SIR,—As a final-year student I am horrified to see in your portrayal of the general practitioner and consultant (Contemporary Themes, 8 August, p. 335) an in-built hostility.

The general practitioner is ignorant, dangerous, and useless, and the consultant appears to consider himself as the direct opposite. If the consultant were to be a little less deprecating towards the general practitioner maybe everyone in the "team" or "division" would appreciate the value of others in patient-care.

Surely the relationships between most consultants and general practitioners are on higher levels than this? If not, where is my future to be?—I am, etc.,

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Inquiry into the Abortion Act

SIR,—It is noticeable that the motion for the demand for an inquiry into the Abortion Act (1967) is sponsored by its chief opponent, the Roman Catholic M.P., Mr. N. St. John-Stevan (1 August, p. 293). The motion claims that "the working of the Act has caused widespread public concern."

The Abortion Law Reform Association was founded in 1936 by a few public-spirited men and women who were deeply concerned by the prevalence of criminal abortions (generally accepted as about 100,000 per annum). Till the A.L.R.A. took the matter up nothing was being done to rescue these women from the hands of people ignorant of anatomy and the elementary principles of asepsis and surgery, who were carrying out the operation in secrecy, in haste, and in squalid conditions at a high price, with no after care. Where was the "widespread public concern" then? After 30 years of struggle the Abortion Act of 1967 was passed to allow performance of the operation openly, with certain safeguards, by qualified doctors in private nursing homes and under the N.H.S. In 1969 there were approximately 54,000 legal abortions performed in England and Wales. Who would wish to drive any of these thousands back into the hands of the illegal abortionists? It is not denied that there have been some abuses of the Act, but these can be dealt with by common law or by the doctors' own tribunal. The young Act appears to be working reasonably well, and it would be a pity to interfere with it at present.

Abortion, however, is not the long-term answer to the unwanted pregnancy. More and more instruction in contraceptive teaching is needed, including domiciliary visiting for the patients most sadly in need of help and least aware of how and where to get it. It is unfortunate that most of the opponents of abortion are also largely against reliable contraceptive methods and offer only the so-called "safe" period, or else abstinence—hardly the way to promote a happy marriage.—I am, etc.,

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Independence and the Presidency

SIR,—It is of course possible to take a different view on this matter from that put forward by Mr. R. S. Murley (8 August, p. 348)—namely, that the letter signed by the presidents of the Royal Colleges of England and Scotland, except one who was out of the country at the time, helped to restore in the eyes of the general public the image of Medicine as a great and dignified profession.—I am, etc.,

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Hypergraphodeixis and Logorrhoea

SIR,—In his interesting letter Professor R. S. Illingworth (25 July, p. 227) has failed to recognize the symptoms of hypergraphodeixis (excessive demonstration of visual information)—a pardonable oversight since the disease never occurs in children. A speaker affected with this distressing condition shows slides each with so much information that it cannot be assimilated within the 10 seconds available, or even read, as in the severe case described by Professor Illingworth. It is closely related to another disease, logorrhoea (word-flow), which is characterized by speaking too fast, speaking too long, or both.

The aetiology of both diseases is similar. They tend to occur in adults from the age of 20 to 50, for after the age of 50 few people need to give papers. They are more frequent in males, probably associated with the greater ambition of the male sex to get a better job. Both occur in individuals whose main object is not communication but a wish to exhibit the vast resources of knowledge at their command. Both occur in individuals who do not know their subject sufficiently well to pick out the parts which are relevant. Hypergraphodeixis occurs particularly in those who are so uncertain about their data that they do not wish the audience to study it in detail. The important point in the differential diagnosis is not to confuse these malignant diseases with the benign and easily treated syndrome of the nervous young person giving his first paper with a chief whose name appears on the paper (often a useful diagnostic point) but who is not sufficiently interested in either the speaker or the subject to give a little friendly help in advance. It is very important to make the correct diagnosis, as the treatment recommended below applied to the benign form could be lethal.

In the treatment of logorrhoea use can be made of a stopwatch and a chairman who suffers from insomnia. If these are not available then a gradual crescendo of feet-shuffling can be effective. Hypergraphodeixis is more difficult to treat, because even a myopic chairman is less likely to diagnose the disease than those sitting in the back seats. The only known treatment is for less inhibited members of the audience to interrupt the lecturer and ask him to read out the information on the slide. If the speaker has a number of slides which even at 10 seconds each there is not really time to present, having to read out all these causes sufficient mental chaos to produce immunity from this disease sometimes for life and usually for at least a few months. In severe cases of recurrence it

may be necessary for the questioner to feign partial deafness so that each slide has to be read out twice. This treatment has seldom been known to fail.

The disease has always been sporadic in the British Isles, but in some parts of the European continent it is endemic. Its introduction into this country has recently been brought under partial control by an ingenious automated device at London Airport which separates would-be speakers from their slides for periods of 24-48 hours, by which time the meeting may be safely over. However, as Professor Illingworth has noted, the disease is now firmly established here, and I hope that responsible clinicians like himself will do their utmost to eradicate it.

I am indebted to Professor R. A. Crossland of the Department of Greek in this University for useful discussion about nomenclature.—I am, etc.,

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Metabolic Effects of Oral Contraceptives

SIR,—Your leading article entitled "Metabolic Effects of Oral Contraceptives" (18 July, p. 121) comments that in a supplement to the *Journal of Clinical Pathology*¹ oestrogens are blamed time and again for unwanted side effects. It is my experience in recent months, that side effects which are possibly due to too small a dose of oestrogen are becoming relatively more frequent.

Twenty-five women discontinued Gynovlar, Minovlar, Minilep, Norinyl-1, or Ovulen 50 because of one or more features of the "pill syndrome." Thirteen had headaches, 18 had mood changes, six vein complaints or leg cramps, four weight gain, and five raised blood pressure. When these results are compared with the side effect distribution among withdrawals from the range of previous combined and sequential preparations,² the incidence of mood change with the low-dose oestrogen products is almost doubled (72% compared with 41% and 34% respectively), while the incidence of the other side effects remains the same.

Of the 18 women with mood change, 11 also had severe headaches or migraine at the same time. Fifteen women complained of depression, and five felt confused and unable to concentrate. Four were irritable and four noticed loss of libido. Other complaints were of tiredness, crying fits for no reason, insomnia, and weakness. Most of the women were under 25 years old and childless. One of them was 16 years old with a nine-month history of depression, crying fits, loss of libido, and recurrent cystitis. A 20-year-old felt suicidal, but improved when given a relatively more oestrogenic product. Aggression was noted by two women taking Minovlar. Confusion and aggression (and in one case temporary amnesia after attacking her husband) was noticeable with the trial product norethisterone acetate 1 mg. and ethinyl oestradiol 0.075 mg., which is very similar to Minovlar. As has been mentioned previously³ these products which have the most marked effect on the development of endometrial arterioles and sinusoids also produce the most acute mental changes.

Some of the mental changes are suggestive of cerebral ischaemia.

Depression and loss of libido were found to be more frequent with strongly progestogenic low oestrogen compounds, and these have a high level of endometrial monoamine oxidase activity for most of the cycle.³ Of the recommended pills, Anovlar, Volidan, Gynovlar, and Minilyn are probably the most progestogenic and therefore likely to have a high incidence of depression. However, the dose of oestrogen is important, as Lyndiol 2.5 and Minilyn cause more depression than Lyndiol, 5 mg.

While the depression per se could often be ameliorated by changing to a high-dose oestrogen product, this is no longer advisable because of the increased thrombosis risk.⁴ It also does not seem wise to resort to antidepressant drugs and even, as happens, E.C.T., without first making a serious attempt to provide an acceptable alternative method of contraception. This is not simple, as the young unmarried student has based her way of life on a "safe" method of contraception, while the older woman may be reluctant to make the effort to revert to mechanical methods or consider sterilization. Nevertheless, we cannot ignore the responsibility which is inherent in prescribing oral contraceptives because of the fear of an unwanted pregnancy.

Baumblatt and Winston advocate further research following their encouraging results for treating the mood changes with pyridoxine,⁵ and it seems important to find out if pyridoxine can also help the vascular aspects of the syndrome.—I am, etc.,

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Herpes Infection after Transplantation

SIR,—We write with reference to the paper by Dr. E. S. Spencer and Dr. H. K. Andersen on infections with herpes virus following renal transplantation (1 August, p. 251). It would be interesting to know whether any of the patients developing a rise in cytomegalovirus complement-fixing antibody received fresh blood preceding, or at the time of, transplantation—as transmission of cytomegalovirus by fresh blood is well documented.¹⁻⁴ Further, in a series of 56 patients receiving fresh blood a fourfold rise of cytomegalovirus complement-fixing antibody was demonstrated in 38%, usually 6-8 weeks after the blood was given.⁵

The statement "that five out of seven patients thought to have cytomegalovirus infections had virus-neutralizing antibodies in their serum before the onset of symptoms" suggests that two of the patients had not previously been infected with cytomegalovirus—and therefore these could not have been due to reactivation of the virus, but must be primary infections. Our own series showed that 55% of the

infected patients were seronegative to cytomegalovirus complement-fixing antibody prior to transfusion, while 45% were seropositive. Therefore though reactivation may be responsible for rising cytomegalovirus complement-fixing antibody following immunosuppression or fresh blood transfusion our work suggests that many cases are due to primary infection. Furthermore infection with cytomegalovirus of a different strain may occur in patients with pre-existing complement-fixing antibody.

Another point of interest is the fact that these patients on immunosuppressive and steroid therapy were capable of producing antibody in response to viral infection. This no doubt explains why their symptoms were those of a healthy adult with a similar infection, and not the disseminated type of infection that tends to occur in immunosuppressed patients.⁶—We are, etc.,

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Hypotension caused by L-Dopa

SIR,—The hypotension produced by L-dopa during treatment of Parkinson's disease (21 February, p. 474) has been attributed by Professor J. H. Burn (7 March, p. 629) to a replacement by dopamine of some of the noradrenaline in the sympathetic fibres. This reduces the effect of the vasoconstrictor activity of the sympathetic nervous system on the peripheral resistance vessels. Recently, Dr. R. C. Duvoisin (4 July, p. 47) has described the use of propranolol in the treatment of the hypotension produced by L-dopa, on the basis that propranolol would antagonize the effect of the dopamine since "dopamine appears to have predominantly beta-adrenergic properties."

This hypothesis is not correct, and does not explain the mechanism by which propranolol might counteract the hypotension induced by L-dopa. The actions of dopamine are complex. It stimulates adrenergic beta receptors in the heart but not in the peripheral resistance vessels. The fall in systemic vascular resistance produced by dopamine results largely from renal vasodilatation. The mechanism of this is not understood but it is not antagonized by a beta-receptor blocking drug. Dopamine increases femoral vascular resistance.¹ Consequently it would not appear possible for propranolol to antagonize the hypotension produced by L-dopa through blockade of adrenergic beta-receptors.

Before the acceptance of propranolol for the treatment of the hypotension produced by L-dopa, more detailed clinical pharmacological studies on this subject are required.—I am, etc.,

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Pulmonary Venocclusive Disease

SIR,—In 1966 Brown and Harrison¹ found eight reported cases of pulmonary venocclusive disease. They added a ninth, later the subject of a clinico-pathological conference.² In 1967 Liebow *et al.*³ presented 16 cases to the American Heart Association. We wish to report an additional case.

A 40-year-old female gave a history of childhood bronchitis and asthma. Skin tests in 1953 revealed a wide range of sensitivity. Chest x-ray was normal. In 1963 the right middle lobe collapsed. Bronchoscopy was normal and the lobe re-expanded; subsequently she noted increasing exertional dyspnoea. A bronchogram in September 1967 showed mild fusiform bronchiectasis in the right lower lobe, and by December 1967 she was admitted to hospital with severe dyspnoea. Chest x-ray showed a right pleural effusion, a generalized increase in pulmonary vascularity, and a normal heart size and shape. E.C.G. revealed right atrial and ventricular hypertrophy. Examination of the pleural effusion was

unhelpful, and all significant tests were normal. The patient remained very breathless, even after aspiration of two litres of fluid. Steroid therapy produced rapid general improvement and clearance of the fluid.

She was discharged on steroids but one month later (January 1968) fluid had re-accumulated. For the first time some definite bronchospasm