develop after vasectomy, and also a glycoprotein contained in the seminal plasma has also been shown to have been an antigen responsible for urticaria in a female partner.

Until now I have not sought information after vasectomy in the male patients with chronic urticaria, and the purpose of this letter is to draw attention to the possible association, and find out if it has already been noted by any of your readers.

ROBERT P WARIN

Bristol

Sexually induced headaches

SIR,—I recently saw a 32-year-old man with a severe form of the type 2, sexually induced headaches described by Lance.[1] His headaches begin occipitally explosively as he reaches orgasm, radiating then to the rest of his head. In view of the proposed vascular nature of this problem I first tried my patient on clonidine (and diazepam) without success, but am happy to report that propranol 20 mg bd has completely abolished his symptoms.

It would seem that this admittedly uncommon syndrome may respond to β-blockade, and that this is yet another indication for this valuable group of drugs. I should add that the patient (and his wife) are considerably happier with this state of affairs than the total abstinence that was suggested to me as the only way to help their problem.

N R NUTT

Swindon

[1] Lance, J W, *Journal of Neurology, Neurosurgery and Psychiatry*, 1976, **39**, 1226.

Psychologically mediated abdominal pain

SIR,—Surely Dr Joan Gomez and Dr P Dally (4 June, p 1451) are not suggesting that 85% of patients referred with abdominal pain require psychiatric management of their symptoms. It is true that tension, depression, and stress may precipitate abdominal pain, but usually when a basic pathological state exists which is exacerbated by these specific causes. The irritable colon syndrome, for instance, is extremely common and the cause of a good deal of abdominal pain frequently precipitated by psychogenic factors. Nevertheless, in these patients a basic colonic motility disorder exists which will require treatment even though all the investigations may be unhelpful. It is possible that these patients are depressed and tense because of the recurrent abdominal pain and bowel symptoms from which they have suffered for many years.

I TAYLOR

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Management of the stove-in chest with paradoxical movement

SIR,—The leading article on the above subject (14 May, p 1242) very admirably described the most recent concepts in this difficult and problematic area. It is, however, unfortunate that the last paragraph should have commenced "Taxing as these cases are, they are few and far between. . . ." Few and far between they certainly are in accident departments, but not in mortuaries. Severe chest injury is one of the commonest reasons for death before transport to hospital.

A recent study[1] has shown that wearing a seat belt results in an 86% statistically significant reduction in life-threatening serious injuries, among which stove-in chest injuries would be included. Your leading article would have been an excellent occasion to have mentioned, as a final point, the value of seat belts in this context and possibly to have urged the profession further to advocate their use to patients. It is my belief that the distinctions between curative and preventive medicine have been sufficiently blurred in recent years to make this not inappropriate in a journal such as yours, which speaks to the whole profession.

C P DE FONSEKA

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Bath

[1] Transport and Road Research Laboratory, Leaflet LF 633, *Alleviation of injuries by use of seat belts*. January 1977.

Transient hypotension following intravenous ethamsylate (Dicynene)

SIR,—We are naturally concerned as a company to read the report by Dr L Langdon of a fall in blood pressure following intravenous injection of our product ethamsylate (Dicynene) (4 June, p 1472). Dr Langdon refers to slight transitory hypotension having been reported. This in fact refers to one case contained within the Committee on Safety of Medicines register of adverse reactions covering the period from January 1964 to October 1971. No other authenticated cases are included in our adverse reaction file. Internationally no confirmed reports of such occurrences have been received. During animal toxicity experiments the only species that showed hypotension was the cat at a dose in excess of 500 mg/kg. This again was of a transitory nature. I fail to follow the statement that the giving of slow intravenous injection is not facilitated by the use of the "theatre pack." Further investigation of this report will be carried out with Dr Langdon's permission and assistance.

B WATSON
Technical Manager,
Delandale Laboratories Limited

Canterbury

Peritoneal fibrosis

SIR,—In reply to Mr M A Morris's letter (21 May, p 1355) concerning adhesions following the use of noxytiolin, I should like to draw his attention to the results of many workers who have shown just the opposite.

Stoller[1] remarked how pleasing it was to find no adhesions when reoperating on patients who had recovered from faecal peritonitis following noxytiolin lavage. Since that time I have used noxytiolin for faecal peritonitis with similar results. Pickard[2] showed it was effective in detaching fibrinous plaques from the bowel wall. Any adhesions that did form in the study carried out by Cleaver *et al*[3] were few and flimsy and were significantly less than the controls. Last year also Gilmore and Reid[4] carried out a controlled trial to study the effect of noxytiolin on adhesion formation and showed that the total and the mean number of adhesions formed as well as the mean length of attachment were significantly reduced if noxytiolin peritoneal lavage was used. Finally, I presented at the Surgical Research Society earlier this year the results of an experiment in which we used topical noxytiolin prior to colonic anastomosis, and among other findings we discovered the formation of adhesions were inhibited, which bore out our clinical impressions.

R D ROSIN

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[1] Browne, M K, and Stoller, J L, *British Journal of Surgery*, 1970, **57**, 525.
[2] Pickard, R G, *British Journal of Surgery*, 1972, **59**, 642.
[3] Tolhurst-Cleaver, C L, Hopkins, A D, and Kee Kwong, K C, *British Journal of Surgery*, 1974, **61**, 601.
[4] Gilmore, O J A, and Reid, C, *British Journal of Surgery*, 1976, **63**, 978.

Tetracycline and toxoplasmosis

SIR,—The article by Dr A Fertig and others (23 April, p 1064) entitled "Tetracycline treatment in a food-borne outbreak of toxoplasmosis" is an example of the misleading literature which has appeared on toxoplasmosis.[1] The authors report what they interpreted as a case of acquired toxoplasmosis which they treated with oxytetracycline, yet the dosage is not stated. The antibiotic was used for a second course, but again no dosage was given. The authors state, "A final month's course of oxytetracycline and prednisolone was given." As corticosteroids may decrease lymph-node size and cause a sense of clinical well-being, it is impossible to attribute either clinical or symptomatic improvement in their patient to oxytetracycline.

The authors cite the study of Garin *et al*[2] as evidence that acute toxoplasmosis responds to tetracycline. Garin *et al* studied demethylchlortetracycline, not oxytetracycline, in their mouse model. There are no data to suggest that the different tetracyclines are equally efficacious. In fact Eyles and Coleman[3] point out, "tetracycline is inferior to chlortetracycline in activity against toxoplasmosis in the mouse model."

In the studies by Garin *et al* 200 mg/kg/day resulted in 60% survival. In other studies Eyles and Coleman found that the mean curative dosage of chlortetracycline and tetracycline in acute murine toxoplasmosis was approximately 1240 mg/kg/day and concluded that tetracyclines are probably of no practical value in acute toxoplasmosis.[3] Expression of dosage in mg/m^2, rather than mg/kg, has been suggested as a means of more realistically comparing doses in man and laboratory animals. (A formula for this purpose has been discussed by Freireich *et al*.[4]) For example, a dose of 2 g tetracycline/day (33·3 mg/kg/day in a 60-kg man), when corrected for dose/m^2 of body surface, corresponds to 410 mg/kg/day in a 20-g mouse. Although extrapolation of tetracycline efficacy in murine toxoplasmosis to acquired human toxoplasmosis may be hazardous, the corrected figures for dose/m^2 for the data of Garin *et al* suggest that this dose of demethylchlortetracycline might indeed be therapeutic in man. In contrast, from the data of Eyles and Coleman 6 g/day of a tetracycline might be required in man. Thus from the limited information and the one case provided in their article it would seem premature for Fertig *et al* to "suggest that an adequately long course of tetracycline should be considered." Although oxytetracycline may have been