to be more appropriate to the other it will, with the permission of the applicant, be passed on.

Interested general practitioners should communicate with one of the undersigned.—We are, etc.,

R. E. HOPE SIMPSON,
Secretary, Medical Research Council Committee for Research in General Practice, 38 Old Queen Street, London S.W.1.

R. J. F. H. PINSENT,
Chairman, Research Committee of Council of the College of General Practitioners, 41 Cadogan Gardens, Sloane Square, London S.W.3.

## New Cases of G.P.I.

SIR,—I was interested to read "New Cases of G.P.I." by Drs. S. Bockner and N. Coltart (January 7, p. 18), since in the past year three new cases of syphilis, contracted during the war, have presented themselves. In the previous ten years I had seen no cases.

One was a woman of 41 with G.P.I. who presented as a psychiatric problem with considerable mental confusion and restlessness. The second was a man of 52 with tabes dorsalis. He presented with an eye injury when his Argyll Robertson pupils were noted. Within a week of being seen he developed acute colicky abdominal pain, which was not due to a tabetic crisis. Operation revealed adhesions of the small intestine causing obstruction. The last case was a man of 48 who was found to have a moderately enlarged spleen. Initial investigations were negative, but six months later his blood W.R. was positive.

The age group 15 to 65 years in 1939 was the one most liable to infection. My practice has 1,264 in that group, of whom three are known to have tertiary syphilis. It is becoming increasingly important to bear this diagnosis in mind.—I am, etc.,

London E.10. J. SAPERIA.

SIR,—The warning of the increased incidence of G.P.I. by Drs. S. Bockner and N. Coltart (January 7, p. 18) prompts me to refer to another aspect of the injudicious use of penicillin, particularly by ship surgeons and others who have limited diagnostic facilities. The implications of the use of penicillin for a coincidental infection during the unsuspected incubation of a venereal disease give food for thought, but a few injections given expressly for an undiagnosed genital lesion (however innocent it may look) should be deprecated. If the lesion is syphilitic, these small doses heal the lesion but do not necessarily cure the disease, and the Wassermann test may be suppressed for a considerable period: in one case there was presumptive evidence that it was sixteen months. The risk of later tertiary lesions of syphilis is considerable. Streptomycin and sulphonamides have no appreciable effect on the *Treponema* but will heal most non-syphilitic genital lesions.

It would be wise subsequently to treat any patient who has received a small dosage of penicillin for a genital lesion with the full course which would be necessary if a diagnosis of syphilis had been established, and to follow the case with serological tests for a minimum of two years.—I am, etc.,

London W.1. DAVID ERSKINE.

## Venereophobia

SIR,—The following somewhat similar cases of fear of venereal disease may be of interest.

(1) A man who had recently retired from the Royal Navy after twelve years' service, whose daughter was suffering from pneumonia, stated that her condition was due to syphilis, which she had inherited from him. Apart from the history of an isolated infidelity there was no evidence of infection or treatment. His W.R. was negative. He became completely obsessional, and eventually entered a mental hospital and made a good recovery. Subsequently he rejoined the Navy and has had no further relapse. (2) A retired seaman of over twenty years' service in the Royal Navy, whose son at 3 was critically ill with bronchopneumonia secondary to whooping-cough, said that the condition was due to syphilis. He also gave a history of a single venereal risk. He had reported to his medical officer, who had taken blood for test, but had received no treatment. His W.R. was negative, but, as he still persisted that infection was present, he was referred to a venereal clinic, where all findings were negative. This man also became obsessional, and entered a mental hospital. Shortly after discharge he hanged himself.

Although the above cases are extreme, it is suggested that this fear must be a frequent, if unrecognized, cause of anxiety states among seamen.—I am, etc.,

Fareham, Hampshire. G. G. THYNE.

## Clients of Prostitutes

SIR,—Dr. Robert Thomson says (December 31, p. 1957) that "almost all prostitutes are . . . completely frigid." Statements of this sort are frequently made by authorities on the subject, although I wonder on what evidence their opinion is based. Is it derived from statements of the ladies themselves of their clients? Or is it merely the puritanical objection of the British (at an unconscious level, of course) to the thought that *filles de joie* take pleasure as well as money from their activities?

I think the matter should be seen against the background outlined by Glover,[1] who pointed out that "although [sexual frigidity in experienced prostitutes] is highly significant it should be remembered that in one form or another frigidity is common both in neurotic and in apparently normal women." Also, I was interested in the firm opinion given me by a criminal who was my patient in prison for over a year and who normally spends much time with and derives a considerable income from prostitutes. It is his experience that while a prostitute may be frigid with her customers she is often an enthusiastic performer with her protector or boy friend. It may be that this facultative frigidity is nearer the truth.—I am, etc.,

Dingleton Hospital, Melrose. J. K. W. MORRICE.

REFERENCE

[1] Glover, E., *The Psychopathology of Prostitution*, 1944. Institute for the Study and Treatment of Delinquency, London.

## Prescribing Costs

SIR,—Now that the Pricing Bureaux have resumed the pricing of scripts in full, they are also examining the prescribing of individual practitioners, and many doctors now find themselves charged with "overprescribing." Why should general practitioners (and indeed in particular single-handed practitioners) be blamed and