sensitivity invoked by the drug acting as a hapten and becoming conjugated with body proteins.

I thank Dr. N. W. Horne for permission to report this case.

—I am, etc.,

D. C. CAMERON

Royal Infirmary,
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- 1 Nevins, M., *et al.*, *Lancet*, 1969, 2, 1358.
- 2 Ogryzlo, M. A., *Canadian Services Medical Journal*, 1956, 11, 66.
- 3 Alarcón-Segovia, D., *et al.*, *New England Journal of Medicine*, 1965, 272, 462.
- 4 Alarcón-Segovia, D., *et al.*, *Medicine*, 1967, 46, 1.
- 5 Siegel, M., Lee, S. L., and Peress, N. S., *Arthritis and Rheumatism*, 1967, 10, 407.

Complications of Laparoscopy

SIR,—A few years ago, because of reported complications of laparoscopy, I introduced at St. Thomas's Hospital what came to be known as a Cusco laparoscopy. In this a 1-in (2.5 cm) incision is made in the pubic hairline and then a small Pfannenstiel approach to the pelvis is developed. Access is made easy by sliding the skin from side to side. The edges of the out peritoneum are stitched to skin. A large Cusco speculum is passed down into the pouch of Douglas and the blades are opened across the pelvis. One or two fingers passed through the speculum allow the gut to be displaced above the sacral promontory, where it can be held out of the way by a gauze pack.

By moving the speculum to and fro and opening and closing the blades the whole pelvis may be visualized. A long Babcock forceps can pick up the ovary and draw it to the surface, withdrawing the speculum at the same time. So that the ovary may not slip back it may be seized again by a forceps introduced between the blades. If the ovary cannot be seen easily the Babcock forceps grasps the round ligament of the uterus and pulls that to the surface. A finger passed behind it will easily deliver tube and ovary into the incision.

Any variety of sterilization operation can be carried out on the tube. The ovary can be handled, inspected, and a specimen taken for biopsy. Everything is under the same sort of control as at laparotomy. If difficulty is encountered the incision can quickly be enlarged. Closure is routine. The peritoneum can be bunched up into a very small hole. The skin requires one or two clips or stitches. Stay in hospital need be only overnight, mainly to get over the effects of anaesthesia.

Anyone who can perform a gynaecological laparotomy safely can do this operation too. It does not require the special expertise of laparoscopy. It might be considered a serious rival to the technically more difficult laparoscopy, for it can be used in all situations where laparoscopy is considered and it has wider scope with fewer of the disadvantages.—I am, etc.,

PHILIP RHODES

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Side Effects of Methyl-dopa

SIR,—We were interested in your leading article on the side effects of methyl-dopa (22 March, p. 646). The list is fairly formidable and not only of academic interest,

since many of the side effects lead to considerable incapacity which in many cases requires alteration of a previously accepted way of life.

We are currently comparing the side effects volunteered by recipients of methyl-dopa with those mentioned by the same patients when given a simple questionnaire with specific questions. We were particularly looking for the incidence of loss of sexual prowess, a symptom seldom volunteered spontaneously through embarrassment and hence probably underestimated. We were also interested in the incidence of postural hypotension. We have currently only 30 patients, all men aged less than 60 years. Methyl-dopa dosage has varied from 1.0 to 2.5 g daily and the duration of therapy from six months to three years. Blood pressure readings were taken with a sphygmomanometer lying, standing, and after running on the spot (30 steps).

Despite the small numbers we felt the preliminary results (see table) were of interest. The table compares the incidence of volunteered symptoms with those that subsequently came to light when patients filled in the questionnaire. The differences are obvious and we think that all patients should be asked directly about sexual function and the significance to them of any change, as much domestic and psychological trauma can ensue from loss of sexual function. Five of the patients admitted to feeling much better generally since starting the drug, and this was usually manifest as a lessening of tension. Postural hypotension, though rarely symptomatic, was detected after exercise in 26 patients: 14 had a drop of systolic blood pressure greater than 20 mm Hg (range 20 to 70 mm) and 12 a drop between 10 and 15 mm. Post-exercise blood pressure readings should be made routinely in all hypertensives taking methyl-dopa, as clearly there may be a significant

Incidence of Side Effects in 30 Patients Taking Methyl-dopa

Symptom	Questionnaire	Volunteered
	No. (%)	No. (%)
Erection failure	16 (53)	2 (7)
Impotence	0 (0)	0 (0)
Drowsiness	18 (60)	14 (47)
Postural hypotension	2 (7)	2 (7)
Asymptomatic	3 (10)	10 (33)
Improvement	5 (17)	5 (17)

postural drop in many patients which is detectable only after exercise.

Patient compliance is a big problem with long-term therapy and intolerable side effects can only aggravate it, particularly since hypertension is essentially an asymptomatic disease. We think that with the introduction of beta-blocking agents with, as yet, relatively few troublesome side effects methyl-dopa should no longer be a first-line choice in the treatment of hypertension.—We are, etc.,

WILLIAM D. ALEXANDER
JOHN I. EVANS

University Hospital of Wales,
Cardiff

Hospital Pharmacy Committees

SIR,—I would like to comment on the membership of hospital pharmacy committees (8 February, p. 323), and on the importance

of including in the membership a number of staff involved directly in patient care. These comments are based on the activity of our own very active district therapeutics committee. When suitably constituted, such groups have an important role in making certain that recommended changes in policy are realistic. Policies decided centrally do not always appear to be influenced by such considerations, nor do those who make these policies appear to be interested in utilizing information on the impact of their policies on patient care.

The membership of our committee has always included a member of the ward nursing staff (as well as of the nursing administration) and members of the non-consultant medical staff (as well as of the consultant medical staff). I consider that the contribution from these representatives has been quite outstanding, and their absence from many similar committees may well have made them less effective. Another addition to our committee, an indirect result of N.H.S. reorganization, is our general practitioner member. There is no reference to the possible contribution of a general practitioner in the recent article, but the interface between hospital and general practice should not be ignored. We have already discussed several important problems on this interface, and have taken active steps to create general interest in one of these (5 October 1974, p. 41).

The membership of our committee has made it an appropriate forum for discussion of a variety of directives issued by the Department of Health and Social Security, who have often been advised by committees whose members may not always be able to claim such a close daily involvement in clinical work. Our views have at times been at variance with the recommendations of the D.H.S.S. On three occasions the committee, supported by the district hospitals medical committee, have reported their views to the appropriate department at the D.H.S.S. It has concerned me that these carefully considered comments have on only one occasion produced a reply from the Department.

The contributions of pharmacy and therapeutics committees should, perhaps, include a role in providing "feed-back" to the D.H.S.S., to region, and to area. These administrative bodies might then be more aware of the views of those responsible for patient care. There are other important contributions that these committees can make in encouraging the efficient use of scarce financial and manpower resources. It is an appropriate time for the B.M.J. to encourage increased interest in their activities.—I am, etc.,

MARTIN S. KNAPP

Chairman,
Therapeutics Committee, North Nottingham District

City Hospital,
Nottingham

Social Work in General Practice

SIR,—At a recent meeting of social workers and general practitioners in Manchester it was decided that there is a need for a group whose special function is to foster co-operation between social work and general practice. It was thought that professional organizations involved in promoting co-operation were too remote to be able to

monitor adequately the problems that occur in the field. It was also pointed out that the professional organizations most intimately concerned, the British Association of Social Workers and the Royal College of General Practitioners, were limited to dealing with their own members when they tried to promote co-operation.

The meeting therefore decided to constitute itself formally and the title chosen for the group was "General Practitioner and Social Worker Workshop." We have drawn up a constitution and have appointed officers for the forthcoming year. It is unfortunately necessary for us to charge a subscription to cover the costs of postage, stationery, etc., and some small-scale research projects that we envisage being undertaken. We would stress that we see ourselves not as a rival organization to other professional bodies but rather as a body which has constituted itself to perform a special task. Should we find that the need for our existence no longer exists we would dissolve ourselves. Our experience so far, however, during two and a half years of informal meeting, is that there is a need for a group which can act as a focal point for those interested in general practice/social work co-operation.

If anyone is interested in joining the group details of our constitution and aims can be obtained by sending a reply paid envelope to me.—I am, etc.,

G. KEELE

Hon. Secretary,
General Practitioner and Social Worker Workshop

Darbishire House Health Centre,
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Manchester

Prescribing Barbiturates

SIR,—Dr. J. G. R. Howie's contribution on the subject of psychotropic drugs in general practice (26 April, p. 177) is as informative as it is thought-provoking. No one would argue with his warning that extreme caution should be exercised when psychotropic drugs are used with other medication.

However, his statement on his personal prescribing policy that he tends to allow patients to go on taking barbiturate hypnotics should not go unchallenged. Most of our patients receiving preparations, whatever their nature, are satisfied with what they get, provided the drug produces the desired effect. But the case against barbiturates has been made and is now widely accepted and to go on prescribing them on their merit of continued acceptability in the light of present knowledge is to be condemned.

In our practice in a matter of a few months we were able to change completely from barbiturates to benzodiazepines without any great difficulty. In fact, save for anticonvulsant medication, barbiturates are proscribed.—I am, etc.,

P. S. BOFFA

Croydon

Long-acting Phenothiazines

SIR,—Dr. P. F. Kennedy gives an excellent summary of the present position of orthodox treatment for schizophrenia and related paranoid psychoses (3 May, p. 257). How-

ever, when he discusses the use of fluphenazine decanoate (Modectate) and flupenthixol decanoate (Depixol) in maintenance therapy he states: "In old age few but the very robust can tolerate long-acting depot preparations. . . ." Experience of treating elderly people with paranoid psychosis over a period of nine years does not substantiate this observation. Fluphenazine decanoate produced few adverse side effects in patients whose ages ranged from 60 to 92 but admirably controlled their psychoses. Evidence of moderate or severe dementia was looked upon as a contraindication, since in these cases there was a risk of fairly serious extrapyramidal reactions.

Latterly I have been using flupenthixol decanoate and to date have treated 29 patients whose ages have ranged from 65 to 97. Four in this series had moderate degrees of dementia but did not develop extrapyramidal symptoms. This preparation has been as effective as fluphenazine decanoate in controlling the psychosis, with the added advantage of activating instead of mildly sedating the patients. The dose has ranged from 20 mg every month to 90 mg every three weeks. The latter dose was given to an 84-year-old woman who weighed about five stone (32 kg). She was maintained on this dosage for four years till her death recently from a cerebral thrombosis.

I would strongly oppose the indiscriminate use of long-acting depot preparations in the elderly, but I do consider that they have a definite place in the treatment of paranoid psychosis in old people provided there is no evidence of a serious degree of dementia and there are adequate community facilities so that they can be supported and observed. The majority of the patients I have treated would have spent their last years in an institution if treatment with long-acting depot preparation had not been available.—I am, etc.,

TONY WHITEHEAD

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Beverdean Hospital,
Brighton, Sussex

SI Units

SIR,—Mr. B. H. Hand and his colleagues (17 May, p. 389) can be assured that their protests, like mine (28 December 1974, p. 267) and those of many others, will be ignored. Consultation in this matter has consisted of informing clinicians that this change is to take place. Serious and cogent objections have been neglected. It is clear that the allegiance of many pathologists is now directed to "pure" science rather than to the needs of clinicians in managing their patients. Moreover, we shall be divorced by the "unit barrier" from easy comprehension of past data, both in our patients' records and in the medical literature, not to mention much of the current U.S. literature. I was glad to see that the American Medical Association has rejected application of SI units.¹

One further point. Your editorial footnote states that representative bodies were consulted. With regard to one of those bodies—namely, the Royal College of Physicians—I can tell you what happened. No reference was made either to Comitia or to the Standing Committee of Members. Judging

by the pained surprise of most clinicians I have met, very few attempts were made by other bodies to apprise their members of the SI bombshell. Considering the danger, expense, and inconvenience of the whole exercise, this can only redound to their discredit. Perhaps, however, we shall at least be able to save the millimetre of mercury as Dr. A. Hollman (3 May, p. 281) proposes. One sighs for the day of the 100% haemoglobin scale and longs for the day of the unit normal deviate. But now we have chaos.—I am, etc.,

G. H. HALL

Exeter

¹ *New England Journal of Medicine*, 1975, **292**, 805.

Drugs for Common Cancers

SIR,—We were very interested to read your leading article (3 May, p. 235) which pointed out clearly the potential importance of adjuvant chemotherapy at an early stage in the management of malignant disease, especially of the breast. Fisher and his colleagues¹ have produced short-term results that appear impressive, but though melphalan has major advantages in terms of convenience and toxicity, it would be premature to draw conclusions on such a small number of cases. It would, however, seem logical to assume that micrometastases would respond optimally to that variety of chemotherapy demonstrated most effective in advanced breast cancer. Melphalan, unfortunately, is relatively ineffective when used in advanced breast cancer, producing short-duration responses in only a minority of cases.

Recent work with combinations of cytotoxic drugs has shown much greater effectiveness in late breast cancer. This group, for example, has completed one study comparing two combination regimens using intravenous cyclophosphamide, vincristine, methotrexate, and 5-fluorouracil. One of the regimens necessitated five daily injections, while the other was carried out as an infusion on one day. The three-month remission rate for the five-day treatment was 59% and the six-month rate 54%. The one-day regimen gave three- and six-month remission rates of 49% and 27% respectively. (There were 39 five-day cases and 41 one-day cases.) In consequence the shorter regimen was discontinued and we are now in the later stages of a second study, using the previous five-day treatment, compared with a two-day treatment in which the two treatment days are separated by four to six rest days. This regimen is currently producing response rates at least as good as the five-day treatment. The three-month remission rate (46 cases) is running at over 60% and the six-month rate (35 cases) at over 50%, while the five-day regimen continues to confirm its effectiveness as shown in the first trial. The statistical significance of the treatment comparison in this study has yet to be determined, but the convenience and low toxicity of this two-day regimen, together with its undoubted effectiveness, make it a strong candidate for evaluation in early cases.

A collaborative multicentre trial for poor-risk early cases using the two-day treatment with a slight dose reduction to minimize any