

support. We have been encouraged by the use of the long posterior flap below-knee amputation in conjunction with a limited myoplasty¹ in patients with femoral artery occlusion and absent popliteal pulsation. We find most cases are suitable for this procedure rather than the occasional patient. We have performed this procedure on 17 patients and will shortly publish the preliminary results.

We would make a plea that amputation is not left until the last moment in the management of the patients, as a patient who has been allowed to lie in bed under heavy analgesics for his rest pain, or who comes to amputation at the end of a series of unsuccessful arterial operations, is less likely to be rehabilitated. To regard amputation as a positive part of the management of a patient with arterial disease rather than a defeat will do much to overcome this tendency.—We are, etc.,

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M. VITALI.

Limb Fitting Centre,
Queen Mary's Hospital,
London S.W.15.

REFERENCE

- ¹ Burgess, E. M., and Romano, R. L., *Clin. Orthop.*, 1968, 57, 137.

The Disposable Nurse

SIR,—I was amused by the Personal View (18 January, p. 179) by a lady whose 25 years of hospital experience seems to have left her without a grasp of the essentials of British nursing.

I have had more than 40 years' experience of most types of hospitals involving intimate contact with nursing, but it took me very few years to understand why British nursing was outstanding and the envy of the world. I found almost every type of nurse conscious of this except perhaps some tutors, who are too concerned about their status. They are full of bright but theoretical ideas, but have little contact with the patient—the hub of nursing—and little understanding of patient care. There are, of course, brilliant exceptions, and some months ago you favoured us with the Personal View of one such.¹

I should be sorry to see the profession built on the lines indicated by the lady who wrote this week. I fear it would mean that nursing, like so many other British activities, would yield the palm to other countries. Nursing would certainly become disposable. Perhaps the lady has a plan for disposable doctors, it would be fun to learn about this too.—I am, etc.,

JOHN T. INGRAM.

Leighton Buzzard,
Beds.

REFERENCE

- ¹ Hector, W., *Brit. med. J.*, 1968, 2, 620.

Inhibition of Lactation

SIR,—With respect to the use of quineestrol, I would agree with Dr. E. M. Barbour and Dr. J. M. McGilchrist (18 January, p. 184) as to the relative efficacy of this new preparation.

In a small trial conducted in Newcastle upon Tyne, six out of 36 patients were classed as being failures of suppression as judged from the need for supplementary oestrogens

within eight weeks of delivery, provided that quineestrol had been given within six hours of delivery. In this trial 30 patients were given a 2 mg. dose and six a 4 mg. dose. Three of the patients taking the larger dose required admission to hospital within eight weeks of delivery because of heavy and protracted vaginal bleeding commencing with the first postpartum period. In all cases curettage produced endometrium that showed undoubted glandular hyperplasia on histological study. All of the patients subsequently settled down to a normal and regular cycle after the curettage.

As a result I am not in favour of exceeding 2 mg. as a therapeutic dose of what would appear to be a very powerful oestrogen.—I am, etc.,

DEREK TACCHI.

Princess Mary Maternity Hospital,
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SIR,—Mr. P. N. Gillibrand and Professor P. J. Huntingford report that quineestrol given as a simple 2-mg. or 4-mg. dose immediately after delivery failed to suppress lactation within eight days of delivery in five of eight patients receiving 2 mg. and 13 of 19 given 4 mg. (21 December, p. 769). These findings conflict with mine.

I have recently completed a trial with this product and have found it efficient in inhibiting lactation. The results of my trial are awaiting publication. Through your columns I wish to record that lactation was completely inhibited in 36 of 50 women given a 4-mg. dose of quineestrol. Not only was lactation inhibited during the immediate post-delivery lying-in period but there was no subsequent leakage of milk secretion or trouble with the breasts in these women. This was confirmed by a follow-up questionnaire sent to the patients concerned some time after their discharge from hospital.—I am, etc.,

M. R. FELL.

Salisbury General Infirmary,
Wilts.

SIR,—While controversy continues about the most effective oestrogen for suppression of lactation (18 January, p. 184), there is increasing concern over the relationship between oestrogen and puerperal thromboembolism.¹ A mother who elects to bottle-feed does not want lactation inhibited; she wishes to be free from breast discomfort. Breast engorgement is self-limiting in the absence of the sucking reflex. The success of any oestrogen in preventing engorgement must be measured against the results using a placebo.

Since such a trial was carried out in this hospital 25,000 consecutive patients have received no specific treatment to inhibit lactation.² Analgesics are available for patients who require them. There has been no death from thromboembolism in this hospital over the same period of time.—We are, etc.,

DERMOT MACDONALD.

KIERAN O'DRISCOLL.

National Maternity Hospital,
Dublin 2.

REFERENCES

- ¹ Inman, W. H. W., *J. Obstet. Gynaec. Brit. Cweth.*, 1968, 75, 1315.
² MacDonald, D., and O'Driscoll, K., *Lancet*, 1965, 2, 623.

SIR,—The inhibition of lactation by prescribing free fluid intake described by Mr. C. K. Vartan (4 January, p. 50) is a most satisfactory method of suppression.

The disadvantages of the stilboestrol method, the secondary engorgement of the breasts and the withdrawal bleeding which sometimes occur, are eliminated. It would appear now that the risk of venous thrombosis is greatly reduced. Free fluids have been used for a considerable time as the sole method of suppression of lactation in our maternity unit and we have found it most effective.

Stilboestrol does not appear to have any superior advantage. I can recommend the free fluid technique to Dr. D. D. Brown (4 January, p. 50) as a thoroughly satisfactory replacement for stilboestrol in the suppression of lactation.—I am, etc.,

A. W. CHESTER.

West Hill Hospital,
Dartford, Kent.

Treatment of Hypertension with
Propranolol

SIR,—We were very interested in the paper on the treatment of hypertension with propranolol by Drs. B. N. C. Prichard and P. M. S. Gillam (4 January, p. 7), in which they disagree with previous reports suggesting the drug has little or no effect.¹⁻⁴

There are, however, obvious potential sources of error in the design of their trial. In particular, we are more than a little surprised that in discussing our own study (2 November, p. 329) of Jamaican patients with hypertension, they make no mention whatever of the fact that our trial, unlike theirs, was *double-blind*. In fact, our study, although small and of relatively limited duration is none the less the only fully controlled trial of the drug's effect in hypertension so far conducted. The value of propranolol in this condition is far from clear. There is an obvious need for a double blind study on a large group of patients over a long period (preferably comparing mean blood pressure on propranolol alone with mean blood pressure on placebo.)

Until such a study is published, we cannot agree with Drs. Prichard and Gillam's contention that propranolol is "at least of similar potency to bethanidine, guanethidine, and methyldopa."—We are, etc.,

Kingston, Jamaica.
London E.C.4.

G. S. HUMPHRIES.
D. G. DELVIN.

REFERENCES

- ¹ Paterson, J. W., and Dollery, C. T., *Lancet*, 1966, 2, 1148.
² Richards, F. A., *Amer. J. Cardiol.*, 1966, 18, 384.
³ Richardson, D. W., Freund, J., Gear, A. S., Mauck, H. P., and Preston, L. W., *Circulation*, 1968, 37, 534.
⁴ Waal, H. J., *Clin. Pharmacol. Ther.*, 1966, 7, 588.

Torsion of Testis

SIR,—Torsion of the testis is not a common emergency. The usual mistake is to diagnose it as acute epididymo-orchitis, with tragic result, as illustrated by the following case.

A boy aged 14 was brought to the hospital. Sudden severe pain in the right scrotum at 5 a.m. four days ago had been diagnosed as due to acute epididymo-orchitis, and Mysteclin