The pathogenesis of thrombosis is still obscure, and it is difficult to say whether the changes described in association with the use of hormonal contraceptives predispose to thrombosis. There are no common characteristic changes in the coagulation factors, the fibrinolytic system, platelet aggregation, or adhesiveness in patients with thrombosis. In recent years, however, it has been shown that a normal fibrinolytic activity in the vessel walls is important for counteracting thrombosis. Thus Pandolfi *et al.*¹ showed that the fibrinolytic activity in the veins of the lower leg, where thrombosis is relatively common, is lower than that in veins of the arms. Isacson and Nilsson² found the local fibrinolytic activity in the blood and/or vessel walls to be low in 73% of a large series of patients with thrombosis.

In a series of 28 women who had continuously taken 0.5 mg chlormadinone acetate a day—that is, the same hormone and dosage studied by Dr. Poller and others as a contraceptive, we studied the local fibrinolytic activity in the blood also after stimulation by venous occlusion of the arms and legs.³ In 10 of the patients we determined the fibrinolytic activity in biopsy specimens of superficial veins by means of Todd's method with grading according to Pandolfi. We found the normal response of the fibrinolytic activity to venous occlusion not to be inhibited. The fibrinolytic activity in the vein walls was unchanged. We also found platelet adhesiveness, various coagulation factors, plasminogen, α_2M , antiplasmin, and the urokinase inhibitors to be normal.

In a similar investigation treatment of postmenopausal women with ethinylestradiol (250 μ g daily for 10 days) before operation for prolapse significantly suppressed the fibrinolytic activity in the vein walls. It should, however, be pointed out that the amount of ethinylestradiol was about five times as large as that in hormonal contraceptives.

Oestrogenic hormones used in conventional, combined contraceptives and given as lactifuges or for suppressing the blood cholesterol are said to be capable of predisposing to thrombosis. So far as we know continuous use of gestogen as a contraceptive (usually in a daily dose of 0.5 mg chlormadinone acetate) has not given reason to suspect that such treatment predisposes to thrombosis. Further development of this type of contraceptive appears desirable.—We are, etc.,

I. M. NILSSON
B. ASTEDT

Malmö, Sweden

- ¹ Pandolfi, M., Nilsson, I. M., Robertson, B., and Isacson, S., *Lancet*, 1967, 2, 127.
- ² Isacson, S., and Nilsson, I. M., *Scandinavian Journal of Haematology*, 1971, Suppl. 16.
- ³ Nilsson, I. M., Kullander, S., and Astedt, B., *Acta Endocrinologica*, 1970, 65, 111.

Utus Paste and Termination

SIR,—Having read the article on "Termination of Pregnancy by the Intrauterine Insertion of Utus Paste" by Dr. S. V. Sood (8 May, p. 315) I am surprised by the conclusions that he has reached in his small series of cases. In the light of our present knowledge on techniques of procuring a therapeutic abortion, it is widely accepted that no one method is completely satisfactory. I would suggest that Dr. Sood's figures show that Utus paste has a part to play in

this field, provided certain precautions are taken.

The complications of urinary tract infection resulting from catheterization, and irregular vaginal bleeding owing to retained products of conception can both be avoided by correct management. Similarly cervical trauma should rarely, if ever, be seen. The main disadvantage is the serious problem of infection. 14.4% of Dr. Sood's patients had a significant pyrexia requiring treatment. However, every other method of termination has this danger. One effective method of reducing this risk is the prophylactic use of antibiotics with routine evacuation of the uterus immediately following spontaneous abortion. This regimen is justifiable in view of the long-term dangers of pelvic infection.

Failed abortion can be a problem especially if insufficient Utus paste is injected into the larger uterus, or if insufficient time is allowed for the abortion. Dr. Sood does not give full details of his two cases. He mentions one case of maternal death resulting from perforation of the uterus. Of all vaginal methods in use for termination of pregnancy, I suggest that the cannula supplied with Utus paste is the instrument least likely to cause this complication. Also, maternal death has been recorded with every other method of termination.

The Utus paste technique is a useful method for between 12 and 16 weeks gestation. The advantages are as Dr. Sood has stated. Also blood loss is small even after evacuation of the uterus which is a great advantage compared with some other methods.—I am, etc.,

ALAN D. G. BROWN

Department of Obstetrics and Gynaecology,
Western General Hospital,
Edinburgh

Emergency Dental Treatment

SIR,—I am sure that most dentists are willing, and, indeed anxious, to attend to any of their patients who suffer a genuine emergency. When a doctor is troubled by dental emergencies it is all too often by a thoughtless patient.

The genuine emergency does have our sympathy. Now that the G.D.C. has relaxed a rule on advertising it is possible for a dentist to display a discreet notice giving his phone number so that his patients can contact him or her at night. With only rare exceptions dentists prefer to attend to any postoperative haemorrhages and these are really the only cases that cannot wait until the next day.

Patients in pain are nearly always seen within a day or so in spite of the fact that the fee for an extraction does not compensate for the disruption caused to normal appointments. Most dentists will do their best and most patients, already booked for appointments, will be tolerant of the patient who is squeezed in to a session.

Emergency services have been tried. In New York there is an Emergency Dental Service advertised in the yellow pages of the telephone book. This scheme is run by the American Dental Association. It is, in fact, a telephone agency that has a rota of dentists who stand by for emergency. The present G.D.C. rules on advertising deter us from suggesting the idea in Britain.

I hope to be able to raise this question with the General Dental Council before the

end of this year, and I would welcome any suggestions from doctors in general practice and from casualty officers who can let me have figures to show the need for a service and ideas on how it should be provided.—I am, etc.,

D. N. BARBER

Chairman, Public Relations Subcommittee,
East Lancashire Branch, B.D.A.

Manchester 14

Jakob-Creutzfeldt Disease

SIR,—Kuru and Jakob-Creutzfeldt disease can be artificially transmitted from man to other primates and there is evidence that the former is naturally transmissible in man. There have been many admirable clinical and pathological descriptions of Jakob-Creutzfeldt disease under many different titles, but these have naturally been in terms of a "degeneration" of the nervous system and not of a possibly transmissible "infectious" disease. There is need for epidemiological study, including detailed medical and environmental histories, which, from the nature of the disease, must be obtained from informed relatives. Sufficient observations could scarcely be made at a single centre, as the disease is rare and wide collaboration is essential.

I would be keenly interested to act as a centre for the collection of such information, and if those with known or suspected cases of Jakob-Creutzfeldt disease under their care would write to me, something useful might be achieved.—I am, etc.,

W. B. MATTHEWS

Department of Neurology,
Churchill Hospital,
Oxford

Hiccup

SIR,—The remark in your leading article (1 May, p. 234) concerning the lack of a potent drug to control hiccup prompts me to report my experience with haloperidol in this condition.

Several patients presenting with persistent hiccup were treated with haloperidol. The dosage given was 5 mg t.d.s. orally or parenterally. Patients suffered from lower brain stem disorders, uraemia complicating terminal stages of renal disease or extensive burns, and idiopathic cases where psychogenic factors could not be excluded. The response has been prompt and sustained in all cases. None of the patients treated by me had the regular hiccup manifested in the cases described by Newsom Davis in his excellent article,¹ and no controlled studies were done. However, the impression was that haloperidol is a reliable drug in this condition.

The rationale for using haloperidol was a comparison of hiccup with vomiting, another lower brain stem response. Both reflexes may originate from the gastrointestinal tract and their efferent impulses affect the respiratory muscles. Chlorpromazine is a powerful antiemetic and has (as mentioned in your leading article) a mild effect against hiccup. Haloperidol is more active than chlorpromazine against nausea and vomiting, and its effect against hiccup was therefore thought to be worthwhile trying.

Whether or not this effect of haloperidol is related to its dopamine blocking activity

remains to be established. One line of investigation could be to find out whether in patients suffering from hiccup, drugs with dopamine-like action, such as apomorphine, will increase this disturbance.—I am, etc.,

A. D. KORCZYN

Beilinson Hospital,
Tel Aviv University Medical School,
Israel

1 Davis, J. N., *Brain*, 1970, 93, 851.

SIR,—Your leading article entitled "Hiccup" (1 May, p. 234) takes me back to 1936, when I was a house physician in the Royal Infirmary of Edinburgh and a patient was admitted almost in extremis with continuous hiccup. My chief ordered 5 ml of 25% magnesium sulphate solution intramuscularly into the upper and outer quadrant of the buttock twice daily for two days and once daily to complete five days. The hiccup was soon reduced in frequency and disappeared completely after around 36 hours.

A chest radiograph revealed chronic pulmonary tuberculosis with cavitation, and the sputum was positive for *M. tuberculosis*.—I am, etc.,

JOHN MACKAY-DICK

Edinburgh

SIR,—In your leading article on Hiccup (1 May, p. 234) you quote Douthwaite as suggesting amitriptyline to treat persistent hiccup. In fact, in his letter to the *Lancet* Dr. Douthwaite commends metoclopramide (Maxolon) as being useful in some cases.—I am, etc.,

T. W. CALVERT

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London W.1

Douthwaite, A. H., *Lancet*, 1968, 1, 144.

*Dr. Calvert is quite right.—ED., *B.M.J.*

Depressive Illness in Children

SIR,—Your leading article on "Depressive Illness in Children" (1 May, p. 237) is indeed apposite when it refers to "parental hostility, rejection (and) distorted family relationships" as causes of such illness. My own feeling, however, is that children subjected to this form of planned psychological abuse tend to show up later as anti-social deviants rather than depressives.

On the other hand, there is a good deal of psychological abuse which shows no outward evidence but which must damage the child emotionally. It is more than emotional deprivation by default or neglect—it is an actively pursued policy of systematic emotional sadism. I often hear of these cases through social rather than professional channels and thus get the impression that they occur largely in social classes 1 and 2, which may or may not be correct. Physical abuse, of course, occurs at all social levels though Helfer and Kempe¹ infer that it may be more common at the lower levels, possibly due to environmental factors.

In the typical case, father is in one of the professions, a church office-bearer, and a member of Rotary and of the "right" golf club, while mother had a rewarding career before marriage and does good works through the W.R.V.S. or Red Cross, being a member of the Bridge Club, Ladies' Circle, etc. More

often than not the health visitor does not call because "it is such a good home and the parents do not consider my visits are necessary." Yet it is these parents (together or one with the approval or condonation of the other) who carry out a planned campaign of psychological abuse of a child or children which would shame an interrogator in a police state. The child's life is a bewildering tangle of broken promises, false hopes, frustrated anticipations and wilful misleadings until he is a seething cauldron of impotent rage. Surely this must cause emotional damage.

In this nebulous field, however, it is difficult to get "hard data." In the community it is difficult to gauge the extent to which it occurs, while in hospital it must be difficult for the child or adolescent psychiatrist to unravel it in case history taking, when the child himself may not even be aware of the extent to which his parents' behaviour is abnormal. Again, some of the more resilient children (and the resilience of children never ceases to astonish me) may survive scarred, but not permanently damaged and never be seen by a psychiatrist at all. Or they may become the drop outs, the misfits, the odd balls whose lives are a pattern of cynicism and mistrust.—I am, etc.,

H. D. WILSON

County Health Department,
Haddington,
East Lothian

1 Helfer, R. E., and Kempe, C. F., *The Battered Child*. Chicago, University of Chicago Press, 1968.

Post-Hypoglycaemic Encephalopathy

SIR,—I was interested in Mr. D. C. Dunn's article (10 April, p. 84) because although mainly dealing with the late effects of removal of islet cell tumours of the pancreas, it touches upon the facts and problems of post-hypoglycaemic encephalopathy. Mr. Dunn reports cases of mental deterioration from the literature on sequelae of insuloma operations—hypoglycaemia having had a similar effect to anoxia—but stresses the *prima facie* "normality" of his follow-up cases (in spite of reduced insulin production), apart from two neurological complications.

On further consideration, the situation may be still more complicated by a further factor. We know from the study of persons with "minimal brain damage" (or "marginal encephalopathies" as I have called them) that their main difference compared with other people lies in their response to stress.¹ Generally speaking, some functional properties of the central nervous system will reveal themselves best under provocation (in the E.E.G. field one speaks of "evoked responses"). This holds good both for the neurophysiological as well as the psychological aspects of the constitutional totality of a person. Mr. Dunn already indicates mild E.E.G. abnormalities resembling "minimal brain damage" in a number of cases. It is furthermore a characteristic of "marginal encephalopathies" that they are predisposed to neurotic reactions under stress.

My experimental investigations into sensory stress response—for example, using the flicker fusion technique and automatic responses recorded on a polygraph²—indicate that this type of stress response is constitutionally determined and therefore "differential" as between types. We have to include

here the possibility of a functional alteration of the nervous constitution. Far be it from me to regard persons with minimal brain damage as "abnormal," but their response to stress can easily be "different." In conclusion, it can be said that the "stress response" consideration is bound to widen the outlook in this field.—I am, etc.,

STEPHEN KRAUSS

Reading

1 Krauss, S., in *Proceedings of the 8th International Congress of Neurology, Vienna, 1965*, 5, 145.
2 Krauss, S., in *Proceedings of the 17th International Congress of Applied Psychology, Liège, 1971*, in press.

Suicide and Euthanasia

SIR,—The present position in Switzerland is that "any person who, for selfish motives, incites someone to suicide or renders him assistance in this, will, if the suicide is perpetrated or attempted, be punished with penal servitude for up to five years or prison."¹ In the case of a patient dying of incurable and painful disease there would be no question of selfish motives, nor would there be incitement though there might be assistance in carrying out the patient's wishes.

One senses from Reverend H. C. Trowell's more tolerant reaction (1 May, p. 275) to a modification of our own Suicide Act (1961) along these lines as a means of introducing voluntary euthanasia that he, like many others, finds an active involvement in the termination of life the really repugnant feature. It might be another matter if the patient (in one of the categories envisaged by the advocates of voluntary euthanasia) were to be given the facility to ask for death and the means to achieve it. The safeguards proposed by Lord Raglan's Bill [see *B.M.J.*, 15 March 1969, p. 725] would continue to apply. The only difference would be that the doctor, having provided the fatal potion, would not even need to be present.

A correlative issue is the question of the resuscitation of potential suicides. It is axiomatic today that suicide is the act of a disordered mind. Society clings to the belief that life, however painful, however undesired by the subject, must always be preferable to death. While admiring the work of psychiatrists, Samaritans, etc., who are able to salvage so many, is it not possible that efforts in this direction can be over-zealous, comparable to over-active treatment of terminal disease?

The philosophical acceptance of death as a merciful episode, rather than as an ultimate catastrophe, is an element of wisdom which medical practice appears to have lost as a result of the enormous powers modern science has provided, powers themselves linked with an ultimately non-Christian and materialistic society.—I am, etc.,

S. L. HENDERSON SMITH

Huddersfield, Yorks

1 *Swiss Criminal Code*, 1937, Article 115.

Keeping it in the Family

SIR,—As a medical student from a non-medical family I wish to reply to the remarks of Dr. John McKee in his "Personal View" (15 May, p. 397) that "all doctors' offspring with reasonable academic standards" should be accepted for medicine before others with