Ambulance personnel and casualty staff in 62 London casualty departments were asked in a questionnaire survey for their recommendations for the management of cases of deliberate self-poisoning. From the 1350 questionnaires distributed, 1248 (92%) were returned, of which 858 were completed by doctors and nurses. Among this group 88% believed that these patients should never be discharged without full psychiatric evaluation, 85% thought that there should be a resident psychiatrist in the hospital to advise patients, and 80% thought that patients with deliberate self-poisoning should always be admitted, at least overnight. Although 73% thought that doctors and nurses should be given additional training to deal with these patients, 57% believed that they should be taken to special emergency centres and not brought to hospital casualty departments at all.

The opinions of these doctors and nurses cannot be lightly dismissed as their experience of all drug-related problems, including that of deliberate self-poisoning, is considerable.¹ In some London casualty departments, for example, there is a daily average of three drug overdose patients compared with 1.3 at Addenbrooke's. It is against this background that the recommendation of Dr Gardner and his colleagues is set; before it is generally adopted the opinions of those who would have to assume greater responsibility for this very large group of patients should be sought most carefully. If, as has been reported,^{2,3} their attitude to deliberate self-poisoning patients is an unsympathetic one the care of these patients might well be affected adversely—particularly if staff in other hospitals are less fortunate and lack the support and instruction of an interested and involved psychiatrist.

In any case, the aim of any amendment to the recommendations of the Hill Report should surely be that the treatment of the patients is improved, not merely shifted from one group of doctors to another.

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¹ Ghodse, A H, *British Journal of Preventive and Social Medicine*, 1976, **30**, 251.

² Patel, A R, *British Medical Journal*, 1975, **2**, 426.

³ Ghodse, A H, *Social Science and Medicine*. In press.

SIR,—Dr M D Enoch and Professor J R M Copeland (4 February, p 300) have touched on the issue of clinical responsibility. When we stated (17 December, p 1567) that "physicians should decide for each of their patients if specialist psychiatric advice is necessary" we were, of course, referring to consultant physicians.

The Department of Health's recommendation¹ does have implications which extend far beyond the management of self-poisoned patients in the general hospital. What if other expert committees were to recommend, say, that in all cases of head injury patients must be clinically evaluated by neurosurgeons, or that all men with chest pain should be referred to cardiologists, or that every patient with abdominal pain must be examined by a general surgeon? Such clinical decisions are usually left to the discretion of the medical practitioner. We decided at Addenbrooke's that physicians must have ultimate clinical responsibility for the self-poisoned patients admitted under their care. It followed that they could overrule psychiatrists' assessments,

and in the clinical trial they did so in five out of 133 instances. Since they requested psychiatric opinions for only 16% of their patients it is unlikely that in other hospitals physicians would require psychiatrists to see every self-poisoned patient.

Sir Denis Hill (11 February, p 362) has done much to improve the whole standard of undergraduate education in psychiatry. But most student psychiatric attachments are for only 8-12 weeks. Is this sufficient training for the future doctor? In general medicine and surgery further training is considered essential during the preregistration year. It is this aspect of medical education which has been neglected by psychiatrists and to which they might contribute with their colleagues in other specialties.

I share Sir Denis Hill's concern lest psychiatrists should now leave physicians to undertake the initial psychiatric assessment of self-poisoned patients without first ensuring that junior doctors and nurses are adequately taught and that both psychiatric treatment and help from social workers are available once such patients have been discharged. What should be taught and how consultation liaison can be achieved might best be discussed at a joint meeting between the Royal Colleges of Physicians and Psychiatrists.

A decade has now elapsed since the Hill report.¹ Is it not time that the standing medical advisory committees reviewed the arrangements for the treatment and after-care of self-poisoned patients and initiated a detailed study of the prevention of poisoning?

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¹ Central and Scottish Health Services Councils, *Hospital Treatment of Acute Poisoning*. London, HMSO, 1968.

Drug treatment of chronic stable angina pectoris

SIR,—Your leading article on the above subject (25 February, p 462) states that studies on prenylamine have generally shown it to be no more effective than placebo. This statement is contrary to the facts and indeed misquotes one of the references.¹ The reference concerned actually states: "Prenylamine (Synadrin—Hoechst) depletes catecholamines in a similar way to reserpine, and acts in angina probably by reducing the sympathetic stimulation to the heart. In several adequately controlled double-blind trials, prenylamine in a dose of 180-300 mg daily was significantly better than placebo in preventing anginal attacks." However, both this paper and another cited² are review articles.

We agree with your statement that "new drug preparations for the treatment of angina invariably have a strong placebo effect, and double-blind trials are essential for their evaluation." Since 1965 there have been a number of double-blind controlled studies published³⁻¹¹ in the world literature definitely reporting the superiority of prenylamine over placebo in reducing the number of attacks and the consumption of short-acting nitrates in patients with angina pectoris. One study¹⁵ reported no difference between prenylamine and placebo in reducing either anginal episodes or nitroglycerin consumption, but even this

investigation, while never reaching statistical significance, shows a trend in favour of prenylamine over placebo.

While there are doubtless criticisms which can be levelled at some of the above studies either on the basis of design or statistical interpretation, the overall weight of evidence demonstrates, in contrast to your leading article, that prenylamine is more effective than placebo as an antianginal agent.

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¹ *Drug and Therapeutics Bulletin*, 1974, **12**, 1.

² Aronow, W S, *American Heart Journal*, 1973, **85**, 132.

³ Kappert, A, *Zeitschrift für Therapie*, 1965, **2**, 82.

⁴ Donat, K, and Schlosser, G A, *Medizinische Klinik*, 1966, **61**, 352.

⁵ Cloarec, M, Proceedings of symposium on "Prenylamine in therapy," Monaco, 1 March 1968, p 52.

⁶ Cardoe, N, *British Journal of Clinical Practice*, 1968, **22**, 299.

⁷ Stoker, J B, *British Journal of Clinical Practice*, 1968, **22**, 384.

⁸ Cardoe, N, *Postgraduate Medical Journal*, 1970, **46**, 708.

⁹ Mikkelsen, E, *Ugeskrift for Laeger*, 1971, **133**, 873.

¹⁰ Sepatia, G C, Jain, S R, and Prakash, J, *Clinical Trials Journal*, 1971, **8**, 43.

¹¹ Winsor, T, et al, *American Heart Journal*, 1971, **82**, 43.

¹² Arora, R, *Indian Heart Journal*, 1973, **25**, 62.

¹³ Tucker, H, et al, *British Heart Journal*, 1974, **36**, 1001.

¹⁴ Kotia, K C, et al, *Medikon*, 1977, **6**, 33.

¹⁵ Bjørum, N, Christensen, M, and Rathach, P, *Ugeskrift for Laeger*, 1967, **129**, 47.

Ectopic pregnancy rates in IUD users

SIR,—In a recent review of ectopic pregnancy and contraceptive use Tatum and Schmidt¹ suggested that "there may be a causal relationship between the use of an intrauterine device (IUD) and the occurrence of an extrauterine pregnancy." This review, in addition, suggested that the Progestasert IUD may carry a higher risk of ectopic pregnancy than other IUDs. In a recent letter (17 December, p 1600) Dr Robert Snowden has also proposed that the Progestasert IUD may carry a selectively greater risk of extrauterine pregnancy.

At a meeting in Geneva from 27 February to 1 March 1978 of the steering committee of the Task Force on Intrauterine Devices for Fertility Regulation of the World Health Organisation's Special Programme of Research, Development and Research Training in Human Reproduction the available published and unpublished data on the occurrence of ectopic pregnancy in IUD users was reviewed, and the committee had the following reservations about the interpretation of these data by the above authors:

(1) It has long been argued on the basis of the mechanism of action that an IUD protects more against intra- than against extrauterine pregnancy. It would therefore be anticipated that there should be a higher ratio of extra- to intrauterine pregnancies in IUD users, a difference in incidence which has in fact been found in many studies. The steering committee believes that the available data indicate a real increase in the risk of ectopic pregnancy among IUD users when compared with non-users. However, the magnitude of this risk is difficult to quantitate with the existing data as there are no studies in which adequate comparisons of risk have been made.

(2) The methods used to present ectopic pregnancies in published studies may give misleading information, especially when ectopic pregnancy rates are presented as a percentage of total pregnancies; such percentages may be affected by the contraception-dependent reduction in intrauterine pregnancy rate. Accordingly ectopic pregnancy rates should be expressed as a