for publication the following open letter to British psychiatrists:

Dear Fellow Psychiatrists,

I understand that it was your intervention that helped me so quickly (and comparatively painlessly) to leave the U.S.S.R., where the right to hold one's own beliefs is being constantly violated.

Life in the Soviet Union has taught me that the authorities in my country are extremely sensitive to the public opinion of the Western powers. I saw that help was especially effective where Western colleagues had interfered resolutely and uncompromisingly. That is why, on behalf of my colleagues in the Soviet Union, who have no possibility of expressing their opinions openly, I ask you to help those who have tried to defend the honour of psychiatry—Vladimir Bukovsky and Dr. Semyon Gluzman. By defending these honest and brave people you are also defending the integrity of our profession.

Whatever decision you choose to take, please keep in mind that while you are able to think and speak freely many sane people are forcibly detained in prison hospitals—with the connivance of our profession.

(Signed) Dr. Marina Voikhanskaya

—We are, etc.,

S. SHAFAR

Psychiatric Day Department,

A. THEODOSSIADIS

Psychiatric Department,
North Manchester General Hospital,
Crumpsall, Manchester

L. STEEN

Psychiatric Department,
St. Thomas's Hospital,
Stockport

Indomethacin, Prostaglandins, and Dysmenorrhoea

SIR,—The Danish general practitioner Dr. A. Christensen, whose serendipitous discovery of the beneficial effect of indomethacin in dysmenorrhoea is mentioned in your recent leading article (31 May, p. 461), perhaps reads *Nature* no more regularly than I read *Ugeskrift for Læger*. An article in the former journal¹ in 1972 stated: "One of the anti-inflammatory drugs could possibly prove of value in dysmenorrhoea, which may be associated with abnormal prostaglandin action; especially as aspirin has commonly been recommended for its simple treatment." The fact that anovulatory cycles (normally pain-free) in one young subject ended with menstrual losses having only one-fifth the usual content of prostaglandin-like material was reported briefly in 1967,² and a little evidence on the prostaglandin content of menstrual fluid from normal and dysmenorrhoeic subjects was given as long ago as 1965.³ Recently, as your article implies, these questions have been further investigated by more powerful methods and with better understanding of prostaglandin metabolism. The work of the Stockholm group is particularly notable. For example, Lundström *et al.*⁴ have recently found that the concentration of the prostaglandin metabolite 15-keto-13,14-dihydroprostaglandin $F_{2\alpha}$ in plasma is high in dysmenorrhoeics and is lowered by indomethacin treatment.—I am, etc.,

V. R. PICKLES

Physiology Department,
University College,
Cardiff

¹ Pickles, V. R., *Nature*, 1972, 239, 33.

² Pickles, V. R., *International Journal of Fertility*, 1967, 12, 335.

³ Pickles, V. R., *et al.*, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1965, 72, 185.

⁴ Lundström, V., Wiqvist, N., and Green, K., *International Conference on Prostaglandins*, Florence, May 1975. Abstracts, p. 222.

SIR,—It seems from your leading article on dysmenorrhoea (31 May, p. 461) that you are more familiar with the correspondence columns of Danish journals than with those of your own.

In 1973,¹ several months before Dr. Christensen's letter, you published a letter from me stating that for several years I had successfully treated most cases of dysmenorrhoea with indomethacin, usually in a dose of 25 mg four times daily. I had in fact mentioned this on more than one occasion to the representatives of the makers but without apparent interest on the firm's part. Subsequently in a letter² Professor V. R. Pickles suggested the possible role of prostaglandins in dysmenorrhoea and drew attention to his suggestion in 1972³ that non-steroidal anti-inflammatory drugs might be of value.—I am, etc.,

G. G. HILL

Hemel Hempstead,
Herts

¹ Hill, G. G., *British Medical Journal*, 1973, 3, 106.

² Pickles, V. R., *British Medical Journal*, 1973, 3, 349.

³ Pickles, V. R., *Nature*, 1972, 239, 33.

SIR,—For a number of years I have been prescribing phenylbutazone for patients with dysmenorrhoea and the results have been very satisfactory. The treatment is started the day before the onset of the period, if this can be calculated, or when the period starts and continues for 24-72 hours as necessary; side effects have been minimal.

Reports on the value of phenylbutazone in dysmenorrhoea first appeared over 20 years ago.¹ By a similar piece of serendipity to that used by Christensen² when he found that indomethacin prescribed for other reasons also relieved dysmenorrhoea (leading article, 31 May, p. 461) Fox—and later others³⁻⁵ found the identical happy result with phenylbutazone when they used it for rheumatic conditions. My memory is that it was the paper by MacQueen⁶ which led me to adopt this treatment.

If any credit is to be given for the earliest uses of prostaglandin synthetase inhibitors in dysmenorrhoea, it should surely go to those who discovered the value of phenylbutazone.—I am, etc.,

STUART CARNE

London W.12

¹ Fox, W. W., *Lancet*, 1953, 1, 195.

² Christensen, A., *Ugeskrift for Læger*, 1974, 136, 592.

³ Strazza, J. A., and Ressetar, M., *Journal of the Medical Society of New Jersey*, 1953, 50, 333.

⁴ Arden, G. P., *Rheumatism*, 1954, 10, 44.

⁵ Black, E., *Canadian Medical Association Journal*, 1958, 79, 752.

⁶ MacQueen, R. L., *Practitioner*, 1960, 184, 787.

Hormonal Pregnancy Tests and Congenital Malformations

SIR,—In 1967, before drawing attention to the teratological effect of the hormonal pregnancy test¹ I consulted the then Committee on Safety of Drugs. Though the committee found that my observation obviously had clinical importance a formal warning was not issued because other data were not available on the topic at that time. This precaution was taken to prevent alarming the public. In 1969, however, the manufacturers were advised by the committee to discourage the promotion of the hormonal

pregnancy test tablets and consequently manufacturers in Great Britain no longer recommend their products for testing pregnancy and have changed the indications for such preparations as Primodos, Amenorone-Forde, and Orasecron. These measures appear to be sufficient to safeguard the manufacturers, but they are less satisfactory from the public point of view as most of these preparations are available and recommended for the treatment of secondary amenorrhoea.

Following the publication of the detailed findings which indicated the teratogenic hazard of the pregnancy test² the problem has gained wide interest, and I am pleased that your recent leading article (30 November 1974, p. 485) and Dr. Gillian Greenberg and her colleagues (26 April, p. 191) have reiterated my view that "unnecessary risks are being taken by diagnosing pregnancy with an in vivo method when many other reliable in vitro methods are available."² Still, it is clear that some general practitioners have continued to use the tablets for pregnancy testing, probably because the changes introduced by the manufacturers were rather inconspicuous.

The warning notice which has now been issued by the Committee on Safety of Medicines (14 June, p. 625) is therefore to be welcomed. It would seem appropriate, however, to reinforce this warning by further measures such as: (1) changing the name of products which were formerly recommended for pregnancy testing and which are at present indicated for the treatment of secondary amenorrhoea not due to pregnancy; and (2) continuing to remind the medical profession of the unnecessary risks of using the tablets either for diagnostic or for abortifacient purposes.—I am, etc.,

ISABEL GAL

Department of Biological Sciences,
The Hatfield Polytechnic,
Hatfield, Herts

¹ Gal, I., Kirman, B., and Stern, I., *Nature*, 1967, 216, 83.

² Gal, I., *Nature*, 1972, 240, 241.

Safer Cigarettes

SIR,—In your leading article (17 May, p. 354) it was pointed out that anti-smoking campaigns had failed and that attention was now being turned to "safer cigarettes." Addiction is suggested as the reason for failure of the former. If this is so no substance with an absent or reduced nicotine content would be an acceptable substitute.

In 1963 I suggested¹ that "any means to reduce the temperature of combustion of cigarettes without lowering palatability would be advantageous to health because burning tobacco at a temperature significantly under 700°C should be successful as heterocyclic carcinogens were produced at combustion temperatures of 700°-900°C when burning skin, yeast, etc."² Pipe and cigar smokers are less subject to lung cancer than cigarette smokers—I believe both because of the lower temperature of combustion of these materials (550-700°C)⁴ and because pipe tobacco is left to "cure" at ambient temperatures. It is also possible to use a coarser flake with pipe tobacco, producing a different ratio of air to tobacco in the smoke, which is probably significant. Beffinger (personal communication) has pointed out that since 1900 most cigarette