established treatment with β blockers, although a high incidence of intolerance has been reported with primidone. We have encountered adverse reactions (nausea, vomiting, dizziness) in some patients after a single small dose—for example, 62.5 mg orally. The cause of this acute sensitivity (toxicity) is not clear. There is, however, evidence to indicate that this problem could be circumvented by prior exposure to phenobarbitone or other drugs to induce the liver enzymes involved in the metabolism of primidone.¹⁰

In our experience tranquillising and sedative drugs can be useful in attenuating essential tremor. Their effectiveness is, however, proportional to the degree of sedation produced. Alcohol, though strikingly effective in some patients, cannot be considered as realistic treatment.

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British cosmetic regulations inadequate

SIR,—The British cosmetic regulations do not always act in the interest of the consumer. We report a case to support this statement.

We recently saw a patient in the dermatology clinic who had noticed patchy depigmentation of the palm of her left hand, the right forefinger, and patches at the base of the neck (fig). She had been using a cosmetic cream, Venus de Milo, made by Cussons Ltd, and the distribution was consistent with the

Depigmentation seen around the neck of a patient after use of Venus de Milo cream.

pattern of its application. The small print on the tube mentioned that the cream contained hydroquinone.

The instructions for application were in French and English and suggested that a "healthy bright and lovely appearance" of the skin would be acquired following frequent use of the cream. No mention of hypopigmentation was made, although it was noted that the cream should not be used "to dye eyelashes" or, in the French version, "décolorer les cils" (there is some inaccuracy in the translation here).

Hydroquinones are well known as bleaching agents, interfering with melanin production. They are often used for this purpose to remove, for example, minor cutaneous pigmentation, and they may be legitimately used in white or coloured people in preference to more noxious agents such as ammoniated mercury or monobenzylether of hydroquinone.

A survey of shops in an area with a large population of West Indian women has shown that many creams similar to the one used by our patient are available (conversely, they are not often seen in shops in areas with small immigrant communities). All contained hydroquinone and suggested that they would tone or brighten the skin ("bright" to some West Indian women does seem to mean "light"). We suggest that the regulations ought not to allow manufacturers to name the constituent without stating its function. Neither the 1978 cosmetic regulations nor the new cosmetic regulations deal adequately with this point, and changes should be made so that the mode of action of constituents becomes understandable.

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The use of a conical spacer after laryngectomy

SIR,—Dr S J Williams (5 May, p 1379) has found a conical spacer device (Nebuhaler) very effective in treating patients with severe asthma, and we have found it useful in treating a patient with bronchospasm who had had a total laryngectomy. The main problems with delivering bronchodilator drugs to patients who have had laryngectomies using pressurised aerosols are obtaining a good seal between the stoma and the aerosol and coordinating delivery of the drug.

Our patient, a 73 year old man, registered blind, had a total laryngectomy in September 1982 for squamous carcinoma. He had chronic bronchitis which was previously well controlled by aminophylline tablets and the occasional use of a salbutamol inhaler. After operation he could not use the inhaler.

In November 1983 he was admitted to hospital with a severe chest infection. He was treated with antibiotics, physiotherapy, and salbutamol given through a nebuliser. We decided to try to control his symptoms with terbutaline given by a Nebuhaler. He quickly mastered the technique (see fig) and was discharged on a dose of 0.5 mg four times daily. He has since shown substantial symptomatic improvement,

A patient after laryngectomy using a Nebuhaler to give bronchodilator drugs.

although the results of pulmonary function tests are equivocal.

The Nebuhaler is cheaper and easier to assemble and use than a nebuliser, and in this patient seems to be as effective.

We thank Mr G J Radcliffe for permission to report this case.

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¹ Davies DS. Pharmacokinetics of inhaled substances. *Postgrad Med J* 1975;**51**, suppl 7:69-75.

Haemoptysis during sexual intercourse

SIR,—I want to add the following complication of sexual intercourse to the recently reported pneumomediastinum (21 April, p 1196).

A 39 year old with a two year history of mild hypertension (treated with bendroflumazide) developed chest discomfort and sudden haemoptysis during sexual intercourse. She continued to cough small quantities of bloodstained frothy sputum and was admitted to hospital. Findings on physical examination and chest radiography were normal. A perfusion isotope lung scan showed multiple perfusion defects compatible with a diagnosis of pulmonary embolism. A ventilation isotope lung scan was normal. There was no previous history of pulmonary embolism, deep vein thrombosis, or chronic bronchitis; and sputum culture was negative. She was given anticoagulants and has remained well. Three months earlier she had given birth by an uncomplicated caesarean section.

This patient may have had one episode of pulmonary embolism during intercourse. A Medline literature search from 1966 onwards produced no information about haemoptysis or pulmonary embolism during intercourse. I do not want to propose a mechanism, but the sexual intercourse was not in any way unusual.

I thank Dr H G Mather for allowing me to report this case.

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Haematemesis and ectopic pregnancy

SIR,—Dr M J Glynn and Mr D Elliot's lesson of the week (28 April, p 1287) reminded me of a case where the resultant stress of an ectopic pregnancy confused the diagnosis.

A young woman with a normal menstrual history was admitted as an emergency to the medical unit. She had been vomiting small amounts of coffee ground fluid that were positive for blood on ward testing. There was no history of drug ingestion, peptic ulceration, repeated retching, or melaena. She complained of generalised abdominal pain of gradual onset.

On examination she was in hypovolaemic shock with diffuse abdominal tenderness. A diagnosis of gastrointestinal tract bleeding probably from a