SIR,—It is regrettable that your leading article on angina pectoris (19 April, p. 134) again fails to stress the importance of a search for and correction of anaemia in the management of this condition.

I have recently seen two patients, (one with iron deficiency and one with vitamin B₁₂ deficiency) presenting with classical effort angina. In both cases the angina was totally relieved by appropriate treatment of the anaemia.—I am, etc.,

P. E. JACKSON.

Stamford and Rutland Hospital,
Stamford, Lincs.

Anencephalus and Spina Bifida

SIR,—With reference to your leading article on anencephalus and spina bifida (12 April, p. 67), it would indeed be surprising if monozygotic co-twins of index patients with anencephalus or spina bifida were very rarely affected. In the largest consecutive series available (unfortunately not widely known), based on the records of a 10-year series of births in New York,¹ the pair concordance figures were:

	Like Sex	Unlike Sex
Anencephalus	4/24	1/15
Spina bifida	3/24	1/14

Further, one like sex pair had anencephalus and spina bifida respectively.

Since about half of like sex pairs are likely to be monozygotic, and the members of the concordant pairs will have usually both been index patients, these findings are certainly compatible with, say, 20% of monozygotic co-twins and 6% of dizygotic co-twins also affected. These proportions would be compatible with the heritability suggested by the sib data.

There is a need for further twin series in which the type of twinning is established—for example, from cord blood.—We are, etc.,

C. O. CARTER.

Medical Research Council,
Clinical Genetics Research Unit,
Institute of Child Health,
London W.C.1.

K. M. LAURENCE.

Llandough Hospital,
Penarth, Glam.

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Complications with I.U.D.s

SIR,—The commonest way in which the average practising gynaecologist in Britain comes into contact with intrauterine contraception is when a patient appears in his clinic with a complication. Often this consists of vaginal discharge, menstrual disturbance, or pelvic pain, which is solved by simple removal of the device. Sometimes the problem is abortion, or continuing pregnancy with the device in situ. Really serious flare-ups of pelvic inflammatory disease are not so common and perforations of the uterus and their consequences relatively rare. In general, the gynaecologist has been able to console him-

self with the thought that innumerable statistically controlled trials have been conducted and that massive international I.U.D. programmes with computer monitoring appear to be proceeding quite happily. It seems to be just a few of the failures that have come his way.

In these circumstances it is a matter of some concern that a year or two ago the association of ectopic gestation with intrauterine devices came to light in the form of a clinical report¹ before statistical verification was provided from large-scale controlled studies.²

Taking a second look at the numerous and comprehensive reports on I.U.D.s, one is struck by two components. The first of these is the almost naive and zealous optimism of the workers in this field, who record incidences of 3% to 30% of expulsions, 1% to 9% of pregnancies, up to 8% of pelvic inflammatory disease, and 2% to 78% of menstrual disorders³ and then tend to conclude that this is a safe, effective, and acceptable contraceptive method. The second component is a small item appearing in one form or another in most of the major statistical studies which boils down to "patients lost to follow-up," and amounts to between 5 and 20% of cases. This is a much more serious factor, which invalidates the major numerical findings of these programmes. It is unfortunate that when an I.U.D. catastrophe occurs the patient does not in general return to the clinic where the device was fitted but has recourse to a hospital with an acute gynaecological unit and resists contact for follow-up purposes. This is not just a matter of resentment—gynaecological patients are loyal creatures, and do not like to upset the kind doctors who fitted the device by recounting a failure. In terms of cold hard fact, it means that when the *Eighth Progress Report of the Co-operative Statistical Programme for the Evaluation of Intra-Uterine Devices*⁴ reports a pregnancy rate of 2.6% in the first year of use, the real pregnancy rate may be anything between 2.6% and 16.1%. When Tietze⁵ reports 43 uterine perforations in 22,403 women, this may mean a perforation rate of anything between 0.2% and 9.8%.

The recent survey of critical illnesses and deaths associated with intrauterine devices⁶ conducted among the Fellows of the American College of Obstetricians and Gynaecologists is also open to objections on statistical grounds. On the other hand, it does present the other side of the picture—the side seen by the practising specialist gynaecologist. Of the ten deaths reported four were due to septic or inflammatory complications of the insertion of the device, and three to infection occurring with the device in situ. In the other three deaths the relation of the I.U.D. to the outcome is by no means clear. The remainder of the report details 369 cases of critical illness due to inflammatory complications and 207 due to perforation of the uterus, 12 of these with consequent intestinal obstruction.

The survey leads one to recall the review of the dangers of intrauterine contraceptive devices published by the American Medical Association Committee on Contraceptive Practices in 1937.⁷ A report on Gräfenberg rings telling of 17 deaths from general peritonitis or septicaemia, 176 major septic conditions where the patient survived, seven perforations of the uterus, and four ectopic gestations is included, and comparable reports on other I.U.D.s are mentioned. The report ends with the committee indicating its complete disapproval of these methods of contraception.

No rational practitioner will deny that many women use I.U.D.s successfully, or that the I.U.D. appears to be the only practical form of contraception for a proportion of patients. In the context of world population problems there is clearly a need for study programmes concerned with the development of safe and effective methods of contraception. Current justifications for the use of I.U.D.s are expediency and experiment. Care should be taken not to give the impression that at the present time there is evidence that the I.U.D.s are the best method of contraception available. We must not blind ourselves to the occurrence of failures and the undoubted existence of hazards to health and possibly even to life which their use involves.—I am, etc.,

DENIS F. HAWKINS.

Institute of Obstetrics
and Gynaecology,
University of London,
Hammersmith Hospital,
London W.12.

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"Cold Cures" and Monoamine-oxidase Inhibitors

SIR,—We were interested to see the experiments reported by Dr. M. F. Cuthbert and others (15 February, p. 404) concerning the interaction of phenylpropanolamine and the monoamine-oxidase inhibitor tranlylcypromine. Their advice concerning communication of the risks involved to physicians and patients is well intended but should be made more explicit.

In 1965 we conducted a survey among the outpatients taking these drugs at the Maudsley Hospital, where these interactions were first discovered and where the dangers were well known and publicized.¹ Even so, 7 out of 50 patients who completed a questionnaire had used cough medicine in the previous month, and less than half the patients knew the identity of the monoamine-oxidase inhibitor they were taking. Some continued to eat potentially dangerous foodstuffs despite warnings, while others were unaware of the risks. In this regard it is worth reiterating several points:

Not all drugs which inhibit monoamine-oxidase are used exclusively in psychiatry. For instance, the hypotensive agent pargyline and the antibacterial drug furazolidone both belong in this category. The former has been shown to cause interactions with dopamine and several foodstuffs²⁻⁴ and the latter with tyramine and amphetamine.⁵

The foodstuffs which contain tyramine or allied amines are unpredictable. The list continues to lengthen and becomes increasingly improbable. We recently encountered a West Indian who experienced a hypertensive