LETTERS

Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing*. Failure to comply with this may lead to delay in publication.

Intrauterine contraceptive device and embryo sharing a bicornuate uterus: case report

Sir,

A bicornuate uterus is an anatomical anomaly of the female genital tract, with a reported prevalence in the fertile population of 1.0–1.5%.[1] Although its presence may often go undetected, various gynaecological symptoms and sequelae have, however, been frequently ascribed to it. Spontaneous abortion, especially after the third month of pregnancy, is a well-established complication of the condition.[2] We would like to report a case of a patient in whom an embryo developed in one horn of a previously undiagnosed bicornuate uterus while the other horn contained an intrauterine contraceptive device.

After the re-establishment of regular menses following the birth of her second child, a 26 year old woman of Moroccan origin had an intrauterine contraceptive device inserted. Several months later she presented to her family doctor with a two week delay in menstruation. A subsequent blood test for pregnancy was positive and the patient requested a termination on grounds permitted by Israeli law.

Before termination was undertaken, an ultrasound scan was performed. This showed a previously unknown bicornuate uterus of a size compatible with seven weeks of pregnancy. The pregnancy sac was demonstrated in the left horn of the uterus and the intrauterine contraceptive device in the right horn (Figure 1).

A few days later, the patient underwent uterine dilatation and vacuum curettage and the intrauterine contraceptive device was removed; the diagnosis of a bicornuate uterus was verified.

Although an unplanned pregnancy may occur in as many as 2–10% of normal uteri which also have an intrauterine contraceptive device in situ[3] the coexistence of an embryo in one horn of a bicornuate uterus along with an intrauterine contraceptive device in the other has rarely been documented.[4,5]

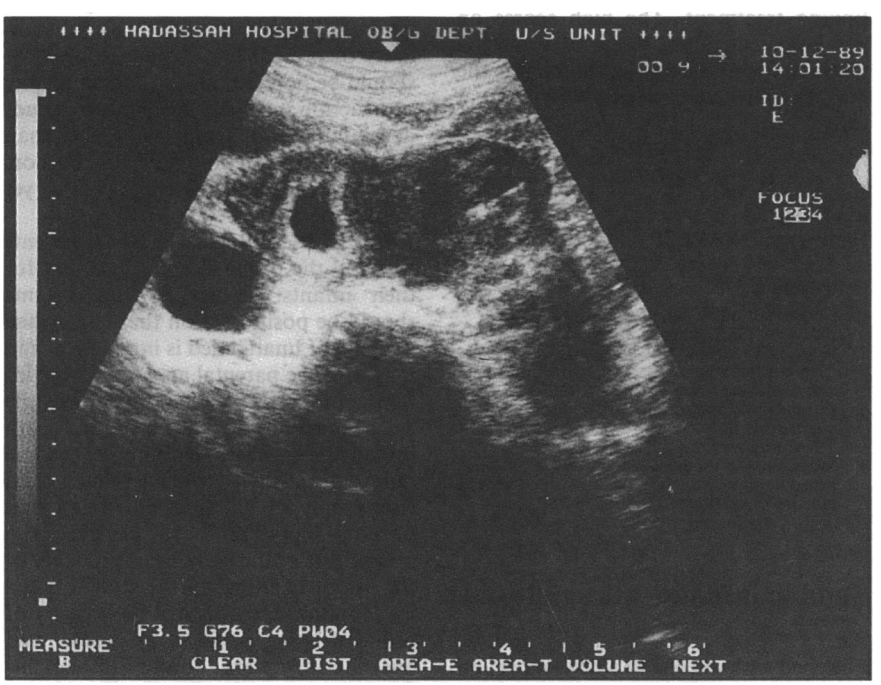

Figure 1. *Ultrasound scan of bicornuate uterus showing intrauterine contraceptive device on the right and pregnancy sac and corpus luteum on the left.*

Pregnancy in an anatomically conventional uterus containing an intrauterine contraceptive device is more often ectopic, culminates more frequently in a spontaneous or septic abortion, and is more commonly associated with premature delivery (if the intrauterine contraceptive device is not removed) compared with the normal situation.[6] Since the chances of implantation in association with an intrauterine contraceptive device are greater when the uterus is malformed this is a major reason why intrauterine contraceptive device insertion is generally contraindicated when the uterine cavity is known to be distorted.[6,7] Knowledge of such a situation is therefore of importance prior to insertion being undertaken.

This case demonstrates that a bicornuate uterus should be considered as an uncommon cause of intrauterine contraceptive device failure. Unfortunately ultrasound scanning may not yet be the best method available for initially detecting its presence, or that of other uterine malformations.[8] In time, however, improvement in ultrasound resolution techniques will perhaps increase its diagnostic accuracy. In the meantime, we suggest that doctors who insert intrauterine contraceptive devices retain the use of the uterine ultrasound for excluding a diagnosis of bicornuate uterus and other uterine abnormalities prior to carrying out the procedure; another method of contraception should be recommended should the presence of abnormalities be discovered.

ARTHUR FURST
HAVA HARATS

Department of Family Medicine
The Hebrew University-Hadassah Medical School
PO Box 1172
91010 Jerusalem
Israel

SHLOMO MOR-YOSEF
Department of Obstetrics and Gynaecology
Hadassah University Hospital
Jerusalem
Israel

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Patients who have discontinued long-term benzodiazepine treatment

Sir,

I would like to report the findings of a study of patients in one practice who discontinued long term use of benzodiazepines over a two year period between June 1988 and June 1990. At the time of the study the practice had four partners and 8900 patients, with an age–sex and social class distribution similar to the national average (15% over 65 years of age and 6% under five years).

All patients who received regular prescriptions for benzodiazepines for over one year were identified retrospectively from existing computer generated lists prepared in June 1988 and with a manual check of prescriptions. From an initial list of 208 patients (2.3% of the practice), 181 (87.0%) were still registered with the practice at the end of the two year period. The practice partners had adopted the Committee on Safety of Medicines' advice on benzodiazepine use of January 1988[1] tailored to each patient individually. Of the 181 patients 41 had discontinued benzodiazepine treatment. This group of patients were compared with a randomly selected control group of 41 patients who had continued treatment.

The median age of the group of ex-users was significantly less than that of the user group (59.4 years versus 69.0 years, Mann-Whitney U test, $P<0.01$). The benzodiazepine taken by the ex-users was significantly more likely to have been for anxiolytic than hypnotic use (67% of benzodiazepines versus 38%, chi square test, $P<0.01$), despite there being no significant difference in the length of time each group had received treatment (ex-users 84 months, users 62 months) or the approximate average dose consumed (equivalent to 11 mg diazepam daily). The consultation rates of the ex-user group did not alter significantly in the two years before and after discontinuing treatment (6.0 and 5.7 per patient per year, respectively) and both groups had similar rates (in two years preceding interview rates for ex-users and users 6.7 and 6.1 per patient per year, respectively). The practice consultation rate remained stable over this time.

Nineteen of the 37 ex-users who agreed to be interviewed (51%) reported no adverse effects when withdrawing from treatment. For the 20 patients who did report distress, the median duration of symptoms was five months. Ex-users continued to use what they perceived as a substitute for the benzodiazepine in 10 cases (24%). The 28-item general health questionnaire and the hospital anxiety and depression scale were administered to the 37 ex-users and 32 users. Among the ex-users 38% scored as 'cases' on the general health questionnaire (score of five or more) despite discontinuing benzodiazepines; among the users 47% scored as 'cases'.

Of the original cohort remaining with the practice 23% of long term users of benzodiazepines had discontinued treatment with no overall change in consulting rates confirming the potential for reductions in benzodiazepine consumption found in other studies.[2-4] The experience in this practice suggests that younger patients on anxiolytic therapy were more likely to discontinue treatment. This may represent both doctor and patient expectations but elderly patients are still at risk from the effects of long term tranquillizers and may require greater help at discontinuing treatment. The high scores on psychological rating scales of some patients in the ex-user group highlights the need to follow up each ex-user with great care.

C J PACKHAM

16 Stocks Road
Kimberley
Nottingham NG16 2QF

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Sudden infant death syndrome

Sir,

I listened with interest to a news report on the recommendations to prevent the occurrence of sudden infant death syndrome, and in particular, to the positioning of the baby. It was suggested that the baby should be placed supine in the cot.

In their letter (October *Journal,* p.431) Drs Moulton and Brown suggest that the most likely aetiology for sudden infant death syndrome is laryngospasm causing upper airways obstruction, precipitated by reflux of inflammatory secretions. They go on to suggest that prone positioning is not recommended, but that side positioning is a safe alternative. Why prone positioning is not recommended is not made clear, although self-suffocation may be a possibility (Marrian VJ, personal communication). However, common sense would point to supine positioning being more likely to cause reflux and inadequate clearing of secretions in the upper respiratory tract.

With anxious mothers seeking advice daily on sudden infant death syndrome, I feel ill-prepared to answer their questions adequately, especially in the light of conflicting official and academic recommendations. I wonder if any readers will be able to provide further suggestions on what is, and what is not, correct?

ANTONI NACZK

15 Almondgrove
Huntingtowerfield
Perthshire PH1 3EE

Sir,

I read with interest the letter by Moulton and Brown (October *Journal,* p.431) on sudden infant death syndrome and wish to comment on the advice given to parents. The authors give a useful summary of present knowledge. However, it should be pointed out that upper airway obstruction is a likely mechanism of sudden infant death syndrome[1] rather than the most likely aetiology; as the authors rightly point out, the aetiology is as yet unproven.

It would seem logical to advise parents to avoid the prone sleeping position for their infants. To specify that infants should be positioned on their side when sleeping or unattended is impractical and may increase parental anxiety. As the infant approaches three months of age, the age of maximum risk from sudden death infant, the child is beginning to become more active. Advice to ensure that a child sleeps only on its side will mean that parents may tend to restrict the movements of the baby, most probably by the use of bedding. In the study quoted by Moulton and Brown,[2] the factors of prone sleeping position of infants and overheating were found to be independently associated with sudden infant death syndrome, so by attempting to avoid