insulin to cover meals there is likely to be sufficient B cell failure for continuation of a sulphonylurea to be of marginal benefit, and it can be withdrawn. Simple guidelines on the use of tablets and insulin⁴ can cater for most patients until long term studies show a different regimen to be particularly beneficial.

RURY R HOLMAN

Diabetes Research Laboratories,
Radcliffe Infirmary,
Oxford OX2 6HE

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In vitro fertilisation

SIR,—Mr David Barlow and others (12 March, p 751), Mr Peter Bromwich and others (12 March, p 759), and subsequent correspondents (9 April, p 1064) discussed means of improving oocyte collection and pregnancy rates and methods of cutting costs. The emphasis has been on various methods of oocyte collection and on the practicalities of sharing the cost between the public and private sectors. We have improved cost effectiveness at the Lister Fertility Centre by routinely using a luteinising hormone releasing hormone analogue before oocyte collection by either the laparoscopic or an ultrasound directed trans-vaginal route.

One hundred and twenty consecutive patients receiving in vitro fertilisation and gamete intrafallopian transfer were treated with intranasal luteinising hormone releasing hormone analogue four hourly from the first day of their cycle until ovulation was induced with 10 000 IU of human chorionic gonadotrophin. Ovarian stimulation was achieved using two ampoules of human menopausal gonadotrophins daily from the third day of the treatment cycle. The mean number of ampoules used in each cycle was 20.7 (SD 9.2). The follicular development was monitored by vaginal or abdominal ultrasound studies without hormonal monitoring.

The cancellation rate because of inadequate ovarian stimulation was 6%, but no cycles were cancelled because of spontaneous ovulation. The flexibility provided by the analogue enabled us to perform an average of 15 procedures in only four operating sessions each week, with no weekend service. The mean number of oocytes collected at each procedure was 8.5 (5-9). The clinical pregnancy rate for in vitro fertilisation was 39% (14 out of 36 cases) and the pregnancy rate for gamete intrafallopian transfer was 41% (35 out of 84 cases). The early miscarriage rate was 14%. These pregnancy rates are higher and the early miscarriage rate lower than those commonly reported.^{1,2} These improvements may be the result of reduced maternal serum concentrations of luteinising hormone at the time of conception after the use of luteinising hormone releasing hormone analogue.

Although using the analogue is associated with a small increase in the amount of human menopausal gonadotrophin needed in each cycle, it obviates the need for serial assays of serum oestradiol or luteinising hormone, reduces the number of cancelled cycles, and allows oocyte collections to be performed on planned lists during normal working hours. These factors, coupled with increased pregnancy rates and reduced miscarriage rates,

suggest that using the analogue will increase the cost effectiveness of in vitro fertilisation programmes.

H I ABDALLA A KIRKLAND
T LEONARD P A R STOCKER
R J BABER E C OWEN
J W W STUDD

Lister Hospital,
London SW1W 8RH

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Induced ovulation in underweight women

SIR,—We were concerned by the recommendations of Mr Z M van der Spuy and others to withhold induction of ovulation and advocate weight gain in underweight anovulatory women (2 April, p 962).

We have compared their analysis of 41 singleton pregnancies resulting from induction of ovulation with our data from 71 singleton pregnancies, 12 induced with pulsatile gonadotrophin releasing hormone and the rest by human menopausal gonadotrophin. Our overall risk of delivering a baby with a birth weight below the 10th centile was 20% compared with 25% in their study, and our risk for underweight women was only 43% compared with theirs of 54%. The risk for women of normal weight was 13%, slightly above their figure of 11%. We found an overall abortion rate of 30%, with 27% in women of normal weight, 50% in the overweight, but only 22% in the underweight group.

It must be emphasised that having a baby whose weight falls below the 10th centile does not necessarily imply intrauterine growth retardation and the dire problems cited by Dr van der Spuy and others. Few of the small babies in our study even required neonatal intensive care.

We have been impressed by the beneficial effects of a successful pregnancy in underweight women on their subsequent weight gain, with the restoration of menses and spontaneous conception. Some of these women respond better to the responsibilities of motherhood than to exhortation to gain weight alone.

What concerns us particularly, however, about the insistence on weight gain and the withholding of stimulant treatment is the well documented evidence of the decline in natural fertility with age and the impairment of response to ovarian stimulants in women aged over 31.¹ By withholding treatment we could be denying them any possibility of fertility. Women requiring ovarian stimulant treatment for conception have a greater risk of a small baby even when they are of normal weight. Rather than denying treatment to the underweight we should be monitoring all such pregnancies closely.

VICKY OSGOOD
JEAN GINSBURG

Department of Endocrinology,
Royal Free Hospital,
London NW3 2QG

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Imaging of the urinary tract

SIR,—We endorse the conclusion by Dr G de Lacey and others (2 April, p 965) that routine urography is unnecessary in the assessment of patients with prostatism, but we are concerned that they make no mention of urine flow rates or

ultrasound measurement of residual urine. They imply that symptoms and, if necessary, cystoscopy are reliable guides to the severity of prostatic obstruction. This is not the case.

The assessment of prostatic size at endoscopy is often inaccurate.¹ The size of the prostate may be misleading as anatomical enlargement is only part of the pathophysiology of bladder outflow obstruction: dynamic and functional mechanisms are also important. The classical prostatic symptoms are a poor guide to the presence of severity of obstruction.^{2,3}

Multiple measures of the rate of urine flow and ultrasound studies of residual urine can differentiate the obstructed from the non-obstructed bladder and identify patients at risk from urinary retention or upper tract dilatation. Patients presenting with prostatic symptoms who do not have significant bladder outflow obstruction will not benefit from surgery, and others, with mild or moderate obstruction but little residual urine, can be managed conservatively.⁴ Objective assessment of patients tends to produce a low operation rate and improves the results of surgery.⁵ A urine flow rate clinic (incorporating a small real time ultrasound machine) is easily incorporated into a urology outpatient department and may be run by a nurse.

M A STOTT
P H ABRAMS
F C L FENELEY

Urodynamic Unit,
Ham Green Hospital, Pill,
Bristol BS20 0HW

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Drug addicts and the GP

SIR,—Dr Tessa Richards (16 April, p 1082) is too optimistic. Few general psychiatrists have much time for addicts, and it is unreasonable to expect general practitioners to be any more enthusiastic, especially when they will not be paid extra for their trouble. This is a pity because they could undoubtedly do a lot for drug addicts, including those addicted to "our favourite drug," alcohol.¹ In Denmark general practitioners routinely give supervised disulfiram.²

General practitioners could easily prescribe methadone for maintenance or withdrawal, and anxiety about diversion of supplies would be reduced if it were swallowed under the pharmacist's supervision. Most pharmacists are willing to supervise. However, general practitioners would need to understand that the success of a methadone programme is judged not only by how many addicts withdraw from opiates but also by how many are able, while taking methadone, to avoid lives of crime, degradation, and infection with the human immunodeficiency virus.

General practitioners should see their local drug dependency units as centres of excellence and expertise. Regrettably, the users say that the standard of service is frequently poor. Time consuming and repeated assessments of dubious value are often required, and clinic hours rarely cater for the many addicts working hard to rebuild their lives and finances. The lack of medical research in many such units is a disgrace.