of postmenopausal women cannot be excluded. The basic activity of progesterone, as part of the postmenopausal diet, also the persistence of enzymatic activity in the ovaries \(^1\) or possibly in the uterine body.

I found that hysterectomized and oophorectomized women tolerate continues treatment for a longer period than "normal" women. Intermittent therapy (thrice weekly) with all forms of oestrogenic substances is the treatment now used in this clinic. This therapy is based on empirical rules.

It would be a great asset if we could evaluate the menopause in a more precise manner to establish or confirm oestrogen lack as the cause of the various postmenopausal symptoms, and research is proceeding along these lines in this clinic.—I am, etc.,

**Geoffrey Dove**

London W.1


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**Decline of the Necropsy**

Sir,—The writer of your leader "Decline of the Necropsy" (24 April, p. 181) must surely have had his tongue in his cheek. In compliment to my clinical colleagues it should be made clear that the decline of the hospital necropsy has arisen since surgeons now send their specimens to the pathologist while the patient is still alive, and advances such as antibiotic therapy have converted necropsies on medical patients to studies in degeneration rather than infection.

As for "back operations"—firstly, these frequently involve the honour and liberty of the subject; insurance, compensation, and legacies; and the reputation of one's colleagues. The same cannot be said of routine hospital necropsies.

Secondly, the principle envisaged by your writer could be extended further. Surgeons might be released from removing normal appendices in nursing homes, gynaecologists from performing routine abortions in private clinics, and physicians from fussing over private neurotics anywhere; these gentlemen would not then be "constrained to neglect more important hospital duties." Moreover there is no reason why a barrister should waste his valuable time attending court for a plea in mitigation in respect of some peculiarly revolting villain; solicitors should not be asked to conduct conveyancing; indeed one can continue ad infinitum.

Although admittedly I must now eschew the higher flights of chemistry and virology for the lower depths of a fundamental interest in haematology has not prevented me from considering myself a better "pathologist" because on occasion I look at sections and even make postmortem examinations. Indeed, I have come to the view that apart from the occasional (very occasional) surgical biopsy it is the coroner's necropsy alone in which the full skill, learning, and responsibility of the pathologist (as distinct from technical and scientific procedures) is seen to full advantage.—I am, etc.,

**J. G. BENSTEAD**

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**Blue Valve Syndrome**

Sir,—Your leading article "Blue Valve Syndrome" (8 May, p. 294) gives a rather incomple picture of a condition which must, by definition, be similar to all other miasms in the heart. This is presumably the condition originally described in 1958 by Fernex and Frenx, \(^2\) which is not uncommon in general hospital necropsy material, at least in this region. \(^3\) Apart from the familial cases, this abnormality is seen mainly in the elderly and was found in 1% of necropsies on patients over 50 in this hospital.

It may well be that the condition proceeds to intractable heart failure, but this process probably takes many years. Histories of loud mitral systolic murmurs for 20 years fore the final illness are not uncommon, and about a third of the cases that I have seen died of non-cardiac disease. Clinicians should be aware that mucoid degeneration predisposes to "spontaneous" rupture of the chordae tendinae as well as to endocarditis (both infective and non-bacterial thrombotic), but apart from these complications the mitral incompetence seems to be relatively well tolerated in the age group in which it is most often found.

Finally, may I protest against perpetuating this new term "blue valve syndrome"? It seems to have been coined on the basis of a single case report \(^3\) whose review of the literature was confined to four American papers. In my experience of over 50 cases the colour is more accurately described as pearly-grey and emphasis on the occasional blue tinge would only add to the number which are incorrectly labelled rheumatic valvarular disease. There is undoubtedly a place for a short, recognizable name for this comparatively common condition but Fernex and Frenx's original term "mucoid degeneration" is as short, and considerably more accurate than the term "blue valve".—I am, etc.,

**Ariela Pomerance**

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**Beta-adrenergic Blocking Drugs**

Sir,—Your leading article on "Beta-adrenergic Blocking Drugs" (30 January, p. 243) raises some fundamental questions in this rapidly expanding field. The first is the distinction between intrinsic sympathomimetic activity and selectivity. There is good pharmacological evidence, in both animals and man, that propranolol has a cardio-selective action. However, it is quite possible that an agent with intrinsic sympathomimetic activity could achieve a selective effect if sympathetic tone were higher in the heart than in the bronchial smooth muscle. It has been shown for agents with intrinsic sympathomimetic activity that where sympathetic tone is low, no change in function results, but when tone is high beta blockade occurs. \(^5\) This is supported by the comparative study on: "airway function in asthmatics done by Connolly and Batten.\(^6\) It would appear that the objective of a beta-blocker should not be to have a cardiodepressant effect but rather to decrease sympathetic tone to have a less effect on airway resistance. In any case whether drugs are cardioselective and/or beta-blockers would have no effect on inhaled bronchodilators that do not have a beta-blocking selectivity. This is shown by the fact that some beta-blockers do not have any adverse effect on bronchial smooth muscle. Therefore, in the case of beta-adrenergic blocking drugs, the concept of selectivity is not important.

**J. W. PATERSO**

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**Breath-activated Aerosol**

Sir,—I should like to report a small study of a new breath-activated, pressurized inhaled bronchodilator drug. "Pulmonate" has been developed in an attempt to overcome the problems which some patients experience in synchronizing the delivery of a metered dose of bronchodilator drug with the beginning of inspiration. This may improve the patient's ability to use a pressurized inhaler, the dis-