mind on the subject. In the interim it is not justifiable to withhold such therapy from the normal informed patient requesting it provided that no contraindications exist, that the patient is properly re-evaluated at frequent intervals, and that appropriate selection of drug, dosage, and therapeutic regimen is considered. Ideally, all this can be accomplished, including the necessary research, through a menopause clinic.⁹

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Depot tranquillisers for disturbed behaviour

SIR,—I was most interested to read the letter from Drs P J Perinpanayagam and R A Haig (26 March, p 835). I have for the past two years been using fluphenazine decanoate in an average dose of 25 mg monthly to treat explosive personality disorders in both sexes, in the first year in a large mental hospital and in the past year in a mental handicap setting. I must emphasise that there was no question of psychotic illness being present in the 16 adolescents nor in the 40 older patients (in their twenties), who displayed psychopathic instability of the usual varieties—for example, self-injury such as repeated drug overdosing or wrist slashing and/or antisocial behaviour such as unreasonable aggressiveness, destructiveness, etc. Alcohol acted as at least a precipitant in a third of the cases of "difficult" behaviour. One case in particular may be of interest to your readers. A delinquent boy of 14 years with a very disturbed family background who had been placed in the care of the social services because of his destructive and life-threatening activities has apparently responded extremely well over a period of a year to fluphenazine decanoate 12.5 mg fortnightly. He has had no further episodes of absconding or getting into mischief at school or at home since starting on the drug.

I agree wholeheartedly with your correspondents that a long-acting tranquilliser can stabilise disturbed behaviour and in many cases open the way to psychotherapeutic, occupational, and other forms of rehabilitation. Thus these individuals don't seem to feel tense enough any more to inflict damage on themselves or others. I would be inclined to generalise from my own and your correspondents' experience and say that a long-acting tranquilliser is a useful means of reducing anxiety in a group classically prone to abuse oral tranquillisers.

I am conducting a mirror image study of the use of fluphenazine in ameliorating difficult behaviours in approximately 100 non-psychotic residents in a mental handicap

hospital, the majority of whom had failed to respond to other types of psychotropic medication, including a variety of other phenothiazines. The institution of the drug has coincided with a dramatic reduction in such behaviour; it remains to be seen whether cessation of the drug, which is at present being effected, will result in a resurgence of "difficult" behaviour. I hope to publish the results in due course.

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Liver biopsy in "difficult" jaundice

SIR,—We feel that the short report by Dr P Lance and his colleagues (23 July, p 236) may give an inappropriate impression of the safety and value of percutaneous liver biopsy for obstructive jaundice. We would, of course, concur with the author's view on the hazards of operating inadvertently on patients with intrahepatic cholestasis. Of 43 such patients in their series, eight underwent a laparotomy, one as a result of an incorrect percutaneous liver biopsy result. This laparotomy rate (18.6%) in intrahepatic cholestasis is unacceptable by modern standards and the dangers are adequately borne out by the 37% mortality in these patients (3/8). With the use of the full range of modern diagnostic techniques available it should now rarely be necessary to perform such laparotomy.

Concerning the important question of identification of large-duct obstruction by liver biopsy, if we exclude the operative biopsies from the authors' series 15 out of 95 percutaneous biopsies in obstructive jaundice either failed or were incorrect or unhelpful (15.8%). This indicates the known difficulty in diagnosing large duct obstruction from a needle biopsy, and indeed interpretation was incorrect or unhelpful even in 6/18 operative liver biopsies from patients with obstructive jaundice (33%). This success rate of 84% is significantly below that which has been reported by the use of grey-scale ultrasonography (GSU)¹ or fine-needle percutaneous transhepatic cholangiography (PTC).^{2,3}

Although the availability of GSU and endoscopic retrograde cholangiography is limited, PTC using the Chiba needle is easily performed and readily available. Recent communications have shown that this procedure is now being widely performed both within and outside the major teaching centres.^{4,5} PTC also has the clear advantage of providing precise anatomical location of extrahepatic obstruction.

While fine-needle PTC carries a risk, it is unlikely, particularly with the facility for percutaneous drainage of a grossly dilated biliary tree, that the risk of biliary peritonitis will be as high as that following needle liver biopsy. In addition, the use of prophylactic antibiotics appears to minimise the risk of septicæmia.⁶ There can be few experienced biliary surgeons who have not had to operate for one of these complications following a percutaneous liver biopsy in obstructive jaundice. There is now a case for restricting the use of liver biopsy to patients in whom a non-dilated biliary tree has been demonstrated by other means.

Dr Lance and his colleagues have reported a series of patients collected over the years 1959-75, an era which predates the widespread use of GSU and the Chiba needle in Britain, and their results must be accepted with

caution. While the figures quoted may be acceptable for such a retrospective series, they do not necessarily reflect current views in the practice of biliary surgery.

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Effect of abortion on obstetric patterns

SIR,—I read with interest the interview with Professor R W Beard (23 July, p 251) and in particular the remarks made by the interviewer, corroborated by Professor Beard regarding the effect of abortion on obstetric patterns. Professor Beard implies that in Sheffield the availability of easy terminations of pregnancy has reduced the number of low-birth-weight babies and he goes on to point out how very difficult it is to deal with a woman who comes in at 26 weeks with ruptured membranes.

Surely it is an established fact^{1,2} that one or more terminations of pregnancy are liable to result in more women coming in at 26 weeks with ruptured membranes, and this would exacerbate the precise problem mentioned by Professor Beard. I would suggest that the effect on living standards which is so reasonably desired, and which might be expected to reduce the number of small-for-dates babies, is more likely to be accomplished by a sensible sterilisation campaign rather than the potentially damaging short-term solution of termination of pregnancy in young women.

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More hydatidiform moles?

SIR,—In the eight months from November 1976 to June 1977 nine cases of hydatidiform mole have been seen at this hospital. This is an incidence of six to seven per 2000 pregnancies where normally only one would be expected.¹

The condition is said to be more common in elderly patients of high parity and in the lower socioeconomic groups. Carr has demonstrated a high incidence of triploidy in both hydatidiform moles² and in aborted conceptions of patients who have recently used oral contraceptives.³ Thus the increase in polyploidy resulting from hormonal imbalance consequent upon recent oral contraception might be expected to give rise to an increase in the incidence of hydatidiform mole. The nine patients were questioned closely about their medical history and contraceptive habits and none had recently used oral contraceptives, nor had they any age group, blood group,