An "excellent" result indicated that objective daily examination of the breasts until the seventh day, and again three weeks later, revealed that they had never been other than soft and had not leaked at all. In addition, the mother had subjectively felt that both breasts had been completely comfortable throughout.

A fair result implied that there had been mild engorgement or slight leakage, or slight discomfort on one day only throughout this four-week period.

A "poor" result implied that two of the above three factors had been present on one day, or that one of the above factors had been present on any two days.

A "fail" result was registered if on any one occasion there had been severe engorgement or considerable leakage or painful breasts, or that suppression had been required either during the week in hospital, or during the subsequent three weeks.

As quinestrol is stored in fat and then slowly released, it might be expected that the fatter the patient the higher would be the failure rate. This is indicated by an analysis of the heights and weights of the patients in the "excellent" and "fail" groups of those given quinestrol.

Result	Number of Patients	Mean Height (in.)	Mean Weight (lb.)	Standard Deviations of Weight (lb.)
Excellent	17	62	128	17·3
Fail ..	25	63	140	18·5

There was no significant difference between the mean heights of the groups.
Student's t test (with Bessel correction) was applied to the mean weights of the two groups, and the difference was significant at the 5% level ($P = 0.05$, "t" = 2.1, d.f. = 40).

I found conclusively that some form of suppression of the initiation of lactation was required if the patient was to be saved undue discomfort. This is contrary to the report of MacDonald and O'Driscoll,[1] but the trials are not comparable, as in theirs the maximum length of follow-up was five days, and neither objective evidence of engorgement or secretion nor subjective degree of discomfort of the breasts was assessed. As some advocate fluid restriction[2] and some fluid overloading with 2 to 5 litres per day,[3,4] I must point out that in the present trial the patients were allowed to drink what they wanted.

It will be seen that the above criteria for success or failure of the trial could hardly be more strict, yet my results using the 2-mg. dose (34% no trouble whatsoever, 50% requiring further suppression) were much better than those of Mr. P. N. Gillibrand and Professor P. J. Huntingford (21 December, p. 769). They combined the results of eight patients given the 2-mg. dose with those of 19 patients given the 4-mg. dose. Twenty-one out of the 27 cases (78%) required further suppression of lactation. Although I have no doubt that they assessed their patients most carefully, it is obvious that the discrepancy cannot be vaguely accounted for by my observer error whereby clinical signs were ignored or not observed owing to inadequate frequency or length of follow-up In the same way, the much better results using quinestrol reported by both Barbour[5] and Kuku[6] cannot be explained by observer error on their part, as the follow-up was equally thorough in these trials. No satisfactory explanation could be given for these marked discrepancies between the results at the colloquium in 1966, and in my opinion none has been given since.

The 2-mg. dose of quinestrol clearly inhibited the initiation of lactation in 34 to 50% of patients. Although too low a success rate for clinical acceptance, the better results in the patients with lower mean weights held out hope that with higher dosage the success rate would improve. This appears to be confirmed by more recent trials.—I am, etc.,

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SIR,—Further to Mr. S. J. Steele's letter (30 November, p. 578) regarding oestrogen inhibition of lactation, I have just completed a small series with this same point in mind. Large doses of stilboestrol for inhibition of lactation had been recommended to me during my formative years, and I wondered whether I was justified in continuing with this treatment. The dose involved is 10 mg. stilboestrol four times a day for four days, 5 mg. four times a day for four days, and 5 mg. twice a day for two days.

In a double-blind trial with stilboestrol and a placebo tablet, 88 mothers who did not wish to breast feed received these tablets at random in the dosage as above; 45 received the placebo; 43 stilboestrol. Each patient was asked daily—twice daily on the second, third, and fourth days—to describe her breasts as "comfortable," "uncomfortable," or "painful," and she was examined to determine whether they were "soft," "tense or patchy tense," or "uniformly very tense." By allocating one adverse point to "uncomfortable" symptoms and "tense" signs, and two adverse points to "painful" and "uniformly very tense" the following figures came out of this series: Symptoms: 14 adverse points were allocated to six of the 43 patients taking stilboestrol whereas 82 were allocated to 27 out of the 45 placebo takers. Signs: Four and 68 points respectively.

The incidence of the uncomfortable leaking of milk was noted. Thirty-nine patients taking the placebo complained of this against 13 taking stilboestrol. I traced eight patients having had the stilboestrol course who needed further treatment for engorged breasts after leaving hospital, as against three who took the placebo.

On the dosage outlined, I would suggest that stilboestrol plainly is effective in suppressing lactation, but that there is a distinct rebound phenomenon. And, of course, as noted by Dr. Steele, there are the worrying thoughts of thromboembolism. There must be a better way of producing symptom-free inhibition of lactation. Preferably a swing away from the present anti-breast-feeding trend.

I am very grateful to the matron and staff of the Bolitho Maternity Home, Penzance, and to Mr. Miller, West Cornwall Hospital, Penzance, for their help.

—I am, etc.,

ROBERT E. SENIOR.

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Scabies in Negroes

SIR,—I can bear out the impression of Dr. F. A. Ive (14 December, p. 706) that scabies may be rare in patients of Negro origin in this country. During six and a half years of clinics in the Hackney E.9 area of London I saw a great deal of scabies. The area is one which has a large immigrant population, mostly from the West Indies. During that time I saw scabies only once in immigrants; this was in a family of West Indians.—I am, etc.,

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SIR,—I was interested to read Dr. F. A. Ive's letter (14 December, p. 706) in which he points out that during the present scabies epidemic he did not find a single case of scabies in patients of Negro origin. In my eight years of dermatological experience in Britain, at the three big industrial towns where there is a considerable coloured immigrant population, I hardly remember seeing scabies in a coloured immigrant patient, in spite of sometimes substandard living conditions, overcrowding, etc.

I wondered whether it was just a question of personal cleanliness or does Mrs. Acarus show host preference?—I am, etc.,

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Vulval Pruritus

SIR,—I am sure that Dr. M. J. V. Bull (11 January, p. 120) has correctly interpreted Dr. L. Tann's (21 December, p. 776) observations, and that the most likely cause of his patients' vulval pruritus is candidiasis associated with the use of the contraceptive pill.

This prompts me to make some further observations on this matter, as in my experience vulvo-vaginitis due to *Candida albicans* is now the commonest cause of a vaginal discharge in women using oral contraceptives. I would agree wholeheartedly with his remark that "the full clinical picture of vaginal candidiasis is not always apparent." In a majority of cases the classical picture of irritation with thick, curdy white secretion is entirely lacking, the patients complaining only of vaginal discharge. This discharge is often copious, frankly purulent, and without any special characteristics. The fungus is often difficult to find in stained smears, a prolonged search being necessary to find an occasional spore or mycelial element. Culture is the most effective means of diagnosis, but even here several specimens may have to be examined before a positive result is obtained.

In these patients cure is often difficult to obtain, and attention should be paid to preventing reinfection from the intestinal reservoir by giving a course of oral nystatin. In a not inconsiderable number it may be necessary for the patients to stop using the pill for some months. The possible co-existence of sexually transmitted disease