Drugs for the Menopause

Sir.—Professor T. N. A. Jeffcoate in his article on "Drugs for Menopausal Symptoms" (Brit. med. J., January 30, p. 340) shows little sympathy with the sufferings of menopausal women, and expresses the general opinion that most of their complaints are neurotic and can be traced to environmental causes. Even admitting that most of the symptoms are vasomotoric, there are other troublesome skin, vascular, articular, and mental conditions from which menopausal women may suffer. Menopause is the time of a woman's life when the ageing process advances, and in modern times the loss of good looks entails serious handicaps for women in occupational or social life. These women deserve our sympathy and help.

It is generally accepted that the climacteric symptoms are the result of the cessation of ovarian function, and the low level of oestrogen is a causative factor of many post-menopausal conditions. The ovaries are the weakest link in the chain of the endocrine glands. Their decline upsets the whole endocrine system and accelerates the process of ageing. The appropriate treatment, therefore, is the giving of sex hormones. There is evidence that these hormones not only relieve the climacteric symptoms but slow down the ageing process in animals and human beings. Masters¹ suggests continuous oestrogen-androgen treatment in old people, and Shelton² calls oestrogen therapy a "physiological gerontological tool" for postponing regresional changes.

There exists an exaggerated fear of using oestrogens in women because of uterine bleeding, and of the possible cancerogenic effect of these hormones. As to the uterine bleeding, this can be prevented by the right dosage and the combination of oestrogen and androgen in a ratio of 1:5. Should bleeding occur, a diagnostic dilatation and curettage might be necessary to exclude a malignant condition, otherwise the bleeding is of no importance. The theory of cancerogenic effect of oestrogen is derived from animal experiments, but there exists no convincing evidence that oestrogens have ever produced cancer in human beings. On the contrary, oestrogens have proved useful in advanced cancerous conditions and in the prostate gland. The fundamental theory of cancer is one of many theories, but, so far, clinical observations have failed to substantiate this theory satisfactorily. I have been using oestrogen and androgen implants, according to the cytological findings in the vaginal smear, for the last fifteen years on 500 menopausal women, and have not encountered the slightest indication that this treatment is cancerogenic. We have been using a course of 30 tablets of stilboestrol given over five months. The usual dose is 0.1 mg. daily. The first course is 10 days; the second is eight days, started 30 days after the first; and the third six days, starting 32 days after the second, etc.

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Menstruation rarely occurs, and, when it does, its timing is a good indication whether or not it is due to oestrogen withdrawal. The low dose makes side-effects unusual, and only occasionally is it inadequate so that a higher dose is indicated. Sometimes a second course is requested from 11 to 15 months later.—I am, etc.,

Edmonton,

JOAN CHAPPELL.

REFERENCE


Sir.—Those correspondents who have commented on my contribution to your series of articles on "The Drug Treatment of Disease" (January 30, p. 340) do not all appear to have appreciated that I was writing primarily on the use of drugs for menopausal symptoms and not on the treatment of climacteric symptoms in general. In indicating the small place of drugs and hormones in its management, I did not decry the importance of the syndrome to the patient nor did I attribute it to neurosis. Rather did I emphasize that sufferers from a genuine and distressing climacteric upset, as well as those who wrongly attribute their symptoms to the climacteric, usually require much more sympathetic and painstaking handling than is involved in the mere administration of a few tablets of oestrogen. This, again, is not to say that oestrogen does not have its place in well-selected cases.

I am sorry that Dr. G. L. Davies (February 27, p. 643) thinks that to distinguish between "climacteric" and "menopausal" symptoms is merely verbal hair-splitting. The distinction appears to me fundamental to an understanding of the problem of which, as Miss Josephine Barnes says (p. 643), our knowledge remains incomplete. Until we do know more, however, it seems illogical to suppose that symptoms can be caused by a lack of oestrogen, and that they can be relieved by administering ethinyl oestradiol in 0.01-mg. doses, when a woman is cyclically secreting oestradiol in amounts equivalent to 0.05 mg. ethinyl oestradiol three times daily—as she must be if she is still menstruating.—I am, etc.,

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** This correspondence is now closed.—Ed., B.M.J.

Oversea Career Appointments

Sir.—Service in overseas territories under the jurisdiction of the Crown has afforded to many a satisfying and honourable career. Doctors from this country have established in these territories traditions of service and created a respect for the best standards of British medicine. As a consequence of political developments officers serving overseas have of recent years in many instances found their careers prematurely terminated.
and have had to return to this country where the opportunities of entering into a satisfying and new career are no longer readily available. The development of National Health Services in this country is responsible for this difficulty. Under these circumstances anyone accepting at the present time an appointment in Her Majesty's overseas services is exposed to grievous hazards. On appointment by the authorities in London he is transferred to the services of an overseas administration which is responsible for his salary, pension, and, in event of political change, for such compensation as he may get. In the event of abolition of his appointment responsibility for reinstatement in this country is the officer's own responsibility.

Our Association has for long urged that the Government in this country should be prepared to accept far greater responsibility for the officer's career, and it is with deepest regret that I personally could not advise any doctor in this country at the present time to apply for the permanent appointment in British Honduras advertised in your issue of April 16 (advertisement p. 47).

The British Medical Association is well aware of the great need for doctors overseas and is ardent in its support of any scheme which will meet those needs, but it is unfair to ask any individual doctor to accept the hazards and uncertainties of career appointments in the overseas services unless, and until, he can be assured that in the event of premature termination of his overseas post he can be guaranteed satisfactory reinstatement in this country. Her Majesty's Government are in large measure responsible for the developments which are occurring overseas. These we do not criticize. What we do criticize is the manner in which doctors in Government services are being individually sacrificed. To advertise a career appointment in British Honduras at the present time would seem to be unrealistic and misleading on the part of the Colonial Office, which even now must be considering constitutional change.—I am, etc.,

Eric C. Mekie.

Speech Therapy and Child Guidance

Sir,—The letter from Dr. David T. Maclay and others (April 2, p. 1054) brings up important issues of principle and practice relating to the proper function of the speech therapist. The authors rightly stress that the emotional factor, whether as a basis or merely a superstructure, has to guide specialized treatment of speech disorders, and this is a strong argument in favour of the speech therapist's working in close liaison with the child-guidance team. When, however, they state that the speech therapists are expected to resolve the emotional difficulties of their patients, and to administer psychotherapy and play therapy, we may well ask, "Who expects it of them, and is it a reasonable demand?" As the writers say, it certainly brings up the question of training, and in an acute form. The speech therapist as such is certainly not trained for this work any more than for psychiatric social work, another role which, we are told, some of them find themselves forced to assume.

The first suggestion of Dr. Maclay and his colleagues, of co-operation with the child-guidance team, is certainly an excellent one. Local authorities should be encouraged to house their speech-therapy clinics as close as possible to the child-guidance clinic, and not to delay referring to the latter all children undergoing speech therapy whose emotional difficulties require psychiatric attention. The manner in which the resources should be pooled requires careful consideration. The writers' second suggestion implies that speech therapists should be given some smattering of training in the techniques of child psychotherapy. To those of us who are actively interested in maintaining the standards of this training (e.g., the Association of Child Psychotherapists) this must appear as a dangerous and reactionary proposal. It would surely be wiser for the therapy of children who require treatment of their emotional problems as well as symptomatic treatment of their speech disabilities to be shared, under the co-ordinating supervision of the child-psychotherapist, between the speech therapist and those whose training should have made them competent to treat emotional disorders (and it is to be hoped that this includes child-psychotherapists, and not only child-psychotherapists, as implied by the writer). The situation would, of course, be different if and when the time comes that speech therapists are adequately trained in child psychotherapy.—I am, etc.,

Helen Gillespie.

SIR,—We agree with Drs. David T. Maclay, Stella E. Mason, and Leopold Stein (April 2, p. 1054) that the work of speech therapists should be related to child guidance. There is indeed a great need for more and better communication of factual data about the child, his family, and what each "therapy" is doing. This is, however, a very far cry from the suggestion that speech therapists should be trained to carry out psychotherapy or play therapy.

The understanding and use of play as a means of helping children to develop emotionally and intellectually is recognized in many fields of education and its value in infant and nursery schools is undisputed. But it is high time that the term "play therapy," used as synonymous with psychotherapy, was abolished. Play has no more therapeutic value than speaking; both are forms of communication in children and used as such in psychotherapy, though always with the aim of increasing verbalization. The therapist helps the child to verbalize his thoughts, but this is not the same thing as interpretation. Interpretation should be reserved for making the child aware of something which was previously unconscious. Slap-happy interpretation of such symbolic or other unconscious material that the unskilled worker may recognize in painting or play can be very traumatic. Many people may know how to manipulate a scalpel, but we would not trust them to do surgery without adequate training. Child psychotherapy is a highly skilled profession, and the so-called play therapists are now being replaced by trained child psychotherapists who undertake several years' training in recognized centres.

Though child-guidance clinics undertake both therapeutic and educational work, the two should not be confused. The therapeutic aim is to set the child free from the difficulties which exist in the present or are relics from the past which prevent its development, while the educational aim is to further the development and provide additional opportunities for children, often only possible after they have been freed sufficiently by psychotherapy. It is in the field of education in its widest sense that the speech therapist should function,