This is how many mothers cope with the situation, especially those who fear that social workers will remove their babies, as many do. They conceal their drug-taking throughout pregnancy, probably with husband or boyfriend smuggling drugs into the lying-in ward. As a profession we should feel ashamed that mothers have so little confidence in us and so much fear. The lack of confidence comes partly from the fact that the addict knows immediately if the doctor is ignorant about drug use, and many doctors are. The fear comes from the press, the attitude of so many professional carers, and the fact that many babies *have* been taken away in the past.

An important subject omitted by Dr Riley is injection. Almost everyone who is heavily addicted to opiates injects. Giving up injecting is as difficult as giving up the drugs themselves, whether in pregnancy or otherwise. What does the caring doctor do about that? Many of the 'good girls' apparently reducing on their daily dose of liquid oral methadone are in fact injecting on the side, often in 'secret' sites. Urine tests will not reveal this unless they inject a different drug, in which case they are probably clever enough to fake the urine test, which is usually easy to do. An addict patient of mine described her care during pregnancy under a doctor at a London teaching hospital. She said, "Dr X is a lovely doctor, ever so sympathetic. The only trouble is that if she looks after you, you have to get your drugs from the black market, and I always felt that couldn't be good for the baby."

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DEAR SIRS

Dr Riley's paper (*Bulletin*, November 1987, **11**, 362–365) was read with interest. In the United States there appears to be a policy of methadone maintenance throughout the confinement.[1] Others have suggested treatments varying according to the trimester with stabilising on methadone during the first and then gradual reduction during the second.[2] If the patient presents as late as the third trimester there is a significant risk that withdrawal of opiates may lead to premature labour, foetal distress, meconium aspiration and foetal death should the mother experience withdrawal symptoms.[1,2,3,4]

In an effort to prevent this development it is suggested that the mother is maintained on the minimum amount of opiates necessary during this final stage. The risk with this approach, however, is that the new-born infant may experience a withdrawal syndrome characterised by vomiting or diarrhoea, hyperpyrexia, irritability, tremors, inability to sleep between feeds and convulsions.[3] This syndrome occurs more frequently and is more severe and protracted in babies born to mothers dependent upon methadone as opposed to heroin, the seizure rate for the former group being five times that of the latter.[3] Consequently we suggest that a case can be made for prescribing heroin to the pregnant drug addict who presents for the first time in the final trimester.

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Dr Riley replies:

DEAR SIRS

Drs Thomas and Osborn are correct in stating that the available evidence shows more prolonged and severe withdrawal effects in infants whose mothers are maintained on methadone as opposed to heroin. However, these effects can be mitigated by good neonatal care, and the advantages of using oral methadone are considerable. Our policy has been to maintain patients in the community once the initial assessment has been completed, and it might be considered unwise to increase the supply of injectable heroin and syringes on the drug scene at large by prescribing them for out-patients.

Dr Dally's patients are clearly a very different group from those generally seen at UCH. Those who can afford private consultation and prescription fees are certainly more wealthy and probably more stable than our patients who are often homeless, living on Supplementary Benefit, usually with a criminal record, and with little community support. However, a few patients who have been maintained on a steady dose of methadone for many years have presented for treatment, and even these women have been willing to reduce the dose in pregnancy to minimise the withdrawal effects in their babies. This willingness is perhaps a measure of their attachment to the pregnancy, and of the time spent by medical and nursing staff in careful explanation.

Dr Dally totally overlooks the fact that we are responsible for the treatment of two patients: the foetus as well as the mother. Severe withdrawal symptoms in the infants may include *grand mal* convulsions: a terrible price to pay for the mother's right to continue a high dosage of opiates. The case she reports gives no details of the opiate dosage or

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