had no hyperacidic peptic ulceration. As regards the second patient, simply overseeing perforations leads to further surgery in 20% of cases in five years. This is extremely rarely required within two months.² The occurrence and timing of recurrence of ulceration in both cases strongly suggests that cimetidine treatment or its withdrawal was implicated.

When H₂-blockade of acid-secreting cells is withdrawn, it is more likely to lead to excessive sensitivity to normal stimuli than to hyperplasia.

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¹ Wychulis, A R, *et al*, in *Surgery, Gynaecology and Obstetrics*, 1966, 122, 89.

² Illingworth, C F S, *et al*, *British Medical Journal*, 1946, 1, 787.

SIR,—The discussion about cimetidine and duodenal ulcer by Dr J H Baron and others (20 January, p 169) has important implications for general practitioners as well as hospital-based specialists.

If, as is suggested, progressively more patients are being treated medically then the disease becomes one which should be treated in the primary care situation. There seems to be agreement that rapid relapse after one or more full courses of treatment warrants referral for surgery even if many patients would prefer the unknown risk of long-term drug therapy to the known risk of operation. What is not clear, in general practice, is which patients should be started on treatment. I, and some of my colleagues, felt initially that the criteria should be relatively rigid. All patients should have had a duodenal ulcer demonstrated radiologically or endoscopically or should have suffered a catastrophe such as haemorrhage or perforation in the past. This may lead to numbers of patients with classical symptoms being referred to outpatients for expensive, time-consuming, and unpleasant diagnostic procedures. If, as Mr J Alexander-Williams states, patients are being referred to him with a diagnosis of duodenal ulcer but with symptoms uncontrolled by cimetidine, and that this almost certainly indicates that the pain is due to something else, then surely we have in our hands a diagnostic weapon which can relieve hospitals and patients of a tiresome burden.

It could be argued that at least in the younger patient with upper abdominal pain a therapeutic trial of cimetidine for one week should be carried out as a first step in investigation. The same argument would hold for differential diagnosis of retrosternal pain when reflux was a consideration. My experience so far has suggested that the answers given by such a policy are helpful.

MICHAEL DRURY

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Colostrum deficiency

SIR,—I wonder if anybody has ever seen a baby die for want of colostrum. Only this week I saw five very agitated mothers who evidently thought that theirs might. One had respiratory distress and another a large cleft palate, and a third persistently vomited all his "unique maternal gift." The mother of the fourth had a complicated delivery and was herself unwell, while the fifth had inverted nipples and was unable to produce any colostrum or milk.

All worked themselves up into a frenzy because their babies had not had their "cholesterol" (sic), although all five babies are making excellent progress.

I am, of course, familiar with the multifarious properties of this substance but colostrum deficiency would appear to be a new iatrogenic disease of the maternal mind, springing from the same sources which are responsible for so much unnecessary anxiety today.

HERBERT BARRIE

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Age and death in breast carcinoma

SIR,—I was interested to read your leading article (27 January, p 211) on the above subject. During the last year before my retirement some 18 months ago, I decided to review all my cases of carcinoma of the breast, to see whether anything of interest might turn up. Despite the small number—about 400—this was a fairly mammoth task, and when it was finished I found that I had really nothing to offer, so did not publish. The survey, however, provided me with two surprises.

The first surprise was that, contrary to what one had always thought, age seemed to have little or no bearing on prognosis and old people seemed to fare no better—or worse—than youngsters. The second fact that emerged—not altogether a surprise—was that small local recurrences treated with subsequent surgery did not seem to prejudice the ultimate result. I was warmly surprised at the number of younger people, either with or without local recurrences, who were alive and well at the 10-year milestone, despite having had no radiotherapy or chemotherapy.

Do we sometimes err on the side of over-treatment, or is that the rationalisation of an old surgeon who is a little out of harmony with the modern young oncologist?

ROBIN BURKITT

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Premenstrual tension syndrome

SIR,—Your leading article on premenstrual tension syndrome (27 January, p 212) clearly documented the conflicting data relating to the aetiology of this common problem with reports of both an increase and a decrease in plasma progesterone, oestradiol, prolactin, and aldosterone levels. However, you failed to mention the obvious conclusion that whatever the details of the hormone imbalance, and no doubt they vary from case to case, the ultimate cause of premenstrual tension must be a change in plasma hormone values from the time of ovulation.

The symptoms for this common condition can usually be relieved by ablating these hormone changes. This can be done simply by the combined oestrogen-progestogen birth control pill given continuously, thus avoiding ovulation and menstruation; a more successful method is the insertion of a 75 mg or 100 mg oestradiol implant into the fat of the abdominal wall. With this method endometrial hyperplasia is avoided by the administration of 5 mg norethisterone for five days each month. It is our experience that many of these implant patients who have their symp-

toms completely abolished by this technique will complain of their own characteristic premenstrual tension symptoms during one or two of the five days of the progestogen, suggesting the likely cause of the syndrome in many of these patients.

JOHN STUDD

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SIR,—One of the now well documented and accepted, yet still sadly neglected, causes of tension and depression in women is included under the blanket heading of the premenstrual syndrome. The possible aetiology is discussed in your excellent leading article (27 January, p 212).

At one time I was using intramuscular progesterone with success in the relief of these symptoms, although the method did not appear to be generally accepted.¹ It seemed that here was a logical form of treatment for a universal problem which had a more reliable physiological explanation than was generally considered at the time. If the endocrine basis of this very common problem can be shown to be the cause, then the prescription of any form of psychotropic medication is inappropriate.

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¹ Waxman, D, *British Medical Journal*, 1968, 4, 188.

SIR,—I am surprised that in your otherwise excellent leading article on premenstrual tension (27 January, p 212) you repeat the myth that progesterone therapy is "expensive." You cite a reference from that well-known journal *Current Medical Research and Opinion*¹ in support of this statement.

I hasten to say that I have no criticism of this particular paper, except that it repeats this strange claim (seen in the advertising literature of a rival product²) that progesterone is "expensive."

I have no axe to grind for either therapy, but I do think we should get our facts straight. I have recently put a number of women on progesterone suppositories—so to speak—and I took the precaution of finding out the cost first, using my trusty *MIMS*.

The truth is that one cycle's treatment with progesterone (Cyclogest suppositories) normally costs £4.20. One cycle's treatment with the rival synthetic progestational agent which you mention in your leader (dydrogesterone—Duphaston) costs £6.70. Which is more expensive?

DAVID DELVIN

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¹ Kerr, G D, *Current Medical Research and Opinion*, 1977, 4, suppl 4, p 29.

² Duphar Laboratories, *Duphaston in Premenstrual Syndrome*, p 12.

Tetracycline preparations for children

SIR,—I must take issue with Dr P G Brock and Maryanne Roach (13 January, p 126) over the use of tetracyclines in the management of infections in children and in pregnant women.

Tetracyclines are valuable drugs, but are never the sole effective agent for any given infection. Erythromycin is effective against the vast majority of strains of *Mycobacteria pneumoniae*,^{1,2} and, unlike the tetracyclines,