health of under 16's, who would be put at risk by the giving of a free rein to those who would through publicity or propaganda, or both, encourage them into early sexual relationships, is considered a "controversial" view by Dr. Gregson. The F.P.A. announcement in February 1973 supporting free contraception irrespective of age had not to my knowledge been put forward by the Clinic Doctors' National Council to our doctors' group for our discussion at any time previously. Are we to take it that fait-accompli decisions are "democratic"?

It surely takes little imagination to see that when an organization which includes doctors (such as the F.P.A.) puts forward publicly an unqualified no age limit for contraception certain of the media for teenagers will for their own purposes, actively encourage early sexual relations and refer teenagers to the F.P.A. clinics. It is then too late for clinic doctors to help the situation, which any doctor can see has gone from bad to worse in the past few years with increasing illegitimacy, abortion, and venereal disease among young teenagers. Public respect for the F.P.A.'s publicity advice to teenagers will return only when a positive health value (physical, emotional, and social) is given for sexual restraint as an alternative to contraception and when the age of consent is actively supported.

Have not we as doctors an obligation to parents and to society to discourage the enticement of young people through misguided publicity into behaviour which puts them at risk to their physical and emotional health? If the F.P.A. is not willing to have this openly discussed perhaps there could be a public discussion through the N.H.S. family planning services?—I am, etc.,

ELIZABETH ELLIOTT

Wisbech, Cambridgeshire

Penicillamine and Creaking Joints

SIR,—We have recently noted three patients who spontaneously remarked that their knee joints had began to creak in an unusual fashion since taking D-penicillamine for severe rheumatoid arthritis. They had been taking penicillamine for at least one month and had shown no other untoward side effects. The rheumatoid disease had improved in two of them. We intend to investigate this phenomenon further by studying the rheology of synovial fluid before and after penicillamine therapy. We would be interested to know if this effect of D-penicillamine has been noted before.—We are, etc.,

R. D. STURROCK
P. M. BROOKS

Centre for Rheumatic Diseases,
Glasgow

Assessment of Surgical Treatment

SIR,—Professor W. B. Jennett's letter (15 June, p. 612) contains a totally false attribution to me, to wit: "Dr. Spodick's demand for sham operations. . . ." I have never, anywhere, proposed—much less "demanded"—sham operations. Certainly not in my paper,[1] which was specifically cited in this connexion by Professor Jennett. His discussion is quite wide of the mark in terms of my paper. His mention that some physicians press surgery on some surgeons, for example, is relevant only to your leading article (13 April, p. 73).

I have indeed fought for equal standards of judgement for all therapies. But nowhere have I proposed sham operations (I have referred to their effects but have not advocated them). Professor Jennett's letter does me serious injustice.—I am, etc.,

D. H. SPODICK

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Lemuel Shattuck Hospital,
Boston,
Massachusetts,
U.S.A.

1 Spodick, D. H., *American Heart Journal*, 1973, **85**, 579.

Halitosis

SIR,—Drs. T. F. Tydd and N. H. Dyer (3 August, p. 321) state that it is often difficult to find a reason for halitosis but that neurosis can be a cause. A relatively common one in general practice is depression of the endogenous type which can present as an unpleasant halitosis as the patient enters the room. The tongue of the sufferer is uniformly covered with a thick white fur. Both signs are presumably due to a slowing down of, among others, the gastrointestinal functions. This condition and the mental state improve together.—I am, etc.,

R. N. COMPTON SMITH

Ilford, Essex

Gonorrhoea in Obstetrics and Gynaecology

SIR,—We would wholeheartedly agree with Dr. R. S. Morton's comments (27 July, p. 253) on the value of gynaecological training for the venereologist and the excellent career prospects in that specialty for those holding the M.R.C.O.G. In this hospital the senior registrar in venereology also works for part of his time in the departments of gynaecology and urology. This is proving to be a most successful arrangement from the point of view of training and for the development of interdepartmental co-operation.—We are, etc.,

J. K. OATES
R. SARKHEL

Cambridge

Progesterone Dermatitis

SIR,—Dr. S. J. Jachuck and Dr. H. L. Franks (3 August, p. 347) report an unusual patient who developed eczematous lesions of the hands following administration of Eugynon 30. The history suggested that dinorgestrel, the progestational agent in this contraceptive pill, was responsible.

Shelley *et al.*[1] described a patient who developed a skin eruption which had regular, severe, premenstrual exacerbations. They drew attention to various skin lesions with similar behaviour, and in particular mentioned eczema of the hands which may appear just before the menses only to disappear completely intermenstrually. However, the patient they described had a condition which clinically resembled dermatitis herpetiformis though the histological diagnosis was erythema multiforme. The history strongly suggested a relationship to endogenous progesterone secretion. Administration of progesterone or the progestational agent norethindrone rapidly induced the skin lesions, while attempts at desensitization with increasing doses of progesterone caused a severe exacerbation of the dermatitis. A complete remission followed ovulation inhibition with ethinyl oestradiol therapy and ultimately by oophorectomy.

It seems that extremely rarely progesterone and its analogues can have a poorly understood, deleterious effect on the skin.—I am, etc.,

L. J. HIPKIN

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Liverpool

1 Shelley, W. B., Preucel, R. W., and Spoont, S. S., *Journal of American Medical Association*, 1964, **190**, 35.

Unsuspected Opiate Overdose

SIR,—Acute poisoning with opiates (excepting codeine, dextropropoxyphene and their compounds) in non-addicts is uncommon. Only six such poisonings from a total of 311 drug overdose admissions to this unit were treated during the five-year period 1969-73. However, recently there have been three salutary reminders that opiate poisoning may occur in the most unexpected of cases.

Case 1.—A 15-year-old girl was admitted to casualty with a story of possible drug overdose. She was unconscious, apnoeic, cyanosed, and hypotensive on arrival. Her pupils were dilated. Assisted respiration with oxygen via a cuffed endotracheal airway was started at once, and gastric lavage performed. Her general condition then improved and her pupils became constricted. Though opiate overdose seemed unlikely, nalorphine 10 mg was administered intravenously with remarkable resuscitative effect. The injection was later repeated and the patient was fully recovered within four hours. Meanwhile it was discovered that she had been prescribed Diconal (dipipanone 10 mg, cyclizine 20 mg) for dysmenorrhoea, and had taken about 20 of these tablets after a domestic argument.

Case 2.—A 63-year-old woman was admitted to the ward with a five-day history of chest infection, treated with antibiotics, and slow onset of coma. She was cyanosed, dehydrated, hypotensive, and had Cheyne-Stokes respiration. She had bilateral bronchopneumonia. Respiratory assistance was immediately given with oxygen via an endotracheal tube, and dehydration was corrected with intravenous fluids. She remained unconscious and her pupils became "pin-point". Though there was no history of opiate medication, intravenous nalorphine 10 mg was given, and later repeated twice, with dramatic improvement. The patient said later that she had taken, for chest pain, about 20 DF118 (dihydrocodeine tartrate 30 mg) tablets from an old supply over the 36 hours before admission. The effects of this normally fairly safe opiate analgesic had presumably been potentiated by dehydration, oliguria, and pre-existing bronchopneumonia.

Case 3.—A 62-year-old man, who had had a recent colonic resection for carcinoma, was admitted to casualty with suspected drug overdose. No information as to the nature of his illness or of drug therapy was available. He was unconscious, cyanosed, apnoeic, and hypotenisve. His pupils were dilated and remained so after respiratory resuscitation. Gastric lavage, with the patient intubated, gave partly digested pink-coloured tablets reminiscent of Diconal (dipipanone 10 mg, cyclizine 20 mg). Intravenous nalorphine 10 mg was given to which the response was good, and the injections were continued for some hours as relapse was observed. The patient said later that he had taken about 20 tablets mixed with sherry.

Poisoning with opiates is one of the rare situations in which an antidote is available.[1] It is worth giving intravenous nalorphine even when there is only slight suspicion of opiate ingestion. Large and repeated doses may be required.[2] Classical "pin-point" pupils may not always be evident, especially if cerebral anoxia has been marked. If no opiate is present, nalorphine itself may

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