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Improvements in obstetric anaesthetic services

SIR,—We welcome the correspondence which our article (22 September, p 698) has promoted, especially the letters from Dr D J Bowen and others (15 December, p 1587) and from Mr G Roberts and Mr P J Bradley-Watson (26 January, p 251).

It is clear that there is concern about the inadequacy of obstetric anaesthetic services and we have endeavoured to stimulate awareness of these deficiencies. We believe, with your correspondents, that in ideal circumstances a full range of methods of pain relief, including epidural analgesia, should be available in every consultant unit. But this will take time and money and we were at pains to draw attention to alternative and we would hope interim measures. No medical administrator could produce logical arguments to block essential improvements in pain relief for obstetrics.

Mr Roberts and Mr Bradley-Watson comment on the uneven distribution of consultant sessions in Wales, a point which we ourselves emphasised, although we deliberately avoided specifying areas of exceptional deficiency for fear of creating public alarm. Since there are only 12 exclusive obstetric anaesthetic sessions in the whole of the principality, it is clear that their assumption that there are two whole-time obstetric anaesthetists in South Glamorgan must be incorrect. Indeed, the number of sessions allocated between the two major obstetric units in South Glamorgan is eight and this includes time spent in the training of junior staff who will ultimately supply the needs of the district general hospitals in Wales. We note with pleasure that for the first time the large unit at Carmarthen is going to have an anaesthetist with designated obstetric sessions. Perhaps our review of the services, to which Mr Roberts contributed, has played some small part in achieving this innovation.

Mr Roberts and Mr Bradley-Watson are also to be congratulated on achieving skill and experience in the administration of epidural analgesia and personally providing this facility for some of their patients. However, only a limited number of obstetricians have the necessary skills, time, and inclination and none could include within their commitments epidural analgesia for all patients who desire it. Your correspondents imply that we suggest that midwives should not be involved in "top-up" injections. This was not the case which we put. We agree that midwives should be involved providing they are trained to cope with any complications which may arise or a trained doctor is within the immediate vicinity.

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**This correspondence is now closed.—ED, *BMJ*.

Treatment of infertility with levodopa

SIR,—We read with interest the paper by Dr M O Thorner and others (29 September, p 771) dealing with bromocriptine and pregnancy. Bromocriptine has been used in a variety of endocrine and neurological disorders, including hyperprolactinaemia, acromegaly, infertility, premenstrual tension, Parkinson's disease, etc, with varying degrees of success. When there is reason to suspect dopamine deficiency as the primary neurotransmitter defect, treatment with this dopaminergic agonist has generally been effective. However, because there is some theoretical concern that bromocriptine may be a teratogen, we have been employing instead low doses of levodopa (a dopamine precursor) with success in the treatment of infertile women.

Since July 1975 up to the present we have treated 17 infertile patients, all of whom subsequently conceived within two months of attempted conception. All the patients were married nulliparous women (age range 34-33 years) who had been trying to conceive for four or more years. Eleven normal babies have been delivered up to the time of writing, and five normal pregnancies are in progress. One spontaneous abortion occurred. All patients reported regular menstrual periods, although five showed high levels of serum prolactin concentration (27, 36, 42, 56, and 75 ng/ml); two of the latter had galactorrhoea. All patients showed normal skull radiographs. In all cases organic diseases were excluded and a psychiatric diagnosis of depression was made. Hypoactivity of the dopaminergic system was established at the level of the distal colon according to a previously described procedure.[1]

One oral daily dose of levodopa (125 mg) was administered, along with 0·3 mg of haloperidol, from the fifth postmenstrual day until the first day of the next period. The experimental finding that high doses of levodopa reverse the induced hyperdopaminergic behaviour[2] led us to employ low doses. Our broad experience in the use of levodopa in many psychosomatic illnesses[3] has shown us that the addition of low doses of haloperidol potentiates and prolongs its dopaminergic agonistic effects.[4 5] Low doses of butirophenones in effect block presynaptic autoreceptors preferentially, thus inducing dopamine release. In all cases the medication was interrupted as soon as the first period was missed by 15 days.

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Debendox and the media

SIR,—In common with many of your readers, we were disturbed to read on the front page of the *Observer* on 20 January a report of impending legal action in the United States against Merrill National Laboratories, the manufacturer of Debendox (dicyclomine hydrochloride, Bendectin in the United States), an antiemetic drug widely used in pregnancy. The report appeared under the dramatic and ambiguous title "New thalidomide-style drug fear." Predictably, women now pregnant who have taken the drug have become extremely alarmed about the possible effects on their fetuses.

So far as retrospective studies in man can ever be totally convincing, the record for Debendox is good. Several surveys[1 2] have failed to detect any increase in birth defects in the newborn in mothers who have taken Debendox, while the Department of Health and Social Security in Britain and the Food and Drug Administration in the United States have been reassuring. However, a number of anecdotal reports[3–5] have involved fairly unusual combinations of malformations in fetuses exposed during the first six weeks of pregnancy. Needless to say, similar malformations have occurred in fetuses of women who did not take Debendox, while some women who did take Debendox during this early stage of pregnancy went on to produce normal children.

We now have a unique opportunity to carry out a prospective study of the effects of Debendox in pregnancy as a result of the publicity given to the drug in the popular media. Following discussions with the Medicines Division of the DHSS, it seems to us to be a good idea to ask doctors to write to us letting us know of any women who they are certain have taken Debendox during the *first six weeks of pregnancy*, together with precise dates and a note of their previous menstrual cycle and immediate contraceptive habits. They should then let us know the outcome of pregnancy, whether this be a normal liveborn child, a child with malformations (including details of type of malformation), or fetal death at any stage. It is essential for any *adverse* reactions also to be reported to the Committee on the Safety of Drugs in the usual way. We also wish to know of any factors such as exposure to other drugs or to infections which are considered to be relevant.

Although open to all sorts of objections, this will be a valuable prospective study of the effects of Debendox in the early stages of pregnancy.

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SIR,—Yet again pregnant women are being subjected to needless anxiety by the uninformed actions of the media. Since the reports, both in the press (as discussed in Medicine and the Media, 2 February, p 320) and on television about the alleged harmful effects of Debendox (dicyclomine hydrochloride), I have had to reassure quite a number of women attending the antenatal clinic. Those who remain anxious, and who are less than 18 weeks' pregnant, are being offered serum α-fetoprotein estimation.

May I suggest through your columns that further cases of the unusual syndrome of fetal gastroschisis[1] are reported to the Committee of Safety of Drugs with details of drug therapy