facial paralysis, as did the nine patients who had no detectable impairment of taste.

Of 14 patients first tested after the 14th day nine had loss of taste, of whom only five had denervation and ultimately did badly. One of the remaining five, who did not show ageusia, had fibre degeneration, and a poor final recovery.

We believe that the discrepancies between these findings and those of Drs. Peiris and Miles cannot be accounted for by the differences in the tests for taste used in the two series. Our findings appear to show that loss of taste (in 32 out of 41 early cases) had no significant bearing on the prognosis. Krarup's findings that every patient tested by him during the first week of the paralysis had measurable gustatory disturbances, as did 84% of 31 patients tested in the first 14 days, also detract seriously from the prognostic significance of these tests.

It is clear that much more work is necessary, and that this will require the study of large numbers of very early cases in well-equipped departments where tests for taste, nerve excitability, and the stapedius reflex (by impedance audiometry) can be expertly and immediately done. It is hoped that early loss of taste in Bell's palsy will not meanwhile be adopted as a justification for drastic intervention—for example, surgical decompression—or as a prognostic yardstick by which the outcome of therapeutic trials might be judged.—We are, etc.,

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Systemic Lupus Erythematosus

SIR,—In their memorandum (20 November, p. 1227) on systemic lupus erythematosus and pregnancy Dr. G. C. Hanson and Dr. S. Ghosh mention the effect of increasing the dose of corticosteroids in the psychosis which accompanies severe episodes of this disease.

I have observed the same effect in a young woman who was controlled on prednisone, 15 mg. daily, and who inadvertently spent an hour sunbathing. This produced an acute exacerbation of the rash on her face and wrists, together with pyrexia, an ulcerated throat, photophobia, dyspnoea, and an acute psychosis, in which the patient, normally very co-operative and sensible, behaved like a 3-year-old having a real temper tantrum, and was very negativistic. With some hesitation the dose of prednisone was raised to 45 mg. daily, and promazine was also given. As the physical signs abated (the rash, the ulcerated throat, and the pyrexia) so the mental state returned gradually to normal in parallel with the physical signs.

One other observation in another patient whose lupus erythematosus was manifest chiefly in her joints produced pain, stiffness, and contractures. During pregnancy she was well controlled with prednisolone, and two months after delivery the prednisolone was slowly withdrawn. She had never shown signs of mental disturbance at any time during the three years of her illness. Four months later she began to relapse and was given indomethacin, 25 mg. three times a day, as an alternative to prednisolone. Her joint symptoms rapidly improved on this drug, and there were no skin manifestations or other signs indicative of active systemic lupus erythematosus at this time. After about six weeks of this therapy she became very depressed, and indomethacin was abruptly discontinued. This withdrawal produced an acute exacerbation of symptoms of lupus erythematosus, reactivating not only the joints but also producing a typical facial rash, desquamation of the skin over the finger-tips, and dyspnoea. Remission was quickly obtained using prednisolone and amitryptyline.

—I am, etc.,

Astley Hospital, Manchester. ALAN J. FRANKLIN.

Vascular Lesions in Diabetes

SIR,—We have read with great interest your leading article (11 September, p. 603) about diabetic microangiopathy. It has been shown by others[1 2] that the levels of serum glycoproteins are raised in diabetics with vascular lesions. We report here our observations in rabbits with experimental diabetes.

We have studied[3] the changes in some neutral mucopolysaccharide fractions—hexose, hexosamine, sialic acid, and seromucoid—in the serum of rabbits in diabetes induced by treatment with alloxan, cortisone, and alloxan combined with cortisone. In alloxan-diabetes the concentrations of hexosamine and sialic acid and in steroid-diabetes that of hexose and seromucoid were found to rise. The changes observed in diabetes induced by alloxan combined with cortisone were similar to those observed in steroid-diabetes. The renal vascular lesions were severest on treatment with alloxan combined with cortisone, and did not parallel the changes in the serum levels of the neutral mucopolysaccharide fractions.

—We are, etc.,

L. JAKAB. J. FEHÉR.
M. BRETÁN. L. KAMMERER.

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REFERENCES

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2 Gilliland, I. C., Hanno, M. G., and Strudwick, J. I., *Biochem. J.*, 1954, **56**, xxxii.
3 Jakab, L., Bretán, M., Fehér, J., and Kammerer, L., *Acta med. Acad. Sci. hung.*, in press.

Origins of Homosexuality

SIR,—In your editorial "Origins of Homosexuality" (6 November, p. 1077) you state that "while F. J. Kallmann observed a 100% concordance rate for homosexuality between monozygotic twins others have cast doubts on his observations," thereby rendering "genetic studies . . . inconclusive." Among these others you list the 1960 paper by Rainer, Mesnikoff, Kolb, and Carr in *Psychosomatic Medicine*, which was entitled "Homosexuality and Heterosexuality in Identical Twins."

I think it is important to point out to your readers that a genetic hypothesis by no means requires 100% concordance in monozygotic twins. Indeed, Kallmann indicated in his original study as well as in his favourable discussion of our paper (published along with it) that such a perfect concordance rate is to be regarded as a "statistical artifact." He stated that the "fixed relationship between primary gene effect and its behavioural endpoint" which the demand for such perfect concordance would imply is inconsistent with the conceptual scheme of modern genetics.

Our paper was the result of an extensive search for discordant pairs. The male pair described therein was intensively studied in the search for psychological similarities as well as divergences; both were found. Investigating the rare cases of dissimilar twins affords an opportunity to learn about the contribution of the "environment" to the heredity-environment interactive process, a process which may start before birth and go on to include the role of life experiences. If "genetic studies" refer to the total elucidation of this interactive process, they are certainly still "inconclusive." To imply, however, that Kallmann and others required a 100% concordance rate, and that finding and studying an occasional dissimilar pair casts doubts upon their observations and hence upon the role of genetic factors, is to build one *non sequitur* upon another. At present it would be more productive to consider the evidence, including the twin studies, for biological, genetic, and psychological factors and to use methods to explore their mutual influences.—I am, etc.,

Department of Medical Genetics,
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New York, U.S.A. JOHN D. RAINER.

SIR,—I am writing to express my surprise that you saw fit to publish the letter from Dr. C. G. Learoyd on the above subject (27 November, p. 1309). I don't ever remember having read such a bigoted or emotionally toned letter in a scientific journal. It would appear to me that this sort of letter is the type one might expect to find in a weekly magazine rather than the *B.M.J.* There are, of course, many arguments both for and against altering the law appertaining to homosexual offences, but I would have felt that in this day and age as doctors we could at least view the problem with scientific detachment.—I am, etc.,

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Intrauterine Contraceptive Devices

SIR,—With reference to your leading article of 31 July (p. 249), I thought you would be interested to hear of our experiences using the intrauterine contraceptive device as an alternative form of contraception at the Sheffield Family Planning Association clinic.

We were fortunate in having Dr. Betty Knowles, head of Family Planning Services in Fiji, to start our clinic for us (in February 1965) and to train the five medical officers. Dr. Knowles had inserted 800 Lippes loops in Fiji, and we used Lippes loop No. 3 or C.

Our patients are all multiparous women, so that no dilatation of the cervix is needed, and in most cases we have managed insertion after caesarean section. Contraindications are severe menorrhagia, cavity or cervical fibroids, and history of endometritis, and overdue menstruation. Loops are fitted at any time in the menstrual cycle.

The patient is shown the loop and warned of possible side-effects—i.e., pain and bleeding. She is instructed to check that the loop is in position by feeling for the threads, and that it has not been extruded into the vagina. This is done weekly and post-menstrually. All three

pregnancies so far have been due to unnoticed extrusion. After vaginal examination and a routine Papanicolaou smear, the loop is inserted by a sterile no-touch technique. After insertion the patient is given a cup of tea, and for 5 to 10 minutes rests on the couch before going home. A detailed letter is sent to each woman's general practitioner.

The second visit is 1–3 months after insertion. The patient is examined and asked about side-effects, and the loop is confirmed in position—by x-ray examination if the threads are not seen.

From February to July 1965 196 loops were inserted. Four were unable to be fitted owing to cervical spasm and fainting. Three loops were removed in the next half-hour owing to uterine cramps. Nine more patients felt faint but recovered quickly (since September, the incidence of fainting has been much reduced). One hundred and ninety-one patients returned for a second visit. Side-effects noted were bleeding—heavy in seven patients (3.6%), four of whom had the loop removed, three treated successfully without removal. Thirty-six (18.3%) had menometrorrhagia. Eighty-four (42.2%) had heavier periods. Three patients had severe pain, for which the loops were removed. Four (2%) had severe dysmenorrhoea, and 50 (25%) had slight dysmenorrhoea. Nine patients had discharges which required treatment, and one loop was removed. Twelve patients had slight brown intermenstrual discharge. From February to November there have been 17 extrusions, 10 of which were reinserted, four refused reinsertion, and three were pregnant (unnoticed extrusion). Three loops were extruded twice.

Patients were mainly social classes 2 and 3, and in the 20 to 39 age group, with 12% over 40. It has proved to be a very popular method, the patients being very satisfied (though it is too early to tell what the long-term results will be), and now two sessions weekly are held, with 12–15 insertions per session, and there is a waiting-list of several months. About 400 insertions have been performed up to November 1965.

—I am, etc.,

JILL M. TATTERSALL.

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Measuring Scalpel

SIR,—Occasionally it is useful to have some form of measuring device on the operating table, and to meet this need the following modification of an instrument has been designed.

It consists of a scalpel handle on one side of which the measurement is marked in centimetres and on the other in inches. The following is a detailed description.

A No. 4 size scalpel blade-holder fitted with a flat solid stainless-steel handle graduated in centimetres on one side (1–10) and in inches (1–4½) on the other side. This instrument is slightly heavier than the usual one (Fig. 1) and is manufactured by Messrs. A. L. Hawkins & Co. Ltd., London W.1.

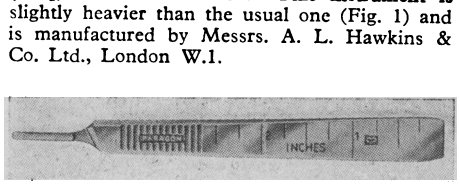

FIG. 1.

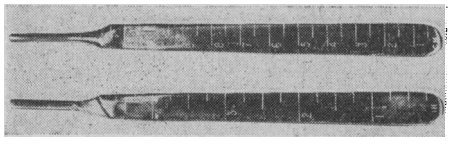

FIG. 2.

The Paragon Razor Company, Sheffield, have also modified their No. 3 knife handle for interchangeable blades. On this scalpel handle approximately 2 in. (5 cm.) is demarcated on one side—the same length is indicated in centimetres on the reverse (Fig. 2).

—I am, etc.,

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Ampicillin in Chronic Bronchitis

SIR,—Bacteriologists, statisticians, and others may argue as to whether the findings described in our paper (16 October, p. 904) do or do not show a statistically significant benefit from treatment with a broad spectrum antibiotic. A clinician should conclude that if ampicillin is a really effective antibiotic against the organisms present in acute exacerbations of bronchitis, then bacterial infection is not an important factor in delaying recovery from such illnesses when they have led to admission to hospital.—I am, etc.,

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Indomethacin and Phenylbutazone

SIR,—In their article (27 November, p. 1281) Dr. F. Dudley Hart and Dr. P. L. Boardman state that the most consistently satisfactory results from indomethacin were obtained in patients with ankylosing spondylitis, osteoarthritis, gout, and some cases of rheumatoid arthritis, especially when the disease was active. To this list of rheumatic conditions I propose to add the relatively rare episodic variety of arthritis known as palindromic rheumatism.

This acutely painful condition, characterized by short recurring episodes of monoarticular or polyarticular joint pain and swelling with almost symptom-free intervals between attacks, usually responds poorly to all the common analgesics, including phenylbutazone. While some patients continue to have attacks for years, many eventually develop permanent joint changes and progress to rheumatoid arthritis. During the past year I have treated three patients with indomethacin during the acute attacks.

The first patient, a 44-year-old woman, has been fully reported elsewhere.[1] She had palindromic rheumatism of five years' duration and also familial hyperuricaemia. Clinical gout was considered unlikely in view of the clinical appearances, hypochromic anaemia, hyperglobinaemia, positive tests for rheumatoid factor, and the failure to respond to colchicine. Indomethacin, 25 mg. thrice daily, resulted in dramatic relief of symptoms within 30 minutes of taking the drug, and has been hitherto consistently effective during attacks.

The second patient was a 50-year-old woman with a year's history of attacks of polyarticular pain and stiffness occurring approximately every month. Each episode lasted 24 hours, and the pains were relieved slightly with phenylbutazone. The haemoglobin was 116%, W.B.C. 6,000/c.mm. E.S.R. 35 mm./hr., latex test positive, serum uric acid 3.7 mg./100 ml. Recently she has had more constant pain and tenderness of the metatarsophalangeal joints of the feet, and radiographs show periosteal reaction at the base of one of the proximal phalanges, suggesting the onset of frank rheumatoid disease. The acute episodes of pain have responded very satisfactorily to indomethacin, 25 mg. three times a day.

In the third patient, a 43-year-old man, the symptoms were of six years' duration. He had severe, flitting joint pains with occasional swelling of the wrists and fingers. Examination on three occasions revealed no significant physical signs. The E.S.R. was constantly in the region of 35 mm./hr., blood count and electrophoresis normal, tests for rheumatoid factor negative, serum uric acid 3 mg./100 ml. Radiographs of hands, feet, and pelvis showed no abnormality. Indomethacin, 25 mg. three times a day, was quite effective in controlling his periodic pains, but he has been obliged to discontinue the drug because of severe headache.

In each of these patients indomethacin was effective in a dosage of 25 mg. three times a day in controlling severe pain during attacks. No medication other than occasional salicylates was indicated between the acute episodes. Systemic corticosteroids will usually control symptoms in palindromic rheumatism but may not be considered advisable for a variety of reasons. Indomethacin therefore appears to be a very useful drug during active phases of this condition.—I am, etc.,

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REFERENCE

[1] Golding, D. N., *Practitioner*, 1965, **195**, 340.

Depression in Children and Adolescents

SIR,—The report of a conference on depressive illness in general practice (30 October, p. 1052) prompts me to mention the commonly held but I feel erroneous concept that endogenous depressive illness, if it occurs at all, is rare in children and uncommon in adolescents.

Morbid depression is not uncommon in the young, but its clinical features are different from those in adult patients. Children, being dependent, are not in the main concerned about future situations, and the majority of depressed children retain an ability to relate to persons. The common adult triad of depressed mood, feelings of guilt, and suicidal ideas and tendencies is uncommon in the young, and "masked depression" is much the more common presenting disorder. A clinical picture may be seen which bears little resemblance to even the milder endogenous depressions of later life. Affective disorder may present in the young as hypomanic activity and the milder degrees will produce a restless, hyperactive child with a smiling face and exaggerated lively responses.

The well-documented neurotic syndromes of childhood and adolescence may frequently be associated with, and follow, an earlier change of prevailing mood which may have been overlooked or forgotten by parents when more florid symptoms become evident. Behaviour disorders, psychosomatic diseases, accident-proneness, and some antisocial activities may be similarly related. So-called reactive depressions, due to an actual or threatened loss of a child's loved object which produced disappointment, frustration, and depressive withdrawal and sadness is common. Although these children appear to be able to behave normally and adjust satisfactorily, they are children who may frequently be having difficulty in forming deep-lasting relationships and may be growing with personality abnormalities which may remain with them.

Profound changes of mood and periodicity are present in many of the clinical syndromes seen, and a history of depression in a parent, most commonly the child's mother, is a frequent find-