limited morbidity registers for the purposes of audit, indeed it has made this an acceptable audit project for the first year or two of audit, and has provided finance accordingly. It is suggested by the Isle of Wight medical audit advisory group that the following conditions should be included in a morbidity register: hypertension, ischaemic heart disease, asthma, chronic obstructive airways disease, gastric and duodenal ulcer, migraine, epilepsy, parkinsons disease, cerebrovascular accident, non-insulin dependent diabetes, hypothyroidism, hyperthyroidism, gout, rheumatoid arthritis and osteoarthritis.

A limited register of this size should not be difficult to compile or keep up to date. Conditions that are mostly monitored in hospital clinics, such as insulin dependent diabetes, are purposely omitted from the recommended list. Of course, practices will expand this list for their own purposes, but no practice however small or understaffed should have difficulty maintaining such a morbidity register, and it will provide audit projects for many years to come.

Another use of such a register is as an indicator of resource needs. If each practice in a district or region kept a morbidity register of the common conditions listed above, it would not be difficult to establish resource needs for that area, and these are conditions which need resources, as opposed to most acute conditions.

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Intermittent self catheterization

Sir,

After our paper on intermittent self catheterization appeared in the *Journal*[1] we received correspondence from a retired general practitioner who stated that we should not hesitate to quote from his letter.

'Referring to your article I thought you might care to hear of my experiences, and benefits which have resulted therefrom. I am 87 years of age. Briefly my history is as follows: 1987 prostatectomy for chronic retention. Failed to regain control. Videocystogram showed a scar on the bladder neck. Further surgery in 1988... Thereafter incontinence at night. Cystoscopy showed no abnormality. Repeat urodynamics showed incomplete emptying of the bladder, but no advice or action from the hospital consultant.

On reading your article in the *British Journal of General Practice* I asked our GP to do something. I had a visit from a lady continence adviser. She advised self catheterization and supplied advice and equipment. This I was able to carry out morning and bedtime without any difficulty. The result was usually about 300 ml [of urine]. I have been on self catheterization for three months now. Nights are now dry which is a great improvement on having to change pyjamas and bedding most nights. I can now go to bed with prospects of a decent sleep. So all I can say is many thanks.'

General practitioners might consider whether any of their patients with urinary incontinence associated with atonic or neuropathic urinary retention might similarly be helped by learning intermittent self catheterization.

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Long term use of IUCDs

Sir,

I read with interest the paper from Israel by Dafni and colleagues (October *Journal,* p.423) as I am at present looking into the use of intrauterine contraceptive devices in general practice in the United Kingdom.

The authors of the paper appeared to be advocating the continued use of inert devices for indefinite periods. I am not sure of the position in Israel, but inert devices are no longer available in the UK, and in our practice the last one was inserted six years ago. Copper devices achieved popularity because in the early years after insertion they gave lower pregnancy rates than the inert devices.[1,2] In the women reported on in the study in Israel, the devices had all been present for five years or more. At this point one would have hoped that problems would have lessened. However, a third of the women had to have the device removed for intolerable side effects and a further third had the device removed for a variety of reasons including intrauterine pregnancy, menopause, patient request and for exchange. Again, this seems a high figure.

No copper device is licensed for use for more than eight years[3] so a direct comparison between inert and copper devices would be difficult. Many of the copper devices have been around for 15 years and many women will have used a succession of such devices, only breaking for the change of device advised by the manufacturers.

Dafni and colleagues also discuss the low rate of pelvic infammatory disease in their subjects. However, they did not look for actinomycoses. They also stated that they did not carry out cervical smears as there is a low rate of cervical cancer in Israel. Is the rate of pelvic inflammatory disease also low?

Although this is an interesting study I am not sure that the authors' conclusions can be justified. It would seem that the copper devices are here to stay and are being continually improved. It is to be questioned whether it is really time that inert intrauterine contraceptive devices were reintroduced.

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Effect of dietary advice on cholesterol levels

Sir,

Robertson and colleagues seem to be disappointed at the small overall effect of the dietary advice given to patients submitting to health checks in their survey of Buckinghamshire general practices (November *Journal,* p.469). But are they justified in expecting a greater change?

They give no details of the dietary advice given to patients by nurses but it may well have been in line with that advocated by the Committee on Medical Aspects of Food Policy (COMA), that is, total fat to