we would suggest that the following method, which we practise, is a further improvement over the taking of posteroanterior and lateral abdominal films.

We use fluoroscopic screening (with image intensification) of the uterus in the postero-anterior and lateral positions (plus oblique views if necessary) with a metal sound in the uterine cavity. In addition to establishing the proximity of the tip of the sound to the IUCD in two planes at right angles it can be determined whether the IUCD moves on manipulation of the sound. Coned "spot" films may, of course, be taken on 70-mm roll film, with consequent saving in cost and radiation exposure to the patient.

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Dysphagia

SIR,—Mr W D Park (5 February, p 382) rightly stresses the difficulties encountered in the management of peptic strictures in the elderly. However, his view that surgery on the hiatus hernia with an attack on the stricture or a bypass operation offers the only hope of success is quite at variance with our experience. Of eight patients in whom the initial dilatation of a peptic stricture was done in 1975, three have not required a dilatation in the past year and medical treatment has satisfactorily controlled symptoms of reflux. Furthermore, of 34 patients undergoing 84 dilatations for peptic stricture in the past three years, only one has died as a result of the procedure. It seems improbable that in such an elderly group of patients surgical resection or bypass would be so safe. In our view surgical endeavour is better directed towards the control of reflux, for if this can be achieved the stricture is unlikely to recur after dilatation.

With regard to neoplastic dysphagia it is even more difficult to accept that in such a debilitating disease the major surgical procedure Mr Park describes carries no greater mortality than that of endoscopic intubation. We have had two deaths resulting from the procedure in 27 endoscopic intubations for malignant stricture of the oesophagus or cardia and no patient was rejected as being unfit or unsuitable. We should be interested to hear whether the operation Mr Park describes is comparably safe.

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Suppressing lactation

SIR,—Unsigned leading articles offer fascinating diagnostic fields for speculation concerning the personality, world-view, and conditioning of their authors. Such seemed to us to be the case with "Suppressing lactation" (22 January, p 189), in which basic clues appeared to be the structure of the opening sentence and the weightage given to the technological in the main portion of the article.

The punchy lead-in—"Many doctors, but few patients, view breast-feeding with enthusiasm"—plainly labels the unknown writer as one who "delivers patients" rather than assisting, when required, a small minority

of mothers to deliver themselves. The word "Many" suggests subtly that this enthusiasm may not include balanced individuals like the author, who regard all the fuss concerning breast *v* bottle as faddish, boring, and peripheral to real issues. The phrase "few patients [mothers] view breast-feeding with enthusiasm" suggests a limited socioeconomic clientele and an unawareness of recent grassroots movements by voluntary women's organisations in various parts of the world. The main body of the text gives a valuable account of present knowledge of the therapeutics of suppressing lactation but also seems to exhibit the common feature in Western medical literature of relief at being able to get into something scientific and actively interventionist, particularly with respectably polysyllabic pharmaceuticals.

Our diagnosis of Dr Inconnu is as a male, subconsciously paternalistic obstetrician with major interests in hospital-bound, more mechanised approaches to childbirth—predictably more involved with the nuances of induced labour and fetal monitoring than with mother-newborn interaction and natural childbirth. Because of compartmentalisation between obstetrics and paediatrics in modern medicine (and, to be fair, limited time) Dr I will have minimal awareness of the flood of new literature on the psychodynamics of lactation etc, including the resurgence of interest by mothers themselves. We would also suggest that Dr I's "patients" are mostly social class 4 and 5 and not yet reached by the changing pattern of infant feeding developing in the UK and elsewhere.

Doubtless our reconstruction is wrong and the column was, in fact, written by an attractive red-headed female obstetrician, herself a mother of two and an enthusiastic supporter of breast-feeding—but we doubt it.

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Abuse of benzodiazepines

SIR,—We were rather surprised by the suggestion of your expert (Any Questions, 11 December, p 1439) that benzodiazepines are "not known to be abused" and do not have important withdrawal effects.

There is increasing evidence that benzodiazepines are widely abused and that withdrawal effects are much more common than was previously supposed. In a recent survey of 2500 patients seen in hospital suffering from drug-induced lethargy, drowsiness, or coma diazepam was second only to alcohol as the most common drug of abuse.¹ In another recent study of 50 patients prescribed diazepam² strong evidence was found of tolerance to the drug leading to increasing dosage and of withdrawal effects, including anxiety and insomnia. A panel of physicians, while blind to the type of drug, rated 40% of the subjects as being at least moderately addicted. However, they changed their opinion to one markedly more favourable to the drug after they learnt that it was diazepam.

Serious withdrawal effects documented for benzodiazepines include fits³ and toxic psychosis.⁴ Less serious withdrawal effects are much more common. Withdrawal from nitrazepam temporarily causes sleep to be worse

than it was before treatment,⁵ and enhanced anxiety is also found after stopping benzodiazepines.^{2,6} These withdrawal effects tend to lead to the represcription of the drug and thus to the unnecessary continuation of treatment for long periods which often occurs.⁷

We suggest that clinicians have become convinced that benzodiazepines do not cause dependence or withdrawal symptoms and that this has led them to overlook the available evidence.

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¹ Rejent, T A, and Wahl, K C, *Clinical Chemistry*, 1976, **22**, 889.

² Maletzky, B M, and Klotter, J, *International Journal of the Addictions*, 1976, **11**, 95.

³ Vyas, I, and Carney, M W P, *British Medical Journal*, 1975, **4**, 44.

⁴ Barten, H H, *American Journal of Psychiatry*, 1965, **121**, 1210.

⁵ Adam, K, et al, *British Medical Journal*, 1976, **1**, 1558.

⁶ Allen, S, and Oswald, I, *British Journal of Clinical Pharmacology*, 1976, **3**, 165.

⁷ Johnson, J, and Clift, A D, *British Medical Journal*, 1968, **4**, 613.

Insulin regimens for diabetic ketoacidosis

SIR,—Concerning the treatment of diabetic ketoacidosis your leading article (12 February, p 405) rightly emphasises the simplicity, safety, and effectiveness of continuous intravenous insulin infusion or frequent small bolus injections intravenously or intramuscularly.

In our opinion the intravenous regimens can be dangerous *in infants*, whose hourly insulin requirements may be less than one unit. This rate of infusion is very difficult to control accurately, and even if an accurate volumetric infusion pump is used the small volume means that several hours' dosage may be given subcutaneously before a "tissued" intravenous line is recognised. The use of larger volumes and more dilute insulin produces the problem of surface absorption¹ on to the plastic of the intravenous line.

The regimen used in this hospital—intramuscular insulin, a loading dose of 0.25 U/kg followed by 0.1 U/kg hourly—has proved itself safe in infants from the first 12 months of life. The extra margin of safety seems to be well worth the unpleasantness of multiple intramuscular injections.

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¹ Weisenfeld, S, et al, *Diabetes*, 1968, **17**, 766.

Nurses and doctors

SIR,—The "Code of Professional Conduct for Nurses" issued by the Royal College of Nursing a short while ago can hardly have escaped the notice of doctors but seems to have produced a deafening silence in the correspondence columns. This means either that no one in the medical profession is particularly interested or everyone is resigned to a gradual and continual erosion of our status as decision-makers as demands for "identification" by nurses increase. I have worked for 18 months in hospital and the impression I get is that the majority of the nursing profession below the level of senior nursing officer tend to take