generally acceptable as the result of individual experience and several publications, but surely the case is overstated by Professor Scott when he says that, in a patient without prolapse, vaginal hysterectomy takes no longer than a laparoscopy, that the patients are more mobile the following day and that complications are fewer.

Laparoscopy takes 10 to 15 minutes and the patient can go home the next day. I have watched and assisted many expert vaginal hysterectomists and I often do the operation myself, but it has always taken longer than this because of the need for care with the bladder, ureters and vascular pedicles. In no case has the patient felt like going home the next day.

It is clear that Professor Scott is a most skilful surgeon but I think herein lies the great danger of his publication, for very many are not quite so skilful and if they embark on a policy of wholesale vaginal hysterectomy in young women, as he suggests, in preference to the minor operations for tubal occlusion, I am certain they will come to regret it. Many patients asking for sterilization are relatively young and both they and their husbands believe it is a minor procedure without risk.

I agree that the uterus should be removed if there is any evidence that it is abnormal and I also agree that it is usually best removed vaginally, but I am not happy about this prophylactic hysterectomy idea.

Victor Bonney wrote "The load of responsibility that a surgeon shoulders every time he performs an operation is surely great enough without adding to it by meddlesome chippings and choppings."—I am, etc.,

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¹ Bonney, V., *Textbook of Gynaecological Surgery*, 6th edn., Cassell, London, 1952.

Skin Reactions to Ampicillin

SIR,—Your leading article (22 January, p. 195) and the ensuing correspondence (19 February, p. 505) has again drawn attention to the interesting relationship between ampicillin rashes and abnormal mononuclear cells.

I have recently seen such a patient in whom the diagnosis was stage IV reticulosarcoma. This 62-year-old man developed a widespread red macular rash 10 days after ampicillin given for a urinary infection. On examination he was noted to have a generalized lymphadenopathy, later shown by biopsy to be reticulosarcoma. There were a large number of abnormal monocytoïd cells in his bone marrow compatible with this diagnosis, and his Paul-Bunnell test was negative. At the time of diagnosis he was slightly anaemic (Hb 12.6 g/100 ml) and leucopenic (W.B.C. 2,800/mm³ of which 1,550/mm³ were neutrophils and 1,000/mm³ lymphocytes). His serum proteins were normal, but unfortunately his immunoglobulin levels were not determined.

A curious feature in his case was a recrudescence of the rash, lasting only a day or so, immediately following biopsy in the area of what was thought to be a painful supraclavicular node. The biopsy was unsuccessful as the material removed proved to be a (? traumatic) neuroma. Subsequent biopsy of an inguinal node revealed the true diagnosis.

It seems that ampicillin sensitivity may be added to alcohol-induced pain as an unexplained curiosity of lymphomatous conditions, and may not be confined to infectious mononucleosis and lymphatic leukaemia. It would be interesting to know whether it occurs in Burkitt's lymphoma.—I am, etc.,

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Clofazimine in Leprosy

SIR,—In commenting on a recent trial of clofazimine in lepromatous leprosy by Dr. A. B. A. Karat and co-workers (27 November 1971, p. 514) Dr. S. G. Browne (19 February, p. 506) remarked on "a small number of patients treated for an insufficient period of time. . . ." This is relevant to their conclusion that the incidence of erythema nodosum leprosum was similar in two groups of patients, one of which was given clofazimine 100 mg daily and the other dapsone 100 mg daily. Experience at Westfort¹ indicates that while clofazimine in a dose of 100 mg daily does not abolish erythema nodosum leprosum it does decrease its incidence during long-term administration to patients with lepromatous leprosy.

We compared two groups of patients, one of which received dapsone 100 mg three times a week and the other clofazimine 100 mg daily in addition to dapsone 300 mg weekly. All patients had had previous treatment with dapsone alone for an average of eight months and at the start of the trial six out of 16 patients in each group (38%) had some form of reaction, mainly erythema nodosum leprosum. At the end of two and a half years in the trial (that is, after 38 months of antileprosy treatment) there were 15 patients left in the group receiving clofazimine in addition to dapsone and 10 patients in the group receiving dapsone alone (three had been removed from the group on dapsone only at 18 months for severe erythema nodosum leprosum not adequately controlled by corticosteroids, and the others had absconded). Seven of the 15 patients receiving clofazimine and five of the 10 patients in the group on dapsone alone had erythema nodosum leprosum at the end of the trial—that is, an incidence of 27% compared to 50%. If the three patients removed from the trial at 18 months for severe erythema nodosum leprosum are included, the figures are 27% and 60%.

About 30% of all patients with lepromatous and borderline leprosy at Westfort develop erythema nodosum leprosum. Although it may occur early and even in untreated patients, in our experience it usually first presents after an average of 16 months of antileprosy treatment. The lack of a suppressive effect of 100 mg clofazimine daily on erythema nodosum leprosum found by Dr. Karat and colleagues may be due to the fact that few of their patients were treated for long periods. Only 12 of their 23 patients (seven in the clofazimine group and five in the dapsone group) were treated for longer than 15 months.

We have treated more than 100 patients with clofazimine for established erythema nodosum leprosum and our results confirm numerous previous observations that response to the drug depends on an adjustment of the dose to the severity of the re-

action. While a minority of our patients respond to 100 mg daily, most need 300 mg daily and some patients are given as much as 500 mg daily to achieve adequate control of erythema nodosum leprosum.—I am, etc.,

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¹ Schulz, E. J., *Leprosy Review*, in press.

Risk with β -Blocking in Bronchial Asthma

SIR,—Adrenergic β -receptor blocking drugs are widely used in the treatment of angina pectoris. Propranolol, the first of these drugs to be introduced into clinical practice, increases airways resistance in asthmatics¹ and the hazards of its use in these patients are well known. We recently observed a case of life-threatening airways obstruction in an asthmatic patient following the ingestion of a single tablet of oxprenolol hydrochloride (Trasicor).

The patient, a 39-year-old barman, had a 30-year history of extrinsic atopic asthma. His symptoms were reasonably well controlled by a salbutamol inhaler used four times daily. He consulted his family doctor on account of episodic aching central chest pain radiating down the medial aspect of his right arm but not closely related to effort. Oxprenolol was prescribed and the patient was instructed to take one tablet (40 mg) at the onset of pain. Eight days later, at work, he experienced an episode of chest pain and took his first tablet of oxprenolol. Within 30 minutes he became acutely breathless and wheezy. He was taken promptly to the casualty department of Aberdeen Royal Infirmary where he was found to have central cyanosis and widespread sibilant rhonchi. Immediate treatment was instituted with oxygen, intravenous aminophylline, and hydrocortisone; his symptoms gradually settled over the following six hours. There was nothing to suggest left ventricular failure and subsequent investigation showed no evidence of myocardial infarction.

All the currently available β -blocking drugs, including propranolol,¹ oxprenolol,² alprenolol,³ and practolol,⁴ have been shown to increase airways obstruction in some asthmatics. The present case further emphasizes the need for extreme caution in the use of any β -receptor adrenergic blocking drug in a patient with airways obstruction.—We are, etc.,

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¹ McNeill, R. S., *Lancet*, 1964, 2, 1101.

² Beumer, H. M., *Pharmacologia Clinica*, 1969, 1, 172.

³ Connolly, C. K., and Batten, J. C., *British Medical Journal*, 1970, 2, 515.

⁴ Palmer, K. N. V., Legge, J. S., Hamilton, W. F. D., and Diamant, M. L., *Lancet*, 1969, 2, 1092.

Treatment for Ovarian Carcinoma

SIR,—Despite the use of maximal surgery, radiotherapy, and cytotoxic drugs, the prognosis for ovarian carcinoma remains poor. Any new form of treatment which can be shown to be of value and which does not preclude the use of any existing form must therefore be welcome.

Recently interest has been aroused in an