and cutaneous anergy to DNCB[12-15] in a substantial proportion of patients with inflammatory bowel disease, Crohn's disease, and ulcerative colitis alike. We have also noted that in ulcerative colitis the anergy appears to reverse after colectomy, whereas in Crohn's disease it persists despite surgical resection.[14 15]

These facts should help provide a clear and definitive answer to your rhetorical "fact or fiction" question. The establishment of anergy as a feature of Crohn's disease may not be a "breakthrough," but it certainly is a fact.

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Contraceptive information and promiscuity

SIR,—With reference to the commendable attempt by Dr Max Elstein and others at a "self audit" from within the profession of the sexual knowledge and attitudes of general practitioners (5 February, p 369) we question whether in fact the statement that "the possession of contraceptives information is often an incitement to promiscuity" can so readily be consigned to the category of myth as the authors assume. The statement, of course, defies absolute proof either way. Nevertheless, it does appear that there is enough considered opinion and related statistics to suggest that the generalised and widespread increase in contraceptive information has accompanied an increase in the results of promiscuity. Whereas contraceptive practice has reduced the fertility of married women among all age groups, it has had no definable effect on the number of illegitimate births to women under the age of 20, while during the same period premarital conception has declined.[1] Cases of venereal diseases (treated in clinics) have increased from 80 000 in 1949 to 282 000 in 1973.[2] Further, despite the increase in sex education in schools, the number of abortions among girls of 18 and under has increased by over 90% from 11 311 in 1970 to 21 764 in 1975.[3] The report on "Unplanned Pregnancy" by the Royal College of Obstetricians and Gynaecologists[4] states:

"Practically nothing is known about the effects of sex education programmes, either in regard to the future health and happiness of the individual children or in relation to unplanned pregnancy. It was suggested that wrongly orientated sex education could be having a result which was the exact opposite of what it was desired to achieve, in that it was arousing curiosity and the desire to experiment. The rapidly rising incidence of unplanned pregnancies in the young age-groups gives some support of this idea."

Then again, in a recent leading article (4 September 1976, p 545) you observed that discussion in schools on contraceptive methods carries the implication of the children being expected to be sexually active. Advice was then given that knowledge of contraceptive methods needs to be strongly supported by moral persuasion to discourage sexual indulgence even in the light of knowing how to prevent the immediate complications of such irresponsibility. Indeed, it would appear that the most reliable method of contraception misses the attention of many who give sex education. This method, for which there is ample support in terms of evidence, reason, and technique, is simply—"No!"

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D-Penicillamine and obliterative bronchiolitis

SIR,—We were interested in Dr D A Brewerton's letter (18 December, p 1507) on obliterative bronchiolitis in adult patients treated with D-penicillamine. We thought that we might be able to contribute to the "extensive inquiries . . . being conducted throughout Britain and elsewhere to learn whether there have been other examples of obliterative bronchiolitis in patients treated with D-penicillamine."

During the outbreak of methylmercury poisoning in Iraq in the winter of 1971-2[1] we gave short and sometimes repeated courses of D-penicillamine and *N*-acetyl-DL-penicillamine as mercury-binding agents to 12 and 7 patients respectively. Their ages ranged between 2 and 48 years and the daily dose from 30 to 60 mg/kg body weight. Each course lasted either 15 or 30 days. Some patients had two or three courses with an interval of two weeks in between. Our patients were closely observed daily for any manifestation that might be attributable to the medication. None of them developed the clinical syndrome of obliterative bronchiolitis.

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[1] *British Medical Journal*, 1972, **2**, 605.

Missing tails

SIR,—We read with interest Mr John Frampton's letter (12 February, p 445) and note that he is advocating not one but two radiographs in addition to uterine sounds in order to locate an intrauterine contraceptive device (IUCD). As he rightly indicates, there are three questions to be answered in a patient with "missing tails" and a radiograph will answer only one of these.

It is our practice to employ diagnostic ultrasound on these patients. Our results suggest that this procedure invariably demonstrates the IUCD if it is within the uterine cavity and will correctly diagnose pregnancy within four weeks of conception. Ultrasound is also very quick, hazard-free, and much less expensive than the procedure advocated by Mr Frampton, and is surely to be preferred. In a recent case, we correctly located an IUCD which had been shown by radiography to lie in the right iliac fossa. Ultrasound revealed a pelvic mass (and correctly suggested a diagnosis of lymphoma) and demonstrated a normally placed IUCD in the cavity of a displaced uterus.

It is our opinion that with the current availability of ultrasound in some 300 centres in Britain radiography is not indicated for patients with this clinical problem.

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SIR,—I agree with Mr J Frampton (12 February, p 445) that the common causes of disappearance of the thread of an intrauterine contraceptive device (IUCD) are too short a length of the thread, occurrence of an intrauterine pregnancy, expulsion or extrauterine position of the IUCD, and occasionally detachment of the thread during attempted removal of the device. I wish to suggest some alternatives to the methods of management described in such excellent detail by the author.

Provided that a coexistent pregnancy can be ruled out a lateral *x*-ray of the pelvis is taken. If the IUCD is not seen in the lateral film, only then is a posteroanterior view of the abdomen (including the upper abdomen) requested. If the device appears to be above the pelvic brim it is visualised and removed through the laparoscope. Only occasionally is a laparotomy necessary for this purpose, especially if the device is embedded in the omentum or other organs.

If the lateral *x*-ray of the pelvis shows the IUCD to be below the pelvic brim this usually indicates an intrauterine position of the device. Presumably an IUCD that is outside the uterus tends to settle high in the abdominal cavity rather than remain within the pouch of Douglas. I cannot agree with Mr Frampton that "no further action need be taken" when the device is thought to be intrauterine. Disappearance of the thread denotes absence of a clinical sign indicative of the correct placement of the device—a sign that can be demonstrated by the patient or the medical attendant. There is the possibility of subsequent expulsion or, rarely, of extrauterine placement of the device, which may have medicolegal implications. Among patients I have examined weeks after alleged disappearance of the thread reported by a general practitioner or family planning doctor I have so far not encountered any instance of "reappearance of the thread" suggested by Mr Frampton.

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SIR,—Mr John Frampton asked questions relating to the location of "lost" intrauterine contraceptive devices (IUCDs) (12 February, p 445). While agreeing with the points made,