the massive doses of testosterone seem to be the prerequisite of the therapy. In this case "*res rediit ad triarios*," and testosterones are *triarii*.—I am, etc.,

London, W.1. ALFRED ALEXANDER LOESER.

REFERENCES
[1] Loeser, A. A., *Brit. med. J.*, 1954, **2**, 1380.
[2] Hatem, S., *C.R. Acad. Sci. (Paris)*, 1957, **245**, 1850.
[3] Loeser, A. A., *J. int. Coll. Surg.*, 1958, **29**, 337.

Serum Gonadotrophin in Acne

SIR,—I would like to record my experience with gonadotrophins and acne vulgaris, having in mind the opposing views of Dr. John H. S. Pettit (*Journal*, February 28, p. 557, and May 23, p. 1351) and Dr. E. Lipman Cohen (*Journal*, March 14, p. 715).

Six hypogonadal males are attending the out-patient clinic here. Four, whose ages range from 18 to 23 years, when first seen had feminine body configuration, scanty body hair of female distribution, but with a luxuriant growth of hair on the head. The penis in all four was infantile and the testes small. Their urinary 17-ketosteroid and F.S.H. excretion was low and testicular biopsy showed atrophy of all elements. The fifth case is 45 years and is an example of a chromatin negative Klinefelter syndrome, while the sixth, 50 years, is a case of Simmonds's disease.

All but the fifth case received gonadotrophins as chorionic gonadotrophins 3,000 units and serum gonadotrophins 500 units intramuscularly twice weekly for a period of two months.

The youths all responded by increased body hair of male distribution, by penile development, and by experiencing erections. Seminal emissions became possible, although all were aspermic. All four developed acne vulgaris, three on the face, chest, and back and one on the chest and back. The sixth case experienced only a gratifying increase in sexual potential.

It would appear that in these four adolescent males the gonadotrophins played some part in the production of the skin lesions, and that the older patient did not develop the condition supports the yet unexplained fact that acne vulgaris is peculiar to late adolescent and early adult life.

I wish to thank Dr. James Ronald for permission to record this note.

—I am, etc.,

Royal Northern Infirmary, Inverness. WILLIAM HAMILTON.

"Tofranil"

SIR,—I am writing to you in connexion with the letter on "tofranil" by Drs. W. D. Boyd and A. D. Forrest (*Journal*, April 18, p. 1043). I would like to draw your attention to my articles[1 2] on this subject, the first one incidentally being the first English language article published. The two problems raised in the letter by Drs. Boyd and Forrest have been dealt with in these publications. In brief, so far as the tofranil rash is concerned, the incidence of this side-effect is very low; and, in our experience of over 300 depressed patients treated with this drug, at no time was it necessary to discontinue tofranil, and the incidence of skin rash was not more than 5%. As for discontinuation of tofranil, the experience has shown that it should be discontinued within 10 days, two months after an appreciable improvement has become discernible.—I am, etc.,

Allan Memorial Institute, Montreal. H. AZIMA.

REFERENCES
[1] Azima, H., *Amer. J. Psychiat.*, 1958, **115**, 245.
[2] —— *Canad. med. Ass. J.*, 1959, **80**, 535.

Attempted Suicide

SIR,—Dr. Cyril Fox (*Journal*, May 9, p. 1244) makes the suggestion that we should report all attempted suicides to the local medical officer of health. Not many weeks ago an eminent medical jurist was reported as advising us to report all patients who we considered were unfit to drive a car. The same authority was also quoted as stating that "All deaths occurring in the kitchen or bathroom or during the child-bearing age in women should be regarded with suspicion" (*Daily Telegraph*, April 1). The ingestion of an overdose of barbiturates is by no means proof of suicidal intention. It seems to me that modern ideas are demanding far more from doctors than mere training in the diagnosis, treatment, alleviation, and occasional cure of disease. They seem to me to require a course of training at the Police College at Hendon or some similar institution.

I belong to that generation of poor under-educated doctors whose only training was received at a medical school. I just cannot cope with all this new trend. I would suggest that a *corps d'élite* of medical police be established, with full medical and police training, and, of course, a little law thrown in. The members could have ranks and receive promotions for merit. They might even have special merit awards based on the number of cases they have successfully brought to court. I myself would not propose joining this *corps*, but would gladly suggest the names of a few of my colleagues who have a natural flair for detective work. The recent circular from the Minister of Health concerning the increase of gonorrhoea suggests to me that health visitors are expected to trace contacts from the clinics. A real professionally trained medical detective could patrol our towns and sea-fronts, and with observation could easily get promotion to the dizzy heights of a sergeant.—I am, etc.,

Denbury, S. Devon. JOHN V. MAINPRISE.

Silent Perforations

SIR,—The following two cases of perforated peptic ulcers may be of interest.

Case 1.—A man aged 64 was first seen on January 28, 1958, complaining of dyspepsia, which was relieved by two weeks of mist. mag. trisil. On March 19, 1959, he complained of pain in the right chest, and stated that he had had abdominal pain the previous day, which had been relieved by two bottles of beer. On examination there was a pleural rub at the right base; temperature normal; liver three fingers below the costal margin; slight rigidity of the abdomen but no complaint of tenderness. Did not feel ill and wanted to get up. The provisional diagnosis was possible secondary carcinoma of liver. On March 20 the pleural rub was still present, and the abdominal signs were unchanged. Radial pulse very weak. He did not feel ill, and wanted to get up. Admission to hospital arranged and a diagnosis of secondary carcinoma of liver made. The patient got out of bed immediately after the visit, and dropped dead. The post-mortem findings were a perforated gastric ulcer on the lesser curvature, subphrenic abscess, general peritonitis, and effusions at the bases of both lungs.

Case 2.—A man aged 61 had a history of oil dermatitis since 1942. He was seen on September 13, 1958, with acute asthma but no other symptoms. On September 17 he developed fever and was treated with chlortetracycline. On September 19 he had improved. Temperature normal. On September 21 he had acute epigastric pain, with board-like rigidity; admitted. A laparotomy was performed the same day and a perforated anterior duodenal ulcer found, and,