drug that is meant when "betamethasone" is referred to, without qualification, for brevity. I must apologize for this, as it will obviously be confused with another product, betamethasone disodium phosphate (Beta-Corlan, Glaxo), which was not used. It should also be pointed out that while betamethasone (Beta-Corlan) is freely available, Betnovate oral pellets as used in this trial are not available on prescription.—I am, etc.,

R. A. CAWSON.

Department of Oral Medicine
and Pathology,
Guy's Hospital,
London S.E.1.

Restrictions on Doctor in South Africa

SIR,—I cannot allow Dr. G. F. C. Troskie's remarks (17 February, p. 445), denying that academic life in South Africa is being intruded on by politics, to pass unchallenged, and I would be interested if Dr. Troskie could clarify and amplify the "half-truths and false impressions" to which he referred in connexion with the recent correspondence (26 August 1967, pp. 512 and 516) concerning the banning of Dr. R. Hoffenberg.

The facts were that Dr. Hoffenberg, teacher and research worker, was arbitrarily banned by ministerial decree without charge, trial, or opportunity to defend himself. In terms of the banning order, Dr. Hoffenberg was deprived of contact with students and access to his research laboratory and the medical library. Further, he was not allowed out of the magisterial district in which he lived. He was allowed social contact with only one person at a time. Initially, the ban stated that he was not allowed to publish any material. Later, in a "clarifying" statement, the Minister of Justice personally gave Dr. Hoffenberg permission to publish scientific material. But what can a research worker publish if he is allowed neither access to his laboratory nor to the medical library? Surely this is "academic life in a politically suppressive atmosphere"? (Dr. S. Shapiro, 16 December 1967, p. 684).

Dr. Troskie has attempted to present this Government as a promoter of racial harmony, especially within the medical profession and in academic circles. Is he aware that the South African Government pays doctors in their employ on different scales? Not according to merit or ability, but based solely on race classification. For example, registrars, white, R.3,000 to R.4,500 (£1,500 to £2,250); Coloured and Asiatic, R.2,070 to R.3,240 (£1,035 to £1,620); and Bantu, R.1,800 to R.3,000 (£900 to £1,500).

Certainly medical and scientific research extend over all sections of the population, but not as Dr. Troskie would have us believe "irrespective of colour, creed, race, or personal political beliefs." This is the sad state of affairs in which we find ourselves in South Africa—academically suppressed, politically frustrated, and legally blocked.

It is significant that this correspondence takes place through the courtesy of the Editor of the *British Medical Journal*, as the *South African Medical Journal* has refused to print any correspondence or comment on the Hoffenberg affair.—I am, etc.,

LOUIS H. DIAMOND.

Groote Schuur Hospital,
Cape Town, South Africa.

SIR,—Dr. G. F. C. Troskie (17 February, p. 445) states that it is false to assert that academic or medical life is influenced by politics in South Africa.

As a non-white medical practitioner in South Africa, I find that life, both medically and academically, exists in a politically suppressive environment. Every facet of medical and academic life is permeated with the Government's policy of apartheid. The non-white patient is provided with separate and inferior medical services. The *per caput* expenditure of both the provincial and central Governments on non-white medical services in urban areas is only a fraction of that spent on the white section of the population. In the African reserves these services are virtually nonexistent.

I do agree that South Africa can boast of having advanced medical facilities, but these unfortunately exist largely for the privileged white section of the community. To illustrate this point, Natal, a province with an overwhelmingly large non-white population, recently acquired artificial kidneys from Government funds for the exclusive use of white patients. No similar service is available for the non-whites. Academic life is riddled with similar injustices. Non-whites are not allowed at the Universities of Pretoria and Stellenbosch. A limited number of non-white medical students are admitted to the Universities of Cape Town and the Witwatersrand, but even here they may not examine a white patient nor are they allowed to be present at the post-mortem examination on a white body.

Postgraduate facilities for non-white doctors are very limited. Furthermore, not only are they barred from working in the white hospitals, but even the doors of some of the non-white hospitals are closed to them. Is it therefore not surprising that some of the most highly qualified from among us have left South Africa to settle elsewhere?

The policy of discrimination in the salaries paid to doctors on the grounds of race and colour is yet another feature that contributes to frustration. This discrimination in salaries is ridiculous to the extent that a non-white consultant gets a lower salary than a white houseman working in the same hospital.

In the light of all this, it is very difficult to accept Dr. Troskie's view that a politically suppressive atmosphere does not exist in South Africa.—I am, etc.,

SOUTH AFRICAN PRACTITIONER.

Missing Loop

SIR,—The interesting and informative paper by Mr. S. S. Ratnam and Dr. J. C. K. Yin (9 March, p. 612) on translocation of Lippes loop focuses attention on this important complication of an I.U.C.D., and reminds me of a case I saw while working in a mission hospital in western India in 1967.

The patient had had seven pregnancies, and a Lippes loop size 30 was inserted six months after her last confinement by a doctor who had several years' gynaecological experience. After the insertion there were no symptoms to suggest perforation of the uterus. Seven months later the patient attended hospital

with the complaint that she could not feel the nylon threads, and she thought she might have passed the loop. Clinical examination confirmed the absence of the threads and x-ray examination of the abdomen showed what appeared to be an intrauterine Lippes loop. Fifteen months after insertion the patient again attended hospital. On this occasion she complained of vomiting and upper abdominal pain associated with pyrexia of some hours' duration. She was sure that her symptoms were due to the Lippes loop, and she requested removal of the loop and tubal ligation.

On pelvic examination the uterus was found to be retroverted, and there was some swelling in the right fornix. On anteversion of the uterus the swelling was more marked, and could readily be defined as a Lippes loop. It transpired that the patient's symptoms were due to enteric fever, and laparotomy was postponed until she recovered. At operation the Lippes loop was found deeply embedded in the right broad ligament, and firmly adherent to the right ovary and Fallopian tube. The leading portion of the loop was adjacent to the right ureter. Right salpingo-oophorectomy, left partial salpingectomy (Pomeroy method), and appendectomy were performed.

Translocation of a Lippes loop may occur more frequently than the literature would suggest, and it would be helpful in assessing the position if all such cases were reported.—I am, etc.,

JOHN BREEZE.

Enniskillen,
N. Ireland.

SIR,—The possibility that the uterus might have been perforated by the I.U.C.D. must be considered whenever the threads are not visible emerging from the cervix. In some cases the device will have been extruded and passed unnoticed, but in the majority, as Mr. H. E. Reiss (6 April, p. 49) observes, the device will have rotated within the uterine cavity. If an x-ray is considered advisable to demonstrate the device in the pelvis it will usually be a sensible precaution to have a uterine sound in place, thus showing more clearly whether the device is still within the uterine cavity.

Complete perforation of the uterus is rare, but partial degrees in which some part of the I.U.C.D. penetrates the myometrium are not so uncommon. In one important respect my experience differs from that of Mr. Reiss. The use of the vulsellum or tenaculum is avoided whenever possible, and among the last thousand or so cases at my clinic no case of complete perforation has been observed. Of the four known cases of perforation in the first 600 cases the vulsellum is known to have been used in three and probably also in the fourth case. On theoretical grounds also it seems extremely unlikely that it would be possible to perforate the uterus unless the cervix was pulled down to counter the thrust of the introducing stilette. The vulsellum is generally necessary for the fully retroflexed or retroverted uterus, and in these cases the danger of perforation is certainly increased.—I am, etc.,

WILFRID MILLS.

Edgbaston,
Birmingham 15