join the rota for experience, and the senior house officer on rotation."

Dr R J Brereton (15 October, p 1021) takes me to task for my careless sentence construction and asks for enlightenment. I had thought that it was obvious from the text that good antenatal supervision and intensive care after delivery, when necessary, contributed to an improved perinatal situation, whereas competent antenatal investigation would reduce the number of children born with disorders such as Down's syndrome and spina bifida.

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Names of drugs

SIR,—I would agree with your leading article (15 October, p 980) defending the non-use of proprietary drug names in medical articles.

Moving from British general practice to an academic job in the USA, I learnt the generic names, where I did not already know them, of all of the drugs I had become used to prescribing by proprietary names. Whether I had been right to do that is open to discussion, but patients and pharmacists (at least in my locality) found proprietary names often easier to use (and therefore less open to error, which is surely the main point). However, on arriving here, to my surprise I found that not only are the proprietary names different, as expected, but the approved names frequently are too (for example, paracetamol is acetaminophen), even with recently introduced drugs (for example, sodium cromoglycate is cromolin sodium).

Neither the *British National Formulary* nor the American Medical Association's *Drug Evaluations* gives these equivalents, and with increasing dissemination of medical personnel and literature I would say that a publication such as Dr G D J Ball suggests (15 October, page 1024), but listing the equivalent generic names as well as proprietary names of products still under patent or widely prescribed under their proprietary names, would be essential in any medical library that contains American as well as British publications (that is, most medical libraries). It would certainly have helped me.

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ECT and the media

SIR,—I have been interested by the comments concerning ECT and the media (22 October, p 1081, and 5 November, p 1215) as I am in the process of carrying out a study into the attitudes of patients to ECT and the effects of the media on these patients. My attention was drawn to this subject by a patient who refused to have ECT despite considerable morbid depression. He gave as his reasons the comments made on the television programme "Panorama." He had interpreted them as being an indictment of ECT. He was particularly worried that he would need repeated courses of ECT for many years and that his memory would be impaired, both being suggestions which came from the programme and both being very far from the truth, as several studies have shown.

I am sure that many psychiatrists have come across similar problems. The interesting point is, how much effect does this publicity, biased or not, have upon the people who are recommended for ECT? These people are almost all depressed by definition; they are therefore more likely to be hopeless and fearful about any treatment. They are also more likely to pick up, or misinterpret, hopeless messages about treatments for depression—"Nothing can really help me." It seems to me that if in fact the media are contributing to the worsening of a clinical condition (that is, depression), then they should rethink their policies.

I am pleased to report that the patient mentioned eventually, after several weeks of worsening depression, was persuaded to have a short course of ECT and is now happy, back at home, and grateful for the treatment.

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SIR,—Dr J F Anderson and his colleagues (22 October, p 1081) complain of the unfavourable "image" of psychiatry conveyed by the media. They argue that especially in respect of ECT the picture painted is not only biased but is likely to deter patients who would benefit from this treatment. They themselves consider that ECT is the most consistently effective treatment for depression and they cite instances of patients being persuaded against it by relatives who had seen television programmes.

I think that these consultants may perhaps overestimate both the extent to which their optimism is shared by former recipients of ECT and the unwillingness of people in severe depression to take risks. In the latter regard one could describe cases of persons improvising their own methods of shock treatment that they know perfectly well are dangerous. The motive, however, is not suicidal but rather an attempt at self-help when all other remedies have apparently failed. Also there were those among us who, before anaesthetics were introduced, asked for ECT. This was despite the fact that each such treatment was almost like going to the electric chair.

In the former regard there are those who, when psychiatrists talk about ECT working "wonderfully well," think about Lourdes. We have had ECT, antidepressant drugs, and group therapy, and none of them helped. We believe we eventually got well not through these techniques but through "natural causes" assisted by some supportive commonsense talk.

It is true that psychiatry is sometimes unfairly attacked, even hysterically. But psychiatrists will not advance their own cause if they ignore a simple fact. This is that the experience of so-called mental illness can rarely be publicly discussed by those who have actually undergone it. They fear, often justifiably, that careers and social reputations will be jeopardised if it is known that they have had treatment, especially as inpatients. These people have, in consequence, very little outlet for their frustration if dissatisfied with psychiatry.

Perhaps this is why there are so many campaigns that are, from the point of view of the Cupar consultants, irrational and even "malign."

FORMER PSYCHIATRIC PATIENT

Gamma-glutamyl transferase in ascitic fluid in primary hepatoma

SIR,—One wonders if the high levels of γ -glutamyl transferase in the ascitic fluid of patients with hepatoma, as reported by Dr T J Peters and others (18 June, p 1576), are not simply secondary to the high serum levels of the enzyme which undoubtedly were present.

The inclusion of this information in their report would have permitted a better appraisal of the potential usefulness of this test in distinguishing hepatoma from other hepatic diseases which also produce greatly elevated serum levels of γ -glutamyl transferase.

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* * * We sent a copy of this letter to Dr Peters and his colleagues, whose reply is printed below.—Ed, *BMJ*.

SIR,—In answer to Dr Noll the *serum* levels of γ -glutamyl transferase were equally elevated in the patients with hepatoma and those with cirrhosis without hepatoma. Several patients with cirrhosis had high serum levels of γ -glutamyl transferase but low levels of the enzyme in ascitic fluid. It is well recognised that assays of serum γ -glutamyl transferase are not helpful in distinguishing patients with hepatoma from those with other forms of liver disease. It is therefore unlikely that the levels of the enzyme in ascitic fluid merely reflect serum enzyme levels.

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Problems with IUCD tails

SIR,—The assessment of intrauterine contraceptive device (IUCD) usage has naturally been mainly concerned with method failure, leading to pregnancy, and with side effects such as bleeding and pain, leading to IUCD removal. Although Gräfenberg¹ felt that the presence of a cervical appendage led to the introduction of bacteria into the uterine cavity, its possible role in the production of serious infection did not achieve prominence until the controversy over the multifilamentous tail of the Dalkon Shield.² Since then it has been shown that all types of IUCD tail result in the continued presence of small numbers of vaginal bacteria in the uterine cavity.³

Oates⁴ has recently described a lesser-known problem. Long tails may become coiled and knotted. The regular use of vaginal tampons may lead to the adhesion of small particles of cotton wool to the knot and the formation of a small mass of foul-smelling material whose presence soon becomes apparent to the patient.

A more important problem is the disappearance of the Gravigard (Copper-7) tail with the device still in utero. The Gravigard is supplied partly loaded into the introducer with a loop of tail alongside it. If the tail is pulled down into the vagina after insertion and cut it is liable to withdraw into the uterine cavity and revert to the looped position it was accustomed to in the introducer. It can then no longer be seen on speculum