CORRESPONDENCE

Correspondents are asked to be brief

Postmenopausal Genital Tuberculosis

SIR,—Towards the end of 1970 a 65-year-old woman presented with abdominal pain she had had for nine weeks, starting in the left loin and radiating into the left iliac fossa and described as a steady ache, relieved by mild analgesics.

She had had a right nephrectomy at 48 years of age for suspected renal tuberculosis. Tubercle bacilli were never isolated but she was treated with streptomycin, P.A.S., and isoniazid for 12 months. She had had two pregnancies, both with normal deliveries. Her periods had been regular and normal, and there had been no postmenopausal bleeding since the menopause at 40 years.

On vaginal examination, a mobile mass was palpable on the left. Radiologically it was a well-defined mass, diameter of 8 cm. Mantoux (1 tuberculin unit) was strongly positive and the E.S.R. was 61 mm/hr.

At operation, a round, red, studded mass attached by adhesions to the small bowel and left Fallopian tube was removed. The mass and both tubes contained caseous material. Histologically the lesion was that of healed tuberculosis. Guinea-pig inoculation and culture were negative. Nevertheless, in view of the findings antituberculous therapy was restarted.

Women with genital tuberculosis presenting postmenopausally may have been fertile in contrast to young premenopausal women, who frequently present with sterility.[1-3] The coincidence of renal tuberculosis with genital tract tuberculosis varies from 5% to 30% according to different authors.[4,5] If genital tuberculosis is present co-incident extrapulmonary infection is most likely to be found in the kidneys and peritoneum.[4] Tuberculosis of the genital tract in postmenopausal women is an uncommon condition which is increasing,[3-6] though this has not as yet been the experience of clinicians in Newcastle (Snaith, personal communication). Diagnosis is often difficult even with the use of laboratory aids.

I would like to thank Mr. Linton Snaith for his help and advice.

—I am, etc.,

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Medical School,
University of Newcastle upon Tyne

1 Dutton, W. A. W., *Canadian Medical Association Journal*, 1966, **94**, 1012.
2 Snaith, L. M., and Barns, T., *Lancet*, 1962, **1**, 712.
3 Ruszkowski, J., and Marynowski, A., *Zentralblatt für Gynäkologie*, 1970, **92**, 592.
4 Schaeffer, G., *Clinical Obstetrics and Gynecology*, 1970, **13**, 965.
5 Barns, T., *Journal of Obstetrics and Gynaecology of the British Empire*, 1955, **62**, 162.
6 Dellepiane, G., *Revue Française de Gynécologie et d'Obstétrique*, 1965, **60**, 21.

Footballer's Migraine

SIR,—I read with interest the paper by Professor W. B. Matthews on migraine in footballers, precipitated by minor head trauma (6 May, p. 326). While reviewing migraine cases attending the Maudsley Hospital I have come across five cases whose migraine started after head trauma. In all five cases, the head injury was severe enough to result in a temporary loss of consciousness, though subsequent E.E.G.'s showed no focal brain damage. Once initiated, the migraine attacks continued, occurring either spontaneously or being precipitated by stress or in one case related to the menstrual cycle.

Thus, while Professor Matthews's paper highlights a group of migraine patients who are susceptible to precipitation of their attacks by relatively minor head trauma and at no other times, in other cases more severe head trauma might be responsible for initiating attacks of migraine, which then continue to occur in the absence of further trauma.—I am, etc.,

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Recurrent Urinary Infections in a Girl

SIR,—We were interested to read Dr. R. R. Bailey's comments (22 April, p. 232) about our article on this subject in the series "Second Opinion, Please" (12 February, p. 428). We are honoured that he should treat our article as an expert treatise presenting all the latest and best views on problems in this field. It was, in fact, a somewhat truncated factual record of an actual child who presented in 1970, when bladder punctures were infrequently done, and was designed to present a few of the problems as seen from family practice and general hospital level. We agree that bladder puncture can be of use under some circumstances, and indeed use it when indicated in hospital practice, but not that it should become a routine procedure in a general practitioner's surgery. We would certainly not like our own children to have this done, which is our yardstick for dealing with other people's children.

With respect to Dr. Bailey's second point, we would still doubt the wisdom of doing both an intravenous pyelogram and a micturating cystogram in all first urinary tract infections in childhood. Some selection of cases is possible, and provided a careful follow-up is done we doubt whether any real harm would come by delaying a micturating cystogram till there is evidence of failure to cure the initial attack, or of relapse. Dr. Bailey's policy is one of

idealistic perfection, our's of the practical care of children.

Finally, a standard dosage regimen recommended for nitrofurantoin is 7 mg/kg/24 hours.[1] For a 2-year-old weighing approximately 12 kg 75 mg per day is not excessive. Not being blessed with foresight, we were not able to foresee the results from Professor de Wardener's department that Dr. Bailey refers to,[2] as these had not been published at the time we drafted our article, let alone at the time we were treating the child concerned.—We are, etc.,

R. H. JACKSON
ANDREW SMITH

Children's Department,
Royal Victoria Infirmary,
Newcastle upon Tyne

1 Nelson, W. E., *Textbook of Paediatrics*, 8th ed., p. 223. London, Saunders, 1966.
2 Bailey, R. R., Roberts, A. P., Gower, P. E., and de Wardener, H. E., *Lancet*, 1971, 2, 1112.

Recurrent Urinary Infections

SIR,—I would like to agree with Dr. H. G. Jones (8 April, p. 113) that it is to be regretted that his regional board does not consider it essential to equip the new district general hospital with tomographic units for excretory urograms. Although there are only one or two centres, so far as I am aware, who now use routine tomography during excretory urography, I am certain that a urogram without tomography will soon be considered an incomplete and unsatisfactory examination. In a recent study[1] using routine tomography in 423 excretory urograms we found that under the age of 40 routine tomography showed a distinct improvement in just over half the patients in both sexes, whereas over the age of 40 there was a further substantial improvement, particularly in males.

As for the bogey of expense, tomography tables are not expensive when considered as a capital outlay, particularly in terms of the usual high cost of radiographic equipment. I am quoted a figure of approximately $5,000 (£2,000) as the difference between a routine and tomographic unit.—I am, etc.,

PETER DURE-SMITH

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Philadelphia, Pa., U.S.A.

1 Dure-Smith, P., and McArdle, G. H., *British Journal of Radiology*, 1972, in press.

Depressive Illness and Aggression in Belfast

SIR,—Drs. J. R. Ashton (11 March, p. 692) and D. Walsh (8 April, p. 115) suggest that the decrease in depression in Belfast in 1970, as described in my paper on aggression and depression in Belfast (5 February, p. 342), could be due to patients being unable to contact their doctors because of the disruption in normal life. In reply to this suggestion I would like to make the following points.

In spite of constant civil disturbance in Belfast in recent years communication between patient and doctor has not been affected to any appreciable extent. Both general practitioners and consultants can move freely throughout the city, and generally patients have no great difficulty in attending surgeries and outpatient clinics. The number of patients attending psychiatric outpatient clinics in Belfast has not shown any significant decrease in recent years—the range from 1964-71 being 699-1,035 new-patient attendances per annum and 3,321-4,389 re-attendances per annum, the respective figures for 1970 being 985 and 4,389 (figures obtained from the Statistics Branch of the Northern Ireland Hospitals Authority).

The number of admissions to Purdysburn Hospital (the main mental hospital for Belfast) has been increasing in recent years. In the five-year period from 1964-8 inclusive there was an approximate 5% increase in the admission rate per year. In the past three years this annual increase has not occurred, the admission rate remaining fairly constant. The fact that the rising admission rate has been halted could be explained by the decrease in depressive illness in Belfast as demonstrated in my paper.

Furthermore, if the decrease in depressive illness was due to patients being unable to visit their doctors or being referred to psychiatrists, one would not expect the highly significant decrease in the suicide rate in 1970 and which continued to remain low in 1971 (figures obtained from the Registrar General's office, Belfast).—I am, etc.,

H. A. LYONS

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Belfast

Oral Prostaglandin E_2 for Induction of Labour

SIR,—We wish to comment on some of the points made by Mr. Ian Craft in his report on induction of labour by the oral administration of prostaglandin E_2 (22 April, p. 191). In our view, it is misleading to use the term "titration" in relation to oral administration of prostaglandin in the same sense as it has been used in relation to intravenous administration of oxytocin. "Titration" of intravenous oxytocin involves rapid adjustment of the dosage in relation to the degree of uterine response. In contrast, oral doses of prostaglandin are given every two hours and the same degree of flexibility cannot be achieved. Furthermore, during "titration" with intravenous oxytocin the dose is progressively increased if uterine response is not adequate, whereas with oral administration of prostaglandin the occurrence of gastrointestinal side effects often sets a limit to the dose.

It is our practice to administer an initial dose of 0·5 mg of prostaglandin E_2. If vomiting or diarrhoea does not occur, the dose is increased to 1·0 mg given every two hours. A maximum dose of 1·5 mg may be given if the cervix is unripe. Administration of doses greater than 1·5 mg is often associated with not only vomiting or diarrhoea but paradoxically also with inefficient uterine activity. Indeed, in the series reported by Mr. Craft in all three women who received doses of prostaglandin E_2 higher than 1·5 mg (Case Nos. 23, 25, and 39) the occurrence of vomiting or diarrhoea was associated with poor uterine action. This poor uterine response may be due to lack of absorption following vomiting as has been suggested by the author. Alternatively, the phenomenon may be a form of tachyphylaxis. The possibility also exists that in these women there is a qualitative insensitivity of the myometrium to prostaglandin. Therefore the uterus fails to respond to not only doses of prostaglandin E_2 between 0·5 and 1·5 mg, but also to higher dosage.

We would like to emphasize the need for close supervision and monitoring of the fetus in labour induced by oral administration of prostaglandin, not only because of any possible adverse effect of prostaglandins, but also because of the underlying risk factor which necessitated induction of labour.—We are, etc.,

H. K. BASU

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H. THELWALL-JONES

Liverpool Maternity Hospital,
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Diabetics and Motorway Crashes

SIR,—Dr. G. E. Leyshon and others (13 May, p. 405) state that diabetics need not disclose their disability on their driving licence application form except if they suffer from disabling attacks of giddiness or fainting.

Perhaps my reading of the driving licence application form is different to theirs but, as a diabetic on oral therapy and one involved in research in this condition, I have always felt obliged to declare my condition in answer to question 7f. This question asks, "Are you suffering from any other disease or disability likely to cause the driving of a motor vehicle by you to be a source of danger to the public?" As I have never suffered from an attack of hypoglycaemia I do not feel obliged to answer in the affirmative question 7b, "Do you suffer from or have you at any time had sudden attacks of disabling giddiness or fainting?" However, I take the view that should I unfortunately be involved in a road accident without having declared my condition both the licensing authority and my insurance company (for whom such information is obligatory) could render me liable on both counts for withholding such information. I do not find the licensing authorities present any difficulties apart from their asking, from time to time, for a medical certificate.

Therefore, it would seem to be in the interests of diabetics to declare their condition on their driving licence application form to safeguard themselves.—I am, etc.,

N. SANTER

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Condylomata Acuminata

SIR,—I was interested in your leading article on "Condylomata Acuminata" (22 April, p. 179). At the West London Hospital a survey was made during 1970 of conditions of dermatological interest presenting in the venereology department. The figures obtained for anal warts were not unlike those obtained by Oriel at St. Thomas's Hospital.[1]

Perianal warts were seen in 154 male patients of whom 126 were homosexual (81·8%). It may be of interest that many of 28 heterosexual patients seen with perianal warts were also found to have co-existent inguinal and penile warts, and in these cases the perianal warts were possibly secondary to the initial condylomata acuminata elsewhere on the genitals.

Similarly during the same period it was noticed that anal warts were five times more common than penile warts in 402 homosexual males studied. This poses the question of why are penile warts relatively uncommon among homosexuals? Although in the series