often develop multiple follicles regardless of the dose given.

What then can be done to reduce the incidence of high order multiple pregnancies without denying treatment to many infertile women? Firstly, clomiphene citrate should be the treatment of first choice for anovulatory patients. Rates of conception per cycle when clomiphene citrate is given are half those when human menopausal gonadotrophin is given, but the incidence of twin pregnancy is also halved and the incidences of triplet and higher order pregnancies are much lower.[3] Secondly, multiple pregnancy resulting from treatment with human menopausal gonadotrophin may be prevented, despite the development of multiple follicles, by gamete intrafallopian transfer, with the number of oocytes returned to the fallopian tubes limited to two or three, and by in vitro fertilisation, with a similar limit on the number of embryos transferred.

Although advanced technologies are expensive, their cost would be saved many times over because they save the high cost of caring for mothers and multiple low birthweight babies in hospital.

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A chance for those who can't pay for IVF

EDITOR,—Margaret Dolley's article on infertility treatment in Denmark raises several issues.[1] One of the main ones is that in Denmark, as in Britain, in vitro fertilisation is a licensed procedure whereas hormone treatment for infertility is unregulated. The debate in Denmark arose because a high order multiple pregnancy resulted after a woman attending a private fertility clinic was given gonadotrophins. This case occurred not long after sextuplets were born to a woman in Leeds after infertility treatment; that resulted in a similar clamour in Britain.

We do not think that the use of gonadotrophins for treatment other than in vitro fertilisation requires regulation. Facilities for treament in the public sector in Britain are woefully inadequate. Government funding for infertility treatment is almost non-existent. As a consequence, such treatment is available mainly to those who can pay for it. This is unsatisfactory. The controversy over regulation of gonadotrophin treatment needs urgent examination. Many of those who cannot pay for in vitro fertilisation are consigned to long periods of expectant management and hopelessness. We believe that gonadotrophin treatment under the auspices of the NHS is an important aspect of proactive management by infertility specialists.[2] The imposition of regulation would imose a burden of cost that would further restrict access to treatment (the Human Fertilisation and Embryology Authority, which licenses about 15 000 cycles of in vitro fertilisation a year, imposes a £30 licence fee per cycle).

In summary, gonadotrophin treatment is important for many patients, and regulation would impose further restraints on already limited access to NHS resources. Clear guidelines, such as those outlined in a book recently published by the Royal College of Obstetricians and Gynaecologists,[3] should be widely disseminated and adhered to. Under these circumstances, access to NHS fertility treatment with gonadotrophins will be maintained.

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Thyroid function in elderly people

EDITOR,—Peter Roe and colleagues outlined a practical approach to managing thyroid disease in elderly people.[1] We were concerned, however, by the subsequent letter recommending the use of the thyrotrophin releasing hormone test as a discriminator in patients with a raised thyroid stimulating hormone concentration and positive for autoantibodies.[2]

Three points need clarification. Firstly, there are few occasions when the ultrasensitive assay of thyroid stimulating hormone fails to diagnose hypothyroidism.[3] Tunbridge *et al* reported that patients who both have a mildly raised thyroid stimulating hormone concentration and are positive for autoantibodies have an annual risk of developing hypothyroidism of 5% and should be treated with thyroxine whereas those with only one of these two factors have no such risk.[4] Finally, thyrotrophin releasing hormone is a vasoactive chemical; side effects are usually mild and include nausea, flushing, and a desire to micturate. Rarely, pituitary apoplexy has been reported,[3] although to our knowledge only in people with pituitary tumours.

The thyrotrophin releasing hormone test should be used judiciously, particularly in frail elderly people. It continues to have a useful role in the evaluation of the hypothalamic-pituitary axis.

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Psychiatric consequences of road traffic accidents

Consider somatoform pain disorder

EDITOR,—Richard Mayou and colleagues found that almost a quarter of their sample of victims of road traffic accidents had long term psychiatric problems at one year follow up.[1] We recently studied a consecutive series of people referred by solicitors for psychiatric assessment because of civil litigation claims. Fifty six of these people were victims of road traffic accidents that did not result in a concussive head injury.

We found a similar range of psychiatric disorders in our series to that found by the authors; it included post-traumatic stress disorder (18 cases), anxiety disorder (10), phobic travel anxiety (6), mood disorder (4), and adjustment disorder (3). In addition, however, 15 people had disorders characterised by preoccupation with pain in the absence of adequate physical findings to account for its duration or intensity. The recommended diagnostic term for such cases is somatoform pain disorder.[2] The mean time from the accident to the psychiatric report was 2·7 (range 1·3-7·0) years. The main site of pain was the back (9), knee (4), shoulder (1), and hip (1). Most of the people had been sent home after treatment in an accident and emergency department, only two having required inpatient treatment. None had suffered fractures.

People with somatoform pain disorder are often described as having "compensation neurosis" despite compelling evidence that similar symptoms occur after traumatic injuries in patients who are not pursuing claims for compensation[3] and that symptomatic improvement rarely occurs after settlement of a claim.[4]

Only three of the 15 people who had somatoform pain disorder had previously been treated by their general practitioners for psychiatric problems. One third were described by informants as having obsessional personality traits. Five were subsequently treated with antidepressants by their general practitioners (including both of those who had previously been treated for depression and two of those who had obsessional traits).

Mayou and colleagues' criterion for including patients in their study (that they had multiple injuries or whiplash injury) was not fulfilled by any of our subjects with somatoform pain disorder. Many patients with relatively minor physical injuries would probably have to be screened for a substantial number of cases of somatoform pain disorder to be picked up prospectively. Nevertheless, we argue that somatoform pain disorder is an important psychiatric consequence of road traffic accidents and merits further research.

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Children may be seriously affected

EDITOR,—Richard Mayou and colleagues highlight the hitherto underestimated psychiatric morbidity among adult victims of road traffic accidents.[1] We suggest that such morbidity is also important in children.

Post-traumatic stress reactions have been estimated to occur in 30-50% of children exposed to psychic trauma,[2] and even children as young as 2½ may be affected.[3] Although symptoms may be modified by a child's cognitive and developmental level, reported behavioural or emotional symptoms or observed play suggest that the child is re-experiencing the trauma, showing avoidance behaviour or increased autonomic arousal in keeping with the definition of post-traumatic stress disorder in the *International Classification of Diseases* (10th revision).[4] Because of the relative lack of awareness about post-traumatic reactions in children we suspect that some morbidity goes unrecognised.

In our clinical practice over the past six months we have seen three children (aged 4, 11, and 13) suffering psychological sequelae of road traffic accidents. Their symptoms included nightmares in which the accident was relived, separation anxiety,