health of under 16's, who would be put at risk by the giving of a free rein to those who would through publicity or propaganda, or both, encourage teenagers into early sexual relationships, is considered a "controversial" view by Dr. Gregson. The F.P.A. announce-ment in February 1973 supporting free contraception irrespective of age had not to my knowledge been put forward by the Clinic Doctors' National Council to our doctors' group for our discussion at any time previously. Are we to take it that fait-accompli democracy? It surely takes little imagination to see that when an organization which includes doctors (such as the F.P.A.) puts forward publicly an unqualified no age limit for contraception certain of the media for teen-agers will for their own purposes, actively encourage early sexual relations and refer teenagers to the F.P.A. clinics. It is then too late for clinic doctors to help the situa-tion, which any doctor can see has gone from bad to worse in the past few years with increasing illegitimacy, abortion, and venereal disease among young teenagers. Public respect for the F.P.A.'s publicity advised doctors will return only when a positive health value (physical, emotional, and social) is given for sexual restraint as an alternative to contraception and when the age consent is actively supported.

Have not we as doctors an obligation to parents and to society to discourage the enticement of young people through mis-guided publicity into behaviour which puts them at risk to their physical and emotional health? If the F.P.A. is not willing to have this openly discussed perhaps there could be a public discussion through the N.H.S. family planning services?—I am, etc.,

ELIZABETH ELLIOTT
Wisbech, Cambridgeshire

Penicillamine and Creaking Joints

Sir,—We have recently noted three patients who spontaneously remarked that their knee joints had begun to creak in an unusual fashion since taking β-penicillamine for severe rheumatoid arthritis. They had been taking penicillamine for at least one month and had shown no other untoward effects. The rheumatoid disease had im-proved in two of them. We intend to in-vestigate this phenomenon further by stud-ying the rheology of synovial fluid before and after penicillamine therapy. We would be interested to know if this effect of β-penicillamine has been noted before.—We are, etc.,

R. D. STIRBROCK
P. M. BROOM
Centre for Rheumatic Diseases,
Glasgow

Assessment of Surgical Treatment

Sir,—Professor W. B. Jennett's letter (15 June, p. 612) contains a totally false attribution to me, to wit: "Dr. Spodick's demand for sham operations..." I have never, anywhere, proposed—much less "demanded"—such operations. Certainly not in my paper, which was specifically cited in this connexion by Professor Jennett. His discussion is quite wide of the mark in terms of my paper. His mention that some physicians press surgery on some surgeons, for example, is relevant only to your leading article (13 April, p. 73). I have indeed fought for equal standards of judgement for all therapies. But nowhere have I proposed sham operations (I have referred to their effects but have not advo-cated them). Professor Jennett's letter does me serious injustice.—I am, etc.,

D. H. SPODICK
Tufts University School of Medicine, Lenox-Shankrrack Hospital, Boston, Massachusetts, U.S.A.

Halitosis

Sir,—Drs. T. F. Tydd and N. H. Dyer (3 August, p. 321) state that it is often difficult to find a reason for halitosis but that neurosis can be a contributory factor, and that in general practice depression of the endo-gerous type which can present as an unpleasant halitosis as the patient enters the room. The tongue of the sufferer is uniformly covered with a thick white film. Both signs are presumably due to a slowing down of, among others, the gastrointestinal functions. This condition and the mental state improve together.—I am, etc.,

R. N. COMPTON SMITH
Ilford, Essex

Gonorrhoea in Obstetrics and Gynaecology

Sir,—We would wholeheartedly agree with Dr. R. S. Morton's comments (27 July, p. 253) on the value of gynaecological training for the venerologist and the excellent career prospects in that specialty for those who hold the M.R.C.O.G. In this hospital the senior registrar in gynaecology also works for part of his time in the departments of gynaecology and urology. This provides a most successful arrangement from the point of view of training and for the development of interdepartmental co-operation.—We are, etc.,

J. K. OATES
R. SARKHEL
Cambridge

Progestogen Dermatitis

Sir,—Dr. S. J. Jackuch and Dr. H. L. Franks (3 August, p. 347) report an unusual patient who developed eczematous lesions of the hands following administration of Eugnon 30. The history suggested that the dermatogist, the prostogestatal agent in this contraceptive pill, was responsible. Shelley et al.1 described a patient who de-veloped a skin reaction which had regular, severe, premenstrual exacerbations. They drew attention to various skin lesions with similar behaviour, and in particular men-tioned eczema of the hands which may appear just before the menses only to dis-appear completely intermenstrually. How-ever, the patient they described had a con-dition which clinically resembled dermatitis herpetiformis though the histodiagnostic dia-nosis was erythema multiforme. The history strongly suggested a relationship to endo-genous progestogen secretion. Administra-tion of progestogen or the progestational agent norethindrone rapidly induced the skin lesions, while attempts at desensitiza-tion with increasing doses of progestogen caused a severe exacerbation of the derma-titis. A complete remission followed ovula-tion inhibition with ethinyl oestradiol therapy and ultimately by oophorectomy.

It seems that expressed progestogen and its analogues can have a poorly understood, deleterious effect on the skin.—I am, etc.,

L. J. HIPKIN
University of Liverpool, Liverpool

Uncorrected Opiate Overdose

Sir,—Acute poisoning with opiates (except-ing codeine, dextropropoxyphene and their compounds) in non-addicts is uncommon. If a patient presents with an overdose, the drug overdose admissions to this unit were treated during the five-year period 1969-73. However, recently there have been three salutary reminders that opiate poisoning may still be a cause for concern in the medical student.

Case 1.—A 15-year-old girl was admitted to casualty with a story of possible drug overdose. She was unconscious, apnoeic, cyanosed and hypo-tensive on arrival. Her pupils were dilated. Assisted respiration with oxygen via a cuffed endotracheal airway was started at once, and gastric lavage performed. Her general condition then improved and her pupils became ccontracted. Though opiate overdose seemed unlikely, nalorphine 10 mg was administered intravenously with remarkable therapeutic effect. The patient was fully recovered and the patient was fully recovered within four hours. Meanwhile it was discovered that she had been prescribed Diconal (dipipanone 10 mg, cyclizine 20 mg) for dysmenorrhoea, and had taken about 20 of these tablets after a domestic argument.

Case 2.—A 63-year-old woman was admitted to the ward with a five-day history of chest infection, treated with antibiotics, and slow onset of coma. She was cyanosed, dehydrated, hypotensive, and had Cheyne-Stokes respiration. She had been receiving prochlorperazine 50 mg and Diclofenac 50 mg tablets twice daily, with the tablets reminiscent of Diconal. Nalorphine 10 mg and nalorphine 10 mg was given, and later repeated twice, with dramatic improvement. The patient said that she had taken three tablets for chest discomfort before admission. The effects of this normally fairly safe opiate analgesic had presumably been potentiated by dehydration, oliguria, and pre-existing broncho-pneumonia.

Case 2.—A 62-year-old man, who had had a recent colonic resection for carcinoma, was admitted to casualty with suspected drug overdose. No information as to the nature of his illness or of drug therapy was available. He was unconscious, cyanosed, apnoeic, and hypotensive. His pupils were dilated and remained so. He was given nalorphine 20 mg, followed by nalorphine 10 mg and nalorphine 10 mg was given, and later repeated twice, with dramatic improvement. The patient said later that he had taken about 20 tablets mixed with cherry.

Poisoning with opiates is one of the rare situations in which an antidote is available.1 It is worth giving intravenous nalorphine even when there is only slight suspicion of overdose.2 Large and repeated doses may be required.2 Classical "pin-point" pupils may not always be evident, especially if cerebral anoxia has been marked. If no opiate is present, nalorphine itself may


depress respiration further but this is readily managed in hospital and the dramatic effects of this type of administration make therapeutic trial very worthwhile.

I am grateful to Professor R. Kilpatrick for permission to report these cases.

— I am, etc.,

B. W. HANCOCK
Royal Infirmary, Sheffield

Expenses for Study Leave

Sir,—There are many young consultants like Mr. N. J. Barwell (27 July, p. 262) who have worked their way up the ladder, often suffering from unfavourable differentials at each stage, only to find that consultant status was not financially Valhalla (defined, I note, as either a palace of bliss or a general burial place for a nation's great men). It is, however, the niggling restriction on expenses that is often the most irksome thing, and nowhere is this more evident than in attitudes to study leave.

The South-east Thames Regional Health Authority recently sent round a circular on this subject, and I would like to quote from the part relating to senior staff: "No financial help will be given for annual meetings of associations held in the United Kingdom . . . No preferential consideration can be given to expenses incurred in staying papers. The normal contributions will be up to half expenses with a maximum contribution of £100 (£200 for visits to U.S.A., Australia, New Zealand, the Far East, India or Pakistan) for whole-time consultants and on a pro rata basis for sessions less than nine per week." How much, I wonder, for cloud cuckoo land?

Surely our employers must be made to realize that study leave with full expenses is a necessary part of postgraduate education and an essential means of communicating medical advances in Britain to the rest of the world. This penny-pinching attitude, furthermore, discriminates against the whole-time consultant, for the tax authorities rightly recognize that attendance at medical meetings, particularly to present a paper, is a legitimate professional expense.

I would also like to point out that the whole system of expenses for study leave is at the whim of the individual regional health authority. It is well known, and I have personal experience of this, that some old regional hospital boards were more generous (or, I should say, fair and enlightened) than others. I am convinced that there should be a national rather than a regional policy on this matter.—I am, etc.,

PETER BANKS
East Grinstead, Sussex

Reporting Deaths to the Coroner

Sir,—Dr. R. N. Palmer (10 August, p. 410) regrets that there is no authoritative definition of the "archaic" phrase "persons about the deceased" who, the Brodick Committee alleges,1 incur an obligation at common law to give immediate notice to the coroner of circumstances requiring the holding of an inquiry. The phrase "persons about the deceased" is not archaic. It first appeared in the edicts of "Jervis and Brodick" which followed the Coroner's Act 1887. Shortly after that the council of the Coroners' Society resolved "that in cases of death from violence or from any unnatural cause, it is a common law duty imposed on the medical practitioner in attendance, among others, to report to the coroner." This provoked a strong leading article in the B.M.J. It observed that "no coroner has yet been rash enough to try the experiment of indicting anyone for not giving him information of a suspicious death," and it concluded that "no medical practitioner need feel seriously disturbed by the announcement of this new addition to his multifarious activities." This view was later reinforced by Sir Roland Burrows when the Medical Protection Society taught his opinion in 1943. He stated: "There is no power in a coroner to require medical practitioners as such to notify any death to him; there is no legal duty on the practitioner to report them; and there is no common law or statutory duty binding any practitioner in these matters to report such deaths and consequently no penalty."2 The most recent editions of Jervis admit that the duty is unenforceable at law.3

It was largely for these reasons that the B.M.A. report of 1962 recommended that medical practitioners should be required to notify the coroner or his officer immediately they become aware that a death has occurred which ought to be investigated by the coroner. It is interesting to note that the Brodick report says of the B.M.A. report, "our own inquiries have left us firmly convinced that the attitude adopted in this report was right, but here we disagree, however, have the advantage of providing references to the evidence on which its recommendations were based.—I am, etc.,

J. D. J. HAVARD
Harpden, Herts

Fenfluramine and Psychosis

Sir,—Your leading article (2 February, p. 168) suggested that fenfluramine might be of use in some obese patients while on psycho-

tropic drugs. Over the past three months we have admitted three patients in whom this drug proved to have problematic effects in precipitating their psychotic decompensation.

The first, a 38-year-old married woman who was admitted in a manic state, had a history of fluctuating mood states but her only previous contact with psychiatric services had been two outpatient attendances for depression. This had quickly resolved without drugs, but she has since taken fenfluramine 2 mg twice daily, which is fairly regularly. Her husband described how 30 to 60 minutes after taking the medication she would become increasingly active and remain so for several hours. This became more and more obvious until her behaviour brought her to the notice of the police and then herself.

The second, a 23-year-old single woman with no previous psychiatric treatment, had become emo-
tionally disturbed after the breakup of a close relationship and a man recently; she continued to harbour paranoid feelings toward him. At the time, however, she had received only a month's treatment and was maintained at home for two weeks. She was admitted in a schizophreniform state with mild clouding of the consciousness. After the clouding cleared she displayed features of paranoid schizophrenia. On admission she was in the fifth week of a course of fenfluramine 60 mg/day for obesity.

The third was a 43-year-old married woman who had had a schizophrenic illness when aged 20. Two years before admission she had had a relapse and had remained on medication since. She was not in hospital at the time, but was troubled with depression. She had been maintained on fluphenazine decanoate 50 mg four weekly, chlorpromazine 200 mg nightly, and imipramine 100 mg twice daily. Increasing homicidal thoughts towards her children and suicidal feelings, even after hallucinations necessitated her admission. She was in the third week of a course of fenfluramine and taking 40 mg twice daily on admission.

Psychiatric complications of fenfluramine have already been noted. Dr. A. Levin reported1 euphoria, derealization, and perceptual changes and also depressive illness in various degrees. Dr. J. D. F. Lockhart (2 March, p. 394) emphasized the danger of combining antidepressant medication with fenfluramine. In addition, from these, the possibility of a psychotic illness in predisposed persons seems a real possibility.—We are, etc.,

P. J. SHANNON
D. LEONARD
M. A. KIDSON
Monash University, Larssud Hospital Unit, Melbourne, Australia.

Aspirin and What Else?

Sir,—Your leading article (6 July, p. 5) stated that alcohol does not affect haemostasis unless it causes cirrhosis. I would point out that alcohol appears to act as a direct megakaryocyte or platelet toxin, or both, with resultant thrombocytopenia.2 This thrombocytopenia, which is dose dependent and reversible upon hypersplenism or folate deficiency, is rapidly reversible on withdrawal of the alcohol, and there may even be a compensatory thrombocytosis in patients with a history of platelet survival and Haut and Cowan,4 studying the effects of ethanol on the haemostatic properties of platelets, concluded that, apart from the thrombocytopenia, ethanol impaired platelet function due to both extracellular and corpuscular factors and platelet injury.—I am, etc.,

PAUL GETAZ
Groote Schuur Hospital, Cape Town, South Africa

Chemotherapy before Bowel Resection

Sir,—Talking to medical representatives recently I learnt how frequently surgery and gastroenterologists give preoperative chemotherapy to patients who are going to have bowel resections, and also that patients are being brought in four to five days before operation to be put on special diet to help lessen the...