

Pulmonary Aspiration after Fibre-endoscopy

SIR,—I was very interested in the article by Drs. B. J. Prout and C. Metreweli on this topic (4 November, p. 269). In my previous department, where we performed about five fibre-endoscopic examinations daily, our patients occasionally developed fever and pulmonary infiltration after the examination. We too used diazepam (5-30 mg intravenously), atropine (0.5 mg), and pethidine, and periodically we used local anaesthesia (lignocaine spray). It was our impression that the use of local anaesthesia had no significant effect on the frequency of the pulmonary aspiration.

In my present department we have the help of an anaesthetist, and the patients receive neurolept analgesia (droperidol, fentanyl). For about four years we have never seen pulmonary infiltration after fibre-endoscopic examination.

I think that it is not very important what sort of anaesthesia is used, but that it is most important to have sufficient anaesthetic assistance to ensure that the patient is properly sedated during the examination and is fully awake soon after the examination has finished.—I am, etc.,

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Previous Tuberculosis Infection and Cerebral Glioma

SIR,—It was noted in the fourth report of the Medical Research Council's trial of tuberculosis vaccines¹ that the mortality from all malignant neoplasms during the 15 years following entry to the trial at age 14½-15 years was greater among those who were initially tuberculin-positive (36 deaths among 21,957 subjects) than among those who were initially tuberculin-negative (29 among 32,282 subjects). The probability of obtaining so large a difference by chance is about 1 in 50. The numbers of deaths from cerebral tumours (not given separately in the report) were nine and five respectively, showing a similar disparity to that for deaths from other malignancies. The association between previous tuberculous infection and cerebral glioma reported by Dr. D. W. Ward and others (13 January, p. 83) from a retrospective inquiry may therefore not be restricted to this specific neoplasm, but may be part of a wider phenomenon involving all neoplasms.

It was also noted in the report of the M.R.C. trial that there was no significant excess (or deficiency) in the mortality from all malignant neoplasms in those initially tuberculin-negative subjects who were then given B.C.G. or vole bacillus vaccine by random selection (namely, 17 deaths among 19,415 subjects) as compared with those who remained unvaccinated (12 among 12,867 subjects). The numbers of deaths from cerebral tumours were three and two respectively. This finding, from a controlled comparison, does not suggest that an (artificial) mycobacterial infection has any immunological consequences relevant to subsequent neoplasia. It therefore seems that the higher mortality from neoplasms among those who entered the trial with evidence of a previous (natural) mycobacterial infection is more likely to be related to some aspect of the environment in which that infection

occurred than to represent an immunological consequence of that infection. Dr. Ward and his colleagues consider only immunological explanations for their association.—I am, etc.,

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¹ Medical Research Council, *Bulletin of the World Health Organisation*, 1972, 46, 371.

Family Planning

SIR,—The recommendations of the General Medical Services Committee on family planning (*Supplement*, 13 January, p. 14) are excellent. The immediate results are likely to be a fall in demands for abortion and an improvement in the doctor/patient relationship, which has deteriorated. The long-term effects are likely to be a curb on population growth reflected in a fall in unemployment and affecting schools, hospitals, housing demands, social services, production of cars for the home market, pollution, and environmental destruction. The social services can take up a great deal of time in a large medical centre with a 10-minute appointment rule. It might be advisable to lower the age to 15—a vulnerable age. It might also be advisable to limit child allowances to the second or third child only.—I am, etc.,

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Side Effects of the Pill

SIR,—Dr. D. A. Varvel (23 December, p. 729) states that "probably 50%" of his patients taking the contraceptive pill have complete loss of libido. In agreeing with this Flt. Lt. D. J. S. Triplett (13 January, p. 111) suggests that the reason may be that the source of the female libido is the urge to reproduce. He also wonders what effect vasectomy has upon the wives.

With regard to the effect of the pill on libido, there have been a handful of published studies, but by far the best is that of Herzberg *et al.*¹ They conducted a detailed prospective study of women in various parts of England. They found that of the women who stopped or changed the pill, 19.8% (8% of all those taking the pill) gave loss of libido as the reason. However, this was not the commonest reason because of those who stopped or changed, 29.1% gave headache and 27.9% gave depression as the reason. Those who did not stop the pill tended to have an increase in libido. The mean libido score for all the women taking the pill showed no significant change. It is interesting that the same study showed that women with the intrauterine device tended to have a substantial increase in libido. Those who stopped or changed the pill because of loss of libido had a depression score (assessed by the Beck Inventory) at their initial assessment which was higher than that of all other women taking the pill. It should therefore be possible to reduce the number of women who get a loss of libido with the pill by trying to avoid prescribing it for those with a predisposition to depression.

With regard to vasectomy, the Simon Population Trust in 1969 reported that 79.4% of the wives of 1,008 vasectomized

men found that their sex lives had improved and only 0.5% found that it had worsened. Female sterilization is also more likely to have a good rather than a bad effect. Steptoe,² in a follow-up of 350 cases, found that 57% reported improvement in sex life and 14% reported worsening. A similar survey of 216 women recently carried out at Nuneaton showed 50% improved and 9.7% worsened, and 83% of those reporting improvement attributed this to the operation (unpublished data).

All these studies, therefore, seem to suggest that the urge to reproduce is not a significant source of the female libido, though perhaps it is so with a few women.—I am, etc.,

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¹ Herzberg, B. N., Draper, K. C., Johnson, A. L., and Nicol, G. C., *British Medical Journal*, 1971, 3, 495.

² Steptoe, P. C., *British Medical Bulletin*, 1970, 26, 60.

³ Simon Population Trust. *Vasectomy: Follow-up of a Thousand Cases*. Cambridge, 1969.

Fenfluramine and Haemolytic Anaemia

SIR,—I refer to the letter from Dr. A. M. Nussey (20 January, p. 177) concerning the occurrence of haemolytic anaemia in a 46-year-old woman who had been prescribed fenfluramine on three occasions during three preceding years. I am able to reassure Dr. Nussey and your readers that we do not have any record on our adverse reaction files of cases of haemolytic anaemia following treatment with fenfluramine (Ponderax). I believe this is also the case so far as the Committee on Safety of Medicines is concerned.—I am, etc.,

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Ampicillin Dosage in Pneumonia

SIR,—I should like to add a comment to the interesting article by Drs. Valentine U. McHardy and M. E. Schonell on ampicillin and prednisolone in treatment of pneumonia (9 December, p. 569). The authors found a statistically significant difference showing that the proportion of patients who became afebrile within a week was larger with a dose of 1 g of ampicillin daily than with 2 g daily and that the difference was statistically significant.

The explanation could be that ampicillin can cause fever. In 1968 I made a comparison of the effects and side effects of phenoxymethylpenicillin and ampicillin in the treatment of scarlet fever (110 cases in each group). Ampicillin rashes occurred in 10 patients on the eighth to tenth day. However, it was also observed that in no fewer than 11 ampicillin cases (10%) the fever returned after the patient had become afebrile, without any clinical explanation. The rise of temperature occurred on the third to the eighth day (nine on the fourth to the seventh day) and reached a peak of 37.8-39.6°C. In most cases the temperature showed a spontaneous tendency to return to normal and the fever disappeared in all cases as soon as administration of the drug was stopped after the tenth day. In my opinion this reaction must represent some non-