seeking AID

SIR,—I can confirm the report of Mr M F Vere and Mr D N Joyce (14 July, p 100) on the effects of stress during artificial insemination by donor (AID) in suppressing ovulation.

I have also noted in the last 30 years that

the wives of sterile men have more problems of irregular menstruation than the wives of fertile men. Nevertheless I have shown^{1,2} that emotional stress can affect some 25% of wives whose husbands are fertile. Where patients have kept preconsultation charts one sometimes sees, in an otherwise normal series, one or two cycles which are poor. Inquiry then elicits the fact that some stress, such as family bereavement or diagnosis of azoospermia, occurred in that cycle. The effects of stress can also be observed in women being treated with bromocriptine, clomiphene, or tamoxifen. For example, a woman ovulates when on holiday, but not when attending for AID or, in another case, when a parent died, and so on.

It would seem therefore that in infertility problems laboratory investigations should not be taken at their face value, but must be studied in relation to the total clinical status of the patient. Hormone assays may well be misleading in these circumstances because of stress, which may not be manifest without close questioning.

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¹ Sandler, B, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1961, 68, 809.

² Sandler, B, *Journal of Psychosomatic Research*, 1968, 12, 51.

Drugs for pain

SIR,—The 16 June issue (p 1619) refers to my work in Dr R G Twycross's review of the book by Parkhouse *et al* entitled *Analgesic Drugs*. Twycross refers to "several debatable American views." I am not sure that I understand why the statement that "morphine is usually given parenterally as its oral activity is low" has "a hollow ring" about it.

I would have thought that in most countries morphine is usually given parenterally. There is certainly no doubt that one has to give seven or eight times the parenteral dose when the oral route is chosen, and even then peak effects are not rapidly achieved or as impressive. Hence in the management of acute pain, which is the usual indication for morphine in most countries, the parenteral route is the most scientific and empirically effective. Recent scientific evaluations of "analgesic cocktails" such as Brompton's mixture indicate that "long tradition" is not necessarily synonymous with scientific fact. One by one the various ingredients of Brompton's mixture seem to be falling by the wayside, despite many years of firm belief in their importance.

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Maintenance of diagnostic equipment in wards and consulting rooms

SIR,—The report of Mr A Shaw and others (24 March, p 789) on errors arising in the use of sphygmomanometers with blocked vents is timely. Other common defects are: (1) dirty graduated tubes causing erratic fall of the mercury column; (2) thinning of the control valve washer causing precipitous fall of the mercury; (3) obstruction of the gauze mesh in the valve by dust resulting in the need for great pressure to squeeze the bulb (very

painful for arthritic fingers); (4) air leaks due to perished rubber tubing.

These faults are easy to identify and their cure can usually be effected in a matter of minutes. The manufacturers of sphygmomanometers might helpfully provide instructions for their identification and correction with each instrument.

This is really part of the wider problem affecting all diagnostic and therapeutic equipment in which faults are just as likely to occur. Clearly all equipment involving moving parts or electrical connections should (like motor cars) be routinely checked and serviced. This would be beyond the capacity of most doctors. At another hospital, where I was formerly on the staff, an attempt was made to set up a system of routine inspection and servicing of ward equipment, but organisational difficulties were encountered and until now no action has been taken.

The time is overdue for the establishment in hospitals of a service for the routine inspection of equipment, for the identification of faults, and for their repair where this is feasible.

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Analgesia in terminal malignant disease

SIR,—The letters by Dr F R Gusterson and others and by Dr I M C Clarke and Miss S M Tempest (7 July, p 47) described clearly some of the advantages of the suppository as a dosage unit for controlling pain in terminal malignant disease. The benefits of using the rectal route for systemic administration apparently are appreciated more widely in continental Europe than in the United Kingdom, if one can judge by the relative numbers of suppository products available. The rate and extent of absorption of suitable drugs from the rectum compare very favourably with the oral route and local adverse effects are rare, other than irritation with certain non-steroidal, anti-inflammatory analgesics.

It is unfortunate, in view of the potential advantages of rectal administration, that there are so few proprietary suppository dose forms containing potent analgesics suitable for the treatment of severe, intractable pain when practitioners without direct access to a hospital pharmacy or dispensary may not be able to obtain readily generic products of this type. The latest copy of *MIMS* indicates that only two proprietary products are available—namely, suppositories of pentazocine lactate and of dextromoramide tartrate. It is our experience that dextromoramide tartrate in Palfium suppositories is rapidly absorbed and well tolerated and that such a dosage form is a useful addition to the normal range of oral and parenteral presentations of potent analgesics.

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Muslims, Ramadan, and diabetes mellitus

SIR,—A Pakistani patient with diabetes mellitus consulted me in a state of agitation. He had heard on a television programme that doctors from a Birmingham diabetic clinic had issued a warning to Muslim diabetics: