This acceptance was due above all to the evident sincerity, sensitiveness, and intellectual power with which the meeting was conducted. It now lies with the college's council and the bodies which derive from it to work hard to make good use of this breathing space. They will need to publish quickly a provisional list of the college members, Fellows, and functionaries; an explanatory syllabus for the membership examination; the plans to improve regional training and provide a special membership course; and what they intend to do about some of the more difficult problems in the regions.

The first five months of the royal college's existence were marred by a lack of understanding of legitimate anxieties, fed by insufficient information. Now that the college has met for the first time the way is open to a smooth development of the work it has set itself in raising the standards of British psychiatry. We wish the college well in its task.

Amenorrhoea after the Pill

Amenorrhoea occurring in patients after taking oral contraceptives was first reported in 1966.[1] There is always some uncertainty about the relationship between them, for we know little of the incidence and causes of secondary amenorrhoea in the general population to compare it with the incidence in women who discontinue oral contraceptives. Many patients with amenorrhoea on stopping the pill have in addition galactorrhoea, and so far 41 well-authenticated cases of this association have been reported.

Prolonged galactorrhoea with amenorrhoea can occur spontaneously after parturition, when it is called the Chiari-Frommel syndrome. In women stopping oral contraceptives the syndrome would appear to be rare. In fact it is worth emphasizing that a return of ovulation can be expected within the first three cycles after stopping oral contraceptives in 98% of women.[2] No specific compound has been identified as causing the syndrome; both combined and sequential oral contraceptives are known to do so. No patient appears to have developed amenorrhoea and galactorrhoea when contraceptives were taken for less than three cycles,[3] but there is no obvious time relationship other than this. In one series[4] the duration of contraception varied from six months to four years, with half the patients being on it for two years or less. None of the patients in the published series had an obvious endocrinological cause either of the amenorrhoea, such as pituitary tumour, or of the galactorrhoea, such as other drugs. It seems that women with pre-existing menstrual irregularities are more prone to the condition than normal women, and in the individual case it is prudent to consider whether other methods of contraception are preferable to the pill.

The cause of amenorrhoea and galactorrhoea, whether these are related to oral contraceptives or occur spontaneously, appears to be prolonged exposure of the hypothalamo-pituitary axis to progesterone and oestrogens. These may have either exogenous or endogenous sources. D. R. Halbert and C. D. Christian[3] found evidence of impaired pituitary function in four out of five patients whose response to hypoglycaemia was measured by the change in levels of growth hormone. Levels of serum follicle-stimulating hormone (FSH) and luteinizing hormone (LH) were either normal or low in 10 patients[4] with the syndrome.

The prognosis of these patients is uncertain. E. Rice-Wray and her colleagues[2] reported the resumption of menstruation spontaneously in eight patients with post-pill amenorrhoea lasting 3-13 months. If the patient does not present with the problem of infertility, the immediate solution is somewhat easier, as the administration of an oestrogen-progesterone compound for five days by mouth will usually induce a withdrawal bleed and thus eliminate some of the anxieties associated with the amenorrhoea. But this form of symptomatic treatment does not cause resumption of normal menses.

Most patients present with infertility, and the aim of treatment is to induce ovulation. The most successful methods are to use clomiphene, which stimulates pituitary secretion of gonadotrophin, and if this fails to follow it with a course of chorionic gonadotrophin. This treatment must be regulated by specialists and demands considerable co-operation from the patient. But even with this the eventual success rate as judged by a subsequent pregnancy is probably no greater than 50%.

[1] Shearman, R. P., *Lancet*, 1966, **2**, 1110.
[2] Rice-Wray, E., Correu, S., Gorodovsky, J., Esquivel, J., and Goldzieher, J. W., *Fertility and Sterility*, 1967, **18**, 212.
[3] Halbert, D. R., and Christian, C. D., *Obstetrics and Gynecology*, 1969, **34**, 161.
[4] Gambrell, R. D., Greenblatt, R. B., and Mahesh, V. B., *American Journal of Obstetrics and Gynecology*, 1971, **110**, 838.

Scientific Basis of Clinical Practice

Anyone who questions the value of the basic medical sciences for a practising clinician should compare the account of the aetiology of diabetes in a modern textbook and, say, Osler's textbook published in 1892. Explanation and understanding of the nature of a disease are greatly simplified by accurate knowledge of its causation. But despite the questions on medical science in some postgraduate examinations, this is one field on the whole still poorly served by our postgraduate centres. The Midlands have long been noted for the vigour and variety of their postgraduate activities, and two years ago decided to add to these a weekly series of lectures in the clinical sciences. As Dr. R. E. Smith pointed out last week,[1] this course has already proved that it can establish important liaisons between the clinician and the teacher of basic sciences, as well as providing valuable training for the potential consultant or general practitioner. In the coming months the *B.M.J.* will be publishing many of the lectures in this series. We hope they will be read by a wide variety of doctors with interest.

[1] Smith, R. E., *British Medical Journal*, 1971, **4**, 482.