which Dr Coope and her colleagues based their statistics are not available and may, in fact, not differ markedly from the range of normal for their laboratory. For example, although they comment on raised levels of factor X, there is no significant difference in this parameter between their oestrogen-treated and placebo groups. The thromboelastogram also showed no significant change. The clinical significance of their reported changes cannot, therefore, be defined.

The main indication for long-term oestrogen replacement therapy is to prevent certain menopausal-related conditions such as osteoporosis. By following patients for more than one year one can frequently detect a biphasic effect in which, for example, disturbed carbohydrate balance is followed by normalization of tolerance.² The same may also be true of the coagulation mechanism. Thus von Kualla *et al*³ concluded that conjugated oestrogens produced a shift toward hypercoagulability as evidenced by a shift of the parameters of the thromboelastogram (in contrast to the findings of Dr Coope and her colleagues) and the detection of fibrin monomers. However, the latter test became positive more frequently after five than after 21 tablets. As far as I am aware, our study is the only long-term evaluation of the effect of natural oestrogens on coagulation.

Finally, it is commonly observed that certain women appear to have an increased sensitivity or idiosyncrasy to oestrogens (including conjugated oestrogens) and react by developing (among other side effects) hyperglycaemia,¹ hyperlipaemia,⁵ and hypertension.⁶ It is therefore essential that greater consideration be given to individual response and that judgment should not be based solely on the reaction of a study group. Although formal long-term epidemiological surveys have not yet been conducted, it is pertinent to note that the conjugated oestrogens have been available for 30 years without any significant clinical association between their use (in the usual dose recommended for oestrogen replacement therapy) and the development of thrombotic sequelae etc, as was reported following the relatively brief exposure to the synthetic oestrogens in the birth control pill.

MORRIS NTELOVITZ

Department of Obstetrics and Gynecology,
University of Florida College of Medicine,
Gainesville, Florida

- 1 Ntelovitz, M. and Grieg, H B W, *South African Medical Journal*, 1975, **49**, 101.
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Information contained in drug advertisements

SIR,—Dr G V Stimson (29 November, p 508) concludes that the low level of information currently presented in drug advertisements, particularly the omission of approved names and prescribing information, may be related to the reliance of companies on supporting data sheets, which the Medicines Act 1968 now requires to be circulated. A comparison with previous advertising practice

is, however, available¹ and suggests that this conclusion may not be correct. Patterns of advertising prior to the Act were not substantially different from those of the present.

In this four-week study of communications received by one general practitioner in direct mail advertisements and those contained in periodicals and magazines there were 697 advertisements relating to 267 drugs. Approved names were omitted in 3.4% of advertisements. Of the drugs advertised, 55.8% were classified by the Standing Joint Committee on the Classification of Proprietary Preparations (Proplist) according to the therapeutic efficiency and acceptability and 6.7% were classified in group B—that is, unacceptable drugs. Only 19.8% of advertisements were supported by reference to journals. Pictorial content was 65.8% and was particularly high in relation to drugs acting on the nervous system, which had the largest number of advertisements (147). The frequency of inclusion of prescribing information was not specifically recorded.

Apart from the requirement for data sheet circulation, it was hoped that the provision of the Act would reduce the quantity and improve the quality of advertising material by ensuring inclusion of the approved name(s) of the active constituent(s), rejecting advertisements with strong emotional orientation, and encouraging a rational scientific basis. With Dr Stimson's confirmatory conclusion on the insufficiency of information in current drug advertisements in periodicals we may possibly see improvements in drug advertising in the near future.

KENNETH S WILSON

Royal Infirmary,
Edinburgh

- 1 Wilson, K S, *Health Bulletin*, 1969, **27**, 40.

What are haemorrhoids?

SIR,—In your leading article (15 November, p 365) the impression is given that I do not consider venous congestion to be important in piles. Such is not the case and I would be grateful for the opportunity of putting the record straight.

My main thesis, certainly, is that the anal canal is lined by discrete cushions of specialised submucosal tissue whose purpose is to assist in continence (incidentally, the three main ones may be subdivided to a greater or lesser extent so that the anal lumen, although usually closing to a more or less triradiate slit, may appear stellate) and that piles are merely the result of their downward displacement. However, in the article to which you refer¹ and elsewhere^{2,3} I have argued that their displacement may be attributable to straining, causing venous congestion and therefore swelling of the cushions, making their expulsion more likely.

Other possibilities exist. First, hard stools may be more likely to push them out or "sticky" ones to drag them. Secondly, a rigid, narrow anal ring might predispose to piles; there would be less likelihood of the cushions flattening when the circumference of the anal canal cannot be much increased on defaecation. Thirdly, irritation of the anal lining (as in diarrhoea) may cause the cushions to swell and thereby be extruded.

Another question on which I would like to comment concerns the bleeding seen in the absence of piles. It is perfectly possible

that in some people only the upper (mucosa-covered) part of the cushion prolapses; this highly vascular tissue may then be nipped between its firm anchorage at the pectinate line and the stool.

HAMISH THOMSON

Gloucestershire Royal Hospital,
Gloucester

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- 2 Thomson, W H F, *Lancet*, 1975, **2**, 494.
- 3 Thomson, W H F, *Proceedings of the Royal Society of Medicine*, 1975, **68**, 574.

Whooping-cough vaccination

SIR,—Apropos the letter from Professor N R Grist (29 November, p 519) it may be worth pointing out that it is common knowledge among experienced paediatricians that phenobarbitone in relatively high dosage is a very effective symptomatic treatment for whooping cough in young infants and will control the spasms without producing untoward side effects.

We have seen a small epidemic of 10-15 cases in young infants at Booth Hall Hospital over the past year and in every case in my care, some of them with alarming symptoms characterised by apnoea and bradycardia, phenobarbitone was rapidly effective, although some babies relapsed when it was discontinued.

If this is general experience, as I suspect, it weakens the argument for exposing older infants to the rashes and discomforts of whooping-cough vaccination in order to reduce the risk of younger and more vulnerable babies becoming infected; it may also cast some light on the mechanism of paroxysmal coughing.

JOHN A DAVIS

University Department of Child Health,
St Mary's Hospital,
Manchester

Acute rhabdomyolysis and renal failure after injection of peanut oil

SIR,—It is difficult to understand what made Dr K L Lynn (15 November, p 385) choose peanut oil as the causative agent of rhabdomyolysis and acute renal failure in a drug addict who had taken seven other drugs at the same time, including alcohol and narcotics, and was brought unconscious to hospital.

Heroin addiction and coma are two well-documented causes of rhabdomyolysis and acute renal failure.¹⁻³ However, the case report contains clues that point to another interpretation. Swollen, painful, and tender muscles with rapid onset of muscle wasting and weakness involving predominantly the lower limbs shortly after a binge and recovering with abstinence is the classical picture of acute alcoholic myopathy. This uncommon but well-defined syndrome is usually accompanied by myoglobinuria and occasionally by acute renal failure.⁴⁻⁸

Dr Lynn describes "a flaccid paraplegia with loss of pain and tactile sensation below L2 with sacral sparing" without comment or diagnosis. This either means a coincidental incomplete transverse myelitis (known to occur in drug addicts⁹) at an unusual level with inexplicable sacral sparing and unexpected preservation of the sphincter function or, alternatively, an attempt to describe in neurological terms myopathic