Provisional figures show that in 1989 the number of live births stated at conception to have been unplanned was 27%, but it dropped to 15% after delivery, which reflects the natural adaptation and amnesia that occurs in these circumstances. If those pregnancies that end in a miscarriage or termination are included, the original unplanned 40% contrasts with the 15% figure recorded after delivery.

Although Alton may not compare with the 20 areas of England and Wales chosen by Ms Fleissig, they suggest that our overall figure for unplanned pregnancies was about twice what would have been recorded by restricting any such inquiry to those women who had had a baby some months earlier.

Ms Fleissig has exposed the deteriorating effectiveness of our current policies on young users of the pill and that there is an urgent need for improved care. These unwanted pregnancies create most of the abortions carried out every year; many produce unwanted children. As the problems seem to follow failure of the contraceptive pill, do we now need to increase the strength of oral contraceptives used by young women?

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1 Fleissig A. Unintended pregnancies and the use of contraception: changes from 1984 to 1989. *BMJ* 1990;**302**:147. (19 January.)

Early pregnancy assessment

SIR,—In their recent paper on the management of women referred to an early pregnancy assessment unit Drs M A Bigrigg and M D Read did not say whether ultrasound scans were done using the transabdominal or transvaginal route.[1] Based on the number of equivocal scan results which they reported (11%), it is likely that the transabdominal route was used.

We have done a pilot study to assess the impact of transvaginal ultrasound scanning of emergency gynaecological cases during the first three months of its use in our department. The admitting doctor made a tentative clinical diagnosis on the basis of the patient's history and physical findings. Transvaginal ultrasonography was done by medical staff; the facility was available 24 hours a day, seven days a week. All scans were done within 12 hours of admission, but most were done within a few hours of the patient's arrival in hospital. A transvaginal Endo V probe (Siemens) with a Sonoline SL-2 ultrasound system was used.

During the study period transvaginal scans were done on 87 patients referred with bleeding or pain in early pregnancy. In 72 a clinical diagnosis of threatened abortion had been made, and in 15 there was clinical suspicion of ectopic pregnancy. After a single scan a definite and conclusive diagnosis was made in 67 of the 72 patients with a clinical diagnosis of threatened abortion (viable intrauterine pregnancy, 27; retained products of conception, 21; missed abortion, 8; blighted ovum, 8; complete abortion, 4). In the remaining four patients the ultrasound findings suggested ectopic pregnancy. In three of these a diagnosis of tubal pregnancy was confirmed at laparoscopy, and in one a diagnosis of complete abortion was subsequently made.

A correct and definite diagnosis was made after a single scan in seven of the 15 patients in whom there was clinical suspicion of ectopic pregnancy. At ultrasonography a live intrauterine fetus was seen in one case, retained products of conception in four, and a viable intrauterine pregnancy in two. In eight a definite diagnosis could not be made at ultrasonography, but the findings suggested ectopic pregnancy, which was confirmed at laparoscopy.

Transvaginal ultrasonography has many advantages over transabdominal ultrasonography, particularly in the management of patients with bleeding and pain in early pregnancy. The quality of the image obtained by using vaginal ultrasonography is vastly superior to that achieved by using abdominal scanning. A clear gestational sac can be detected in all patients at 4·5 weeks after the last menstrual period, and fetal heart beats are detected by the end of the fifth week.[2] In most cases the superior quality of the image achieved with the vaginal probe allows a definite diagnosis of nonviability to be made with confidence after a single scan at an earlier gestational age, obviating the need to repeat a scan at a later date. In addition, transvaginal ultrasonography is superior to transabdominal ultrasonography in detecting ectopic pregnancy.[3]

During our pilot study we found that one of the main advantages of transvaginal ultrasonography was the saving in time taken to make a diagnosis as emergency cases could be scanned on admission without waiting for the bladder to fill. The patients were starved from the time of admission so that there was no delay after scanning for those patients requiring surgery. The potential savings in hospital resources, particularly in terms of bed occupancy, that can result from the introduction of this technique are considerable.

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1 Bigrigg MA, Read MD. Management of women referred to early pregnancy assessment unit: care and cost effectiveness. *BMJ* 1991;**302**:577-9. (9 March.)
2 Timor-Tritsch E, Rottem S, Thaler I. Review of transvaginal ultrasonogrpahy: a description with clinical application. *Ultrasound Quarterly* 1988;**6**:1-34.
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Anaesthetists against incompetence

SIR,—I must correct a historical point in Dr Richard Smith's article on the college's scheme for competence.[1] The sick doctor scheme, the first in the United Kingdom, was introduced by the Association of Anaesthetists of Great Britain and Ireland. This occurred promptly through the coincidence that the president, Dr C F Scurr, had been a member of the Ament committee, which produced an important report, and I, as secretary, had close contact in Cardiff with Professor K Rawnsley, then president of the Royal College of Psychiatrists. Vital for acceptance, as for the present scheme, was the confidence shown by anaesthetists in their organisations and, more importantly, in themselves.

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1 Smith R. Anaesthestists against incompetence. *BMJ* 1991;**302**: 371. (16 February.)

SIR,—Dr Richard Smith reports that the College of Anaesthetists has decided that doctors should be disciplined if they have a "high incidence of complications as evidenced by audit, or fail to comply with generally accepted practice."[1] This represents a great threat to clinical freedom. When medical audit was introduced promises were made that it would not be used against individual doctors; education and persuasion were the keys to improvement. Now audit is to be a stick to force doctors into complying with the prejudices of the majority.

For hundreds of years medical progress was blocked because doctors were compelled to comply with "generally accepted practice," as had been taught by Galen. Happily those days passed and doctors such as Withering, Lister, Semmelweis, Pinel, and Morton, none of whom complied with "generally accepted practice," were able to make their great contributions to medical progress.

The present proposals will stifle medical innovation and flexibility as original thinkers are compelled to conform. No one likes his or her cherished nostrums to be challenged, and hence innovators automatically generate hostility. Assessors, before condemning a colleague, should exercise the same scientific and statistical standards as they would before accepting any other medical evidence. Anything less is glorified witch hunting. In the mean time perhaps doctors should consider abstaining from any audit lest they create rods for their own backs.

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1 Smith R. Anaesthetists against incompetence. *BMJ* 1991;**302**: 371. (16 February.)

Hormone replacement therapy and ovarian cancer

SIR,—Despite concern that hormone replacement therapy may hasten the spread of disease in women with ovarian cancer Dr R A Eeles and colleagues report that the survival of women who received such therapy was similar to, or possibly better than, that of women who did not receive it.[1] Interpretating their data, however, is not straightforward as they show clearly that hormone replacement therapy was given preferentially to women with a good prognosis: young women and women with early stage disease and well differentiated tumours.

The prognostic factors analysed are relatively crude predictors of survival, and statistical adjustment for them does not ensure that the groups compared are similar in other respects. Unmeasured features, such as the woman's progress after ovarian cancer was intially diagnosed, are likely to have influenced the decision to give hormones and would also have a profound effect on survival. Differences in prognosis between the treated and untreated groups that are not explained by the factors analysed in their paper might even be so great that they mask a detrimental effect of the therapy.

We believe that the influence of hormone replacement therapy on survival cannot be reliably judged from this study, and we agree with the authors that the only way to resolve this question is with a randomised trial.

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Reporting of fine needle aspiration

SIR,—As a histopathologist who takes and immediately reports on fine needle aspirates of the breast (and other sites) in outpatients I was delighted to see the article by Mr J Michael Dixon advocating this practice.[1] I concur with his comments that this facility is sensitive and lessens patients' anxiety

caused by delays in diagnosis. I find that the presence of the histopathologist in the outpatient department ensures that multiple aspirators are not used, which reduces the sensitivity of the technique considerably.[2] The extra clinical information gained by taking the aspirate myself further maximises sensitivity.

Many histopathologists are deterred from offering this service by a certain amount of myth surrounding the expertise and facilities required. Mr Dixon states that a technician is necessary. Removal of staff from the laboratory for this purpose is often impossible, especially in district general hospitals, where staffing may already be stretched to the limit. It is also unnecessary. At the fine needle aspiration clinic where I work slide preparation takes less than two minutes for each case and I do it myself without causing noticeable delay. Mr Dixon also states that an "experienced breast cytopathologist" must be available. All histopathologists in training must complete at least three months of their training in cytology before taking the final part of the MRCPath examination. Most will be experienced in breast cytology, which for several years has formed the bulk of fine needle aspiration work in most hospitals. Immediate reporting should not be difficult for histopathologists with this background, although it would take a few months to build up skill and confidence. During the first six months that I provided immediate reporting while a senior registrar I achieved a complete sensitivity of 93%, which compared favourably with that of a consultant histopathologist at the same centre with over three years' experience.

I am sure that the "best practice" is not available in Britain because there is not the historical tradition in this country—unlike in the Scandinavian countries, where fine needle aspiration clinics are the norm—to support it. This situation is now slowly improving as results from scattered clinics providing immediate reporting of fine needle aspiration are being reported. It is to be hoped that this will gather momentum as the implications of an accurate fine needle aspiration service with consequent reduction of unnecessary biopsies and more efficient use of both outpatient and inpatient time becomes apparent.

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1 Dixon JM. Immediate reporting of fine needle aspiration of breast lesions. *BMJ* 1991;**302**:428-9. (23 February.)
2 Lee KR, Foster RS, Papillo JL. Fine needle aspiration of the breast—importance of the aspirator. *Acta Cytol* 1987;**31**:281-4.

Funding for psychiatry

SIR,—Some two years ago as chairman of the regional specialist subcommittee in psychiatry I took part in a review of services in Mersey region. We recommended a redistribution of resources, closing the three peripheral large psychiatric hospitals and transferring resources to the urban areas of Liverpool, south Sefton, and Wirral. The calculation was based on the population of electoral wards, age, sex, and a variety of deprivation indices. Unemployment was found to predict 80% of the variance in admission rates throughout the region. Liverpool stood to gain some £3m a year, which would increase its revenue for psychiatry by 25%.

We are now faced with writing care plans and relying on case managers to increase funding for individual patients' needs. How do we compete with medicine and surgery on grounds of quality in psychiatric services, particularly as the population of Liverpool continues to decrease, influencing the district health authority's funding, and we move towards independent trust status?

We may look closely at the value of screening "customers" of primary care and social services to identify cases they may have failed to recognise. We may also look at other specialties in our liaison practice.

Unlike Professor Elaine Murphy,[1] most psychiatrists would welcome any move Mr Heseltine might make to hand community care responsibilities to the health service. This would enable us to develop further comprehensive mental health treatment settings for acute and chronic psychiatric disorder.

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1 Murphy E. Delaying community care. *BMJ* 1991;**302**:361-2. (16 February.)

The normal life

SIR,—"The myth of the normal life" is a cri de coeur from someone whose life has been devastated by severe and protracted mental illness,[1] but it must not be taken as representing an inevitable or even typical outcome of such disorder.

Any serious psychiatric illness can demolish self confidence, alienate friends and relations, and destroy hope. Where there has been abuse of drugs or alcohol or a prolonged stay in hospital the experience is even more difficult to come to terms with or recover from.

None the less a majority of those who suffer from major affective disorder, even when it is chronic or recurrent, make a good recovery and subsequent readjustment. The experience of a journey into madness or despair remains with the individual and may cause profound changes in self perception, but these are not always negative.

A recent biographical account by William Styron describes not only the depths of illness but joys of recovery,[2] and there are many similar accounts. Many people are now happily and successfully fulfilling their ambitions after recovery from serious illness and without friends or employers knowing of their past suffering.

Deep compassion for the sufferer must not be allowed to obscure the need for and efficacy of prompt and effective treatment for most who experience manic-depressive illness.

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1 Anonymous. The myth of the normal life. *BMJ* 1991;**302**:476-7. (23 February.)
2 Styron W. *Darkness visible*. London: Cape, 1991.

Neglected specimens

SIR,—It was timely for Dr Fiona Godlee to draw attention to the increasingly neglected human pathology specimens contained within the various museums of the London teaching hospitals.[1]

My experience suggests that for many years the stewardship of these collections was of very high order. In 1976 I made an attempt to locate specimens described in books written by John Hilton (1863), Christopher Heath (1884), and John Howship (1816). I approached Guy's Hospital's Gordon Museum and Mr John Maynard (honorary curator); with the help of his senior technician I located the required specimen, which was duly photographed and a contact *x* ray film obtained. I moved on to St Bartholomew's Hospital, where an equally valuable specimen of ankylosis was uncovered. John Howship's description had been accurate to the letter, and the specimen was identical with the superb lithograph that appeared in the frontispiece of his book. The Rev Dr Martin Israel was able to find this specimen for me. At University College Hospital Mr W R Merrington located a further example. My knowledge of mandibular ankylosis was greatly enhanced as a result of my seeing these specimens, which had remained extant upwards of 160 years. The catalogue (Red Book) at Guy's Hospital contained further material not gleaned from Hilton. I had no idea old bones could generate such excitement.

As a result of the generosity of various medical schools and the Royal College of Surgeons I have been able to reproduce photographs and radiographs of these specimens in a textbook published recently with my senior colleague, Professor Sir Paul Bramley.[2]

There are cogent reasons for preserving these valuable specimens. Not only are they of historical value but they are of seminal and practical value, and they should be conserved for those who follow.

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1 Godlee F. Neglected specimens. *BMJ* 1991;**302**:198. (26 January.)
2 Norman JEdeB, Bramley P. *A textbook and colour atlas of the temporomandibular joint: diseases, disorders, surgery*. London: Wolfe Medical, 1990.

NHS trusts

SIR,—Hart seems to question the validity of support by the National Association of Health Authorities and Trusts (NAHAT) for NHS trusts.[1] The report by a firm of independent management consultants mentioned in the article was one part of the detailed assessment of NHS trust applications provided for the secretary of state. No one outside the department, including the *Lancet* and *Independent*, was privy to the full assessments.

In voicing NAHAT's view that trusts will succeed, however, we were working on the basis that any application that was successful would have been the subject of rigorous analysis within the department. We are also confident that the structure of the financial regimen for trusts will ensure that those which are established from 1 April will be able to meet their statutory financial obligations.

I emphasise that financial success is just one of the targets trusts are expected to achieve. Every trust will be expected to demonstrate that, as a trust, it provides tangible benefits for NHS patients. All of the first wave trust applications indicated plans to achieve this, and my visits to 43 of the first wave trusts over the past three months has not dispelled my impression that trust managers and professional staff will follow up these innovative and practical plans with enthusiasm.

We will all be interested to see how trusts do in the first years of the reforms, and NAHAT will undertake research on the subject. But we must not forget that trusts are part of a wide range of changes being introduced on 1 April. The degree of success of the trust programme must be viewed in the context of the progress of the reforms as a whole.

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1 Hart. The week. *BMJ* 1991;**302**:492. (2 March.)

Correction

Drug points

An editorial error occurred in "Severe hypoglycaemia after treatment with diphosphonate and aminoglycoside" by Drs Ulrik Pedersen-Bjergaard and John Myhre (2 February, p 295). It should have been entitled "Severe hypocalcaemia after treatment with diphosphonate and aminoglycoside" to accord with the text.