symptoms in this group is judged by Nilsson and Almgren to be unlikely, though unfortunately they provide none of the evidence on which this judgement is based. In fact, looking at their own results we might be led to the opposite judgement. For their results show that the incidence of psychiatric symptoms tends to rise in both groups during pregnancy, and that the difference in the post-partum period results from the failure of the oral contraceptive group to return with the other group to the pre-pregnancy levels. The persistence of the high level in the oral contraceptive group suggests, if anything, a high incidence of psychiatric symptoms soon after delivery, when the method of contraception is decided upon and commenced. It seems just as likely that the choice of contraception is the result of the psychiatric symptoms rather than the cause. The actual nature, causal or otherwise, of the relation between contraception and psychiatric symptoms cannot therefore be determined by the method employed in this paper, and the introduction of hormonal factors is unwarranted at this stage.

We would also like to take this opportunity to point out the alacrity with which hormonal factors (usually unspecified) are brought out and used as an umbrella explanation for a wide array of differing psychiatric manifestations resulting from contraceptive agents.[1] Various sociological factors have been observed in relation to the use of contraceptives,[2 3] and these imply psychological attitudes. Pohlman[4] has emphasized the neglect of psychological factors in research on family planning, and has pointed out that their importance as both dependent and independent variables may be considerable. We are ourselves completing a study of antecedent factors in the family histories of family-planning clientele and their husbands.

It would seem unnecessary to plead the point that, whatever hormonal factors there are, they first of all arise within the framework of preceding psychological attitudes which have led to the choice of oral contraception, and, secondly, they operate in conjunction with the psychological attitudes resulting from the choice of oral contraception. Yet in the paper by Nilsson and Almgren this psychological background is unnecessarily excluded.—We are, etc.,

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Oestrogen Therapy and Migraine

SIR,—Migrainous types of headache frequently occur in women taking various oestrogen-progestogen preparations for contraception. Both women with or without previous history of migraine are susceptible (13 April, p. 99). These headaches are thought to be vascular in origin and are often associated with nausea, vomiting, vertigo, or visual disturbances.

Recently we have seen two postmenopausal women at the King County Hospital Pain Clinic who developed severe unilateral headaches after being placed on oestrogen (diethylstilboestrol) therapy. The onset of pain in each patient was related temporally to the initiation of medication, and the disappearance of pain followed promptly the cessation of hormonal treatment.

The first patient, a 60-year-old widow with osteoporosis, had had migraine headaches in her early 30's but no recurrence for over 20 years. She was presented to us as a case of occipital neuralgia. However, although she had marked hyperaesthesia over the distribution of the right greater occipital nerve, she described her pain as deep, continuous, bursting, and throbbing. It was associated with facial flushing and lacrimation but no visual or gastrointestinal symptoms. A neurological examination was not remarkable. A radiograph of the cervical spine showed only moderate osteoporosis. A cervical plexus nerve block abolished the pain but not the throbbing. When we discontinued her oestrogen therapy the headaches subsided and the hyperaesthesia disappeared completely in three days.

The second patient, a 51-year-old spinster with no previous history of migraine, was being evaluated and treated by us for lower back pain when her internist placed her on oestrogen. She developed a throbbing right parieto-occipital headache associated with weakness and nausea. When the hormone was discontinued her headaches stopped.

Whether the headaches in these two patients were caused by the same mechanisms as in women taking oral contraceptives is not known.—I am, etc.,

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Herpes Gestationis and the "Pill"

SIR,—I wish to report a case of herpes gestationis in a patient on oestrogen-progesterone oral contraceptives.

A female patient (para-2) aged 28 years developed an itchy polymorphic symmetrical grouped eruption on thighs, legs, arms, and chest on four separate occasions, consisting of bullae, principally with some erythema and small papules.

The initial attack was in July 1966, when she was placed on oestrogen for lactation suppression, disappearing when this therapy ceased. A second attack occurred in the last month of her second pregnancy in August 1967, going soon after parturition.

The third attack began a week after starting on an oestrogen–progesterone oral contraceptive in October 1967, ceasing only when tablets were stopped. Changing the brand to another oestrogen contraceptive produced her last attack.

When seen in February 1968 the diagnosis of erythema multiforme and dermatitis herpetiformis were considered, but the lesions were grouped, very itchy, absent on hands and feet, and no ringed lesions were seen, and a therapeutic trial of dapsone 100 mg. b.d. for dermatitis herpetiformis for a week had no effect. The only successful measure was to stop oral contraceptives.

In view of the paucity of reports (26 November 1966, p. 1324, 30 May 1964, p. 1425) of herpes gestationis on patients receiving oral contraceptives and the aetiology of this condition being sometimes attributed to hormonal imbalance, I thought it worth while to bring it to your attention.—I am, etc.,

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Paracervical Block with Bupivacaine

SIR,—I was interested to note that foetal bradycardia was not a complication in the 40 cases of paracervical block reported by Mr. D. H. Gudgeon (18 May, p. 403). My own experience is more in line with that of Mr. F. C. R. Picton's series (1 June, p. 561).

In a group of 150 patients 50 blocks were inserted using lignocaine 1%, 50 were inserted using lignocaine 1% with adrenaline 1:200,000, and 50 were inserted using bupivacaine 0.5% with adrenaline 1:200,000. A temporary foetal bradycardia of 10 beats or more per minute occurred in 12% of the cases with plain lignocaine, in 14% with lignocaine and adrenaline, and in 10% with bupivacaine and adrenaline. Once, when plain lignocaine was being used, the foetal heart rate dropped to 100 per minute, and once with bupivacaine and adrenaline it slowed to 110 per minute. In both these cases the bradycardia was short-lived and the infants were unaffected at birth.

I have yet to hear a satisfactory explanation for the transient alteration in foetal heart rate that may occur with paracervical block, but these findings certainly appear to exonerate adrenaline.—I am, etc.,

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Records System for General Practice

SIR,—We were particularly interested in Dr. E. V. Kuenssberg's article (18 May, p. 420), because the general practitioners in Wantage are designing a records system with the help of the Berkshire Health Authority and, we hope, with the support of the Ministry of Health, with whom we have had preliminary discussion.

We agree that the present medical record envelope (introduced in 1920) is hopelessly inadequate. Indeed, we would go further and say flatly that it is a source of continual frustration, delay, and actual danger, because it makes efficient record-keeping impossible. We also agree that the first essential of a new folder is that it should be possible to file separately various kinds of records, such as hospital letters, pathology reports and *x*-ray reports, and a summary of important illnesses, instead of leaving them inextricably mixed as they are in the present record envelope.

From this point on, however, we disagree fundamentally with the design of the Scottish folder and feel that its widespread introduction in general practice would be a mistake. Probably we would not have recognized its faults six months ago, but, as we have spent these months discussing and planning and experimenting with folder designs, we have decided there are certain essential features that must be present in any folder used for general practice.

Firstly, it must be substantially bigger than the present record envelope, so that it is possible to file all the usual sizes of letter paper without folding them, and to allow adequate space for clinical notes.

Secondly, its size must be related to international paper sizes.

Thirdly, it must be possible to adapt it to the present system, as it is bound to be introduced gradually and the existing record envelope cannot be destroyed. In this we agree with Dr. Kuenssberg.