which would implicate propranolol to a greater extent than oxprenolol as a cause of cold extremities. However, we agree that prospective studies could provide a definitive picture and would be particularly useful in establishing the clinical significance of this side effect.

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¹ Zacharias, F J, *Postgraduate Medical Journal*, 1971, 47, Suppl, 75.

Doctors, contraception, and sterilisation

SIR,—Mr A R Hill's letter (31 July, p 303) concerning the vocation of doctors seems to introduce a fundamental issue regarding their function in modern-day practice. I had always understood that the purpose of the family physician is to offer total patient care. Naturally this includes the prevention and treatment of disease and injury, but surely it includes much more. The right to avoid an unwanted pregnancy must surely be available to any woman or couple, and I cannot believe that any general practitioner would abrogate this responsibility (other than on genuine religious grounds) to any other member of the community such as a chemist or nurse. The side effects of the oral contraceptives are many and may be serious, and the community doctor is in an ideal position to be consulted should untoward reactions occur. Even where religious beliefs preclude prescription or advice on contraception, usually the caring general practitioner is able to make alternative arrangements with another doctor or a family planning clinic.

With reference to the second part of the letter, vasectomy is a quick, efficient procedure to render the male sterile. It is a very satisfactory method of absolute contraception in those cases where the family is complete. If in Dr Hill's experience the operation seems to be mutilating, then I fear that the surgeons he has encountered are not of a high standard.

Please do not let us remember only the sick and infirm. There are also the unlucky, the unfortunate, and the unhappy. It is often these latter groups that medicine can help most.

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Cardiac failure

SIR,—In the paper on cardiac failure by Dr John Hamer (24 July, p 220) I missed a reference to the increasingly widespread use of vasodilators such as nitroglycerin, isosorbide dinitrate, and nitroprusside in the management of this condition, either acute or chronic.

Isosorbide dinitrate is given preference for long-term therapy of cardiac failure, as the other nitrite compounds either have transient effects or require continuous infusion and invasive haemodynamic monitoring.^{1,2} For the same reasons nitroglycerin ointments are recommended by some workers.³ Improvement of cardiac function following vasodilator therapy is so striking that some authors⁴ no longer regard digitalis as the drug of choice for heart failure—for example, after myocardial

infarction. In many cardiological intensive care units nitrite therapy of this condition has, under careful monitoring of filling pressures, become a routine measure for preventing or controlling pulmonary oedema. The beneficial results obtained in this field have led to the extension of the indication for nitrite therapy to chronic forms of congestive heart failure.^{5,6}

The main haemodynamic responses to vasodilator therapy may be summarised as follows: substantial increase in venous capacitance; diminished venous return; lowered ventricular filling pressure and wall tension; improved ventricular wall motion and ejection rate¹⁰; lower pulmonary wedge pressure^{10,11}; and hence a reduction in myocardial preload and afterload—that is, in oxygen demands. Implicitly, normal myocardial metabolism is restored.¹² As a consequence exercise tolerance and haemodynamics in patients with heart muscle failure of various origins are significantly improved by nitrite therapy.^{13,14} This class of drugs should therefore be kept in mind as a possible alternative or addition to the traditional treatment of congestive heart failure.

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¹ Gray, R, et al, *American Heart Journal*, 1975, 90, 346.

² Mikulic, E, et al, *Circulation*, 1975, 52, 477.

³ Taylor, W R, et al, *Abstract in Circulation*, 1975, 51, 52.

⁴ Forrester, J S, et al, *Surgical Clinics of North America*, 1975, 55, 351.

⁵ Bussmann, W D, et al, *Deutsche medizinische Wochenschrift*, 1975, 100, 749.

⁶ Kaltenbach, M W D, et al, *Zeitschrift für Kardiologie*, 1976, 65, 424.

⁷ Bussmann, W D, *Medizinische Klinik*, 1975, 70, 1697.

⁸ Cohn, J N, *Circulation*, 1973, 48, 5.

⁹ Rudolph, W, et al, *Herz*, 1976, 1, 1.

¹⁰ McNulty, J H, et al, *Circulation*, 1975, 51, 140.

¹¹ Zelis, R, and Cross, C E, *Internist*, 1975, 16, 293.

¹² Franciosa, J A, et al, *Circulation*, 1974, 50, 1020.

¹³ Borer, J S, et al, *American Journal of Cardiology*, 1975, 35, 123.

¹⁴ Chiche, P, and Baligado, S, *Coeur et Médecine Interne*, 1976, 15, 139.

"Pastoral Paediatrics"

SIR,—Dr John Apley (7 August, p 374) does not see Dr A W Franklin "as a wandering shepherd carrying a caduceus." This is no wonder since shepherds have not habitually carried one. According to the Roman poet Virgil the shepherd's staff was the pedom. The caduceus was the herald's staff, the token of a peaceful embassy. Mercury, the messenger of the gods, carried one with two serpents twined around it. Heralds have been described as sophisticated communicators, and as Dr Franklin is without doubt one of the latter he is entitled to carry a caduceus. In any case a casual observer would take it for the staff of Aesculapius.

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Epilepsy and the pill

SIR,—There is evidence, reviewed by Robertson and Johnson,¹ that some anticonvulsants can accelerate the breakdown of oestrogens and progestogens. There have been reports^{2,3} of pregnancies in epileptics taking oral contraceptives which have been ascribed to such interaction, with the recommendation that women taking anticonvulsants should not rely on oral contraception. The situation, however,

has been analogous to a clinical trial of a new pill in which the numbers of failures are known but not the time the pill has been tested or the number of women involved. While analysing records of inadvertent pregnancies in the Royal College of General Practitioners' oral contraceptive study⁴ in connection with recurrent pill failures I thought the data might help to quantify the increased risk of oral contraceptive failure in epileptics.

By April 1976 there were 100 women in the RCGP study who had taken combined oral contraceptives for a total of 262 years after a diagnosis of epilepsy had been recorded. The medication prescribed for epileptics is not recorded in the RCGP study. Five pregnancies had occurred, made up of one apparent method failure and four patient failures. (There was doubt about one of the patient failures in that conception may have occurred with a progestogen-only preparation just before a change was made to a combined pill.)

My data from the whole study included 97 failures in approximately 48 350 years, 10 of the failures being apparent method failures. The difference in failure rate from that of the epileptics was statistically significant at the 1% level for total failures, but not statistically significant for apparent method failures. Thus it seems that an epileptic taking a combined pill is not as well protected against pregnancy as most women using this method: however, the protection is likely to be as good as that offered by other reversible methods.

I should like to thank the staff of the RCGP oral contraceptive study, particularly Miss Jean Dufty, for their help and generosity in providing me with data.

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¹ Robertson, Y R, and Johnson, E S, *Current Medical Research and Opinion*, 1976, 39, 647.

² Hempel, E, et al, *Zentralblatt für Gynäkologie*, 1973, 95, 1451.

³ Janz, D, and Schmidt, D, *Lancet*, 1974, 1, 1113.

⁴ Royal College of General Practitioners, *Oral Contraceptives and Health*, London, Pitman Medical, 1974.

Management of sexual dysfunction

SIR,—We were interested to read the views of Drs C Q Mountjoy and T F Davies (17 July, p 176) on the importance of adequate physical screening in cases presenting as disorders of sexual function. Indeed, we wholeheartedly agree that the effects of physical factors should not be underestimated, but we feel that emphasis should be placed on the notion of multifactorial causation, also referred to by your correspondents, because of the implications for diagnostic and therapeutic services. It is precisely this diversity of possible causal and/or contributory factors which necessitates thorough assessment of each case presenting; sophisticated screening for physical and endocrine abnormality should be matched by equally sophisticated assessment for psychological bases of the dysfunction.

One must then ask, however, how adequate screening can be ensured. Sexual problems may present in a variety of settings and the helping agents involved may be from a variety of disciplines. Within the health services gynaecologists, specialists in genitourinary medicine, endocrinologists, psychiatrists, clinical psychologists, and members of the primary health care team may be presented with complaints of sexual dysfunction in their patients. If one accepts the possibility of