effects, as Beaconsfield and his colleagues' maintain, surely the kind of evaluation of them which is required is different from that which we read about? What is the type of testing for drugs taken in the long term that they have mentioned?[3] Has it been spelt out anywhere and I have missed it? If new testing is required, whose responsibility is it to see that it is done? And in which way can this help to improve the present pill?—I am, etc.,

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REFERENCES

1 Beaconsfield, P., Abrams, M. E., Ginsburg, J., and Rainsbury, R., *Lancet*, 1968, **2**, 832.
2 *Daily Telegraph*, 10 October 1968.
3 Beaconsfield, P., and Ginsburg, J., *Lancet*, 1968, **1**, 592.

Long-acting Synthetic Corticotrophin in Dermatology

SIR,—The latest paper by Dr. A. H. El-Shaboury (14 September, p. 653) showing that the long-acting synthetic corticotrophin Synacthen Depot is safe in patients sensitive to animal corticotrophin prompts me to describe our experience with its use in certain skin diseases.

Our interest was aroused by the work of Besser *et al.*[1] in this hospital, who showed that it had equivalent potency but a longer duration of action than corticotrophin gel. This was confirmed by Dr. J. K. Nelson and colleagues (2 March, p. 557). Increasing the dose extends the duration of action. Our dosage has, therefore, varied between 0.5 and 2 mg. and our usual regimen has been 1 mg. twice weekly. We naturally started with problem cases, but have been sufficiently impressed with the results over the last few months that we are extending its use. A fuller publication is in prospect, but meanwhile the Table shows the results so far in the first six patients treated.

Synacthen Depot is given by subcutaneous or preferably intramuscular injection into the buttock or thigh. Discomfort at the site of injection with the depot preparation seems to be less common when the intramuscular route is employed. Though this new preparation has advantages over natural corticotrophin and should prove useful in the acute and maintenance treatment of corticotrophin-responsive skin conditions, it must be remembered that it is a corticotrophin and that typical side-effects may occur.

Case No.	Diagnosis	Dosage	Comment
1.	Female, aged 60. Widespread pustular psoriasis	Initial dose 2 mg. Now receiving 1 mg. twice weekly	18 months history of pustular psoriasis treated in the past with oral steroids and oral methotrexate with little benefit. Marked improvement over palms and soles within 24 hours of her first injection of Synacthen Depot and now requires 1 mg. twice weekly as maintenance therapy. Glycosuria was noted after about 6 weeks therapy and she also shows increased skin pigmentation.
2	Female, aged 79. Severe pompholyx with secondary spread	Initial dose 2 mg. Now receiving 0·5 mg. weekly	Some improvement in hands within 48 hours of initial dose and has continued to improve over a period of weeks. Some discomfort noted at site of early injections.
3.	Female, aged 27. Generalized erythrodermic psoriasis	Initial dose 2 mg. Now receiving 1 mg. twice weekly	On and off oral steroids since 1959 and is still receiving 15 mg. prednisolone (her usual dose) while on Synacthen Depot. Definite improvement. Some pain at site of early injections. Steroids will be tailed off.
4	Female, aged 23. Recurrent oral and genital ulceration	Initial dose 2 mg. Now receiving 1 mg. twice weekly	15 month history of recurrent severe ulcers and had not improved with corticosteroid pellets by mouth, oral tetracycline, nor with a contraceptive tablet. A.C.T.H. gel had given some relief but she developed a skin eruption with this. She has shown marked improvement since on Synacthen Depot.
5	Male, aged 27. Bullous lichen planus	Initial dose 2 mg. Now receiving 1 mg. weekly	Started Synacthen Depot five weeks after eruption appeared in view of the bullous nature and severe irritation of the lesions. He showed definite improvement within one week of commencing therapy.
6	Male, aged 24. Exacerbation of atopic eczema with asthma	Initial dose 2 mg. Now receiving 1 mg. twice weekly	History of atopic eczema since infancy. Improvement noted by patient within 24 hours of first injection and clinical improvement already marked one week after therapy commenced.

I am grateful to Dr. T. B. Binns, of CIBA, for generous supplies of Synacthen Depot.—I am, etc.,

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REFERENCE

1 Besser, G. M., Butler, P. W. P., and Plumpton, F. S., *Brit. med. J.*, 1967, **4**, 391.

Duodenal Haematoma

SIR,—I was interested to read the case report on duodenal haematoma by Dr. S. Mindel and Dr. Louis Kreel (28 September, p. 785). I have seen three such cases[1] and I would agree entirely that this is a recognizable clinical entity, which may be diagnosed radiologically. The history of a blow in the epigastrum followed 24 hours later by symptoms suggestive of pyloric obstruction is typical.[1 2] However, there are two points which might profitably be emphasized.

Plain radiographs of the abdomen may themselves be diagnostic of this condition, and will certainly indicate the necessity for barium meal. Gas may distend the duodenum and outline it as clearly as does barium. In one of our cases the principal features of intramural haematoma, as described by Felson and Levin,[3] were clearly demonstrated in this manner. Drs. Mindel and Kreel suggest that adequate *x*-ray studies may obviate the necessity for laparotomy. There are many reports which suggest that laparotomy should be performed immediately the diagnosis of intramural haematoma is made[2 4–6] in order to exclude concomitant undiagnosed injury, and to avert later complications. Having successfully managed two out of three patients conservatively, I agree that operation is not mandatory. However, the injury is, of course, much more extensive than the simple term "intramural haematoma" would suggest. The patient must be kept under very close observation for many days, and if there are any doubts at all laparotomy should be performed. It is because of the extensive nature of the injury, although intramural may be the central feature, that I would prefer the more non-committal term "duodeno-jejunal haematoma" to describe this condition.—I am, etc.,

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REFERENCES

1 Essenhigh, D. M., and Toland, J., *Brit. J. Radiol.*, 1968, **41**, 349.
2 Webb, A. J., and Taylor, J. J., *Brit. J. Surg.*, 1967, **54**, 50.
3 Felson, B., and Levin, E. J., *Radiology*, 1954, **63**, 823.
4 Cooke, R. V., and Southwood, W. F. W., *Brit. J. Surg.*, 1964, **51**, 767.
5 Davis, D. R., and Thomas, C. Y., *Ann. Surg.*, 1961, **153**, 394.
6 Lampert, E. G., Goodfellow, J. G., and Wachowski, T. J., *Ann. Surg.*, 1954, **140**, 768.

SIR,—May we record another case of duodenal haematoma (28 September, p. 785) due not to trauma but to a carcinoma of the ampulla of Vater?

The patient was a female aged 52 years, who had had jaundice for four weeks, followed by abdominal pain for one week. She was admitted to this hospital after the pain became severe. She was dyspnoeic and comatose and died shortly after admission.

Necropsy revealed a large haemorrhagic sac attached to the lower border of the third and fourth parts of the duodenum, filling a large proportion of the lower abdomen. It was entirely retroperitoneal. The pancreas showed haemorrhagic inflammatory changes, blood from which had tracked into the region of the ampulla and dissected the wall of the duodenum to produce an intramural haematoma. The ampullary region was the seat of nodular ulcerated growth, sections from which showed undifferentiated carcinoma. Other necropsy findings included a neurofibromatous hamartoma of the left lobe of the liver, and partial glial stenosis of the aqueduct of Sylvius.—We are, etc.,

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