and on both occasions a blizzard prevailed. The *Mercury*, a Hobart newspaper, reported on 21 September 1903, "They had to face a snowstorm, with a strong south-westerly wind. Many of them were dressed only in singlets and light knickers, . . . and the top sides of the mountain were covered with some feet of snow . . ." One of the participants noted some years later, "They were lying over logs, on the ground, and under trees, too exhausted to continue." Thus the deaths were a result of hypothermia, the end result of exhaustion and inadequate or wet clothing in a cold, windy environment.

It is clear that lightly clad runners are vulnerable to environmental conditions, both hot and cold, and the organisers of any community jogging events should realise that weather conditions can create a medical nightmare out of a "fun run."

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¹ Sutton, J R, *et al*, *Medical Journal of Australia*, 1972, **2**, 127.

² Sutton, J R, and Harrison, H C, *Medical Journal of Australia*, 1977, **1**, 193.

³ Hughson, R L, and Sutton, J R, *British Medical Journal*, 1978, **1**, 1158.

⁴ Robinson, C R R, *New England Journal of Medicine*, 1971, **285**, 1267.

Canvasser's knuckle

SIR,—We are all aware of such complaints as "housemaid's knee," clergyman's knee," "student's elbow," "miner's elbow," and "weaver's bottom"; but I would like to introduce another member of this family, which I have discovered recently—namely, "canvasser's knuckle."

During the course of the recent election I knocked on dozens of doors and subsequently developed painful swelling and inflammation of the proximal interphalangeal joints of my right hand. At a conservative estimate I would say that 50% of party workers who laboured hard during the last campaign suffered from "canvasser's knuckle" and that their discomfort could be relieved by a liberal application of cold hand cream.

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Illness seen at menopause clinic

SIR,—The recent paper by Mr S Chakravarti and others (14 April, p 983) noted that a group of the patients presenting in a menopause clinic had symptoms which were not apparently attributable to the oestrogen deficiency of the climacteric.

Of the first 40 patients referred to a menopause clinic in Newcastle, 19 were found to be suffering from conditions requiring treatment but unrelated to oestrogen deficiency (although this was judged to be present in at least nine of the 19 on the basis of characteristic symptoms and raised plasma concentrations of follicle-stimulating hormone). The range of diagnoses included hyperthyroidism, primary hyperparathyroidism, hypertension, cardiac failure, and alcoholism, as well as depressive illness.

Undoubtedly there is a tendency for women aged around 50 to attribute any untoward

symptoms to the menopause and their doctors may sometimes accept this explanation too readily. A major function of a menopause clinic is a full diagnostic appraisal of the patient.

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Cervical cytology

SIR,—Since becoming a principal in general practice in 1973 I have been concerned about the accuracy of technicians' reports on cervical smears.

In 1977 in Gloucestershire I and a partner were running a family planning clinic in a practice of 10 000 patients. We became worried when it seemed to us that there were too many reports of squamous cells only, requesting the smear to be repeated. We collected reports on smears done on our patients over a six-month period. These smears were taken by the doctors in the Family Planning Association clinic, the consultant gynaecologists, and the partners in our practice.

We found that of the three technicians who reported, one requested a significantly higher number of repeats than the other two, and it did not seem that any one doctor was requested to repeat his smear more than another. We pointed this out to the pathology department and realised that a larger study was needed—perhaps nationally—really to prove our point, formally and statistically, that there may be a vast amount of public expenditure wasted because of mistakes in cell typing.

I am now in a smaller general practice in Yorkshire and again became worried because every single cervical smear I have taken is simply reported "no malignant cells." This is a complete contrast to my reports in Gloucestershire and I have not changed my technique. I therefore did two slides. One was of cells from my buccal cavity (stuffed squamous) and the other slide was prepared by my scraping the inside of my nose with a finger nail (mainly mucous cells, but the slide may have had some pseudostratified columnar ciliated cells or goblet cells). These were fixed and sent to Leeds as though they were smears. Each was reported as "normal smear, no malignant cells."

The reporting aspect of the national cytology service should be investigated. I and some of my GP colleagues feel we may be wasting our time and that of the patient's as well as a lot of public money.

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Pituitary suppression in chronic airways disease?

SIR,—We were interested to read the paper entitled "Hypopituitarism in normal-pressure hydrocephalus" by Drs S G Barker and H Garvan (21 April, p 1039), having recently discovered some similar endocrine abnormalities among 16 male patients with chronic obstructive airways disease.¹

Serum tri-iodothyronine, thyroxine, cortisol, and oestradiol levels were normal in our patients but there was depression of serum testosterone, the degree of depression apparently being related to the degree of hypoxia and hypercapnia. Normal serum luteinising

hormone and follicle stimulating hormone values suggested hypothalamic or pituitary suppression rather than testicular failure. Three of eight hypercapnic patients had high serum prolactin values not attributable to drug consumption.

As hypoxia of altitude has been shown to cause depression of adrenal and gonadal function,^{2,3} we assumed hypoxia or hypercapnia to be the likely cause of the endocrine abnormalities in our patients. However, in view of the findings of Drs Barker and Garvan it seems possible that the raised intracranial pressure known to occur in hypercapnia, even to the extent of causing an eroded pituitary fossa on x-ray,⁴ may account for our findings. We are currently involved in further studies in this field.

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¹ Semple, P d'A, *et al*, *Thorax*, in press.

² Pugh, L G C E, *British Medical Journal*, 1962, **2**, 621.

³ Guerra-Garcia, R, Velasquez, A, and Coyotupa, J, *Journal of Clinical Endocrinology and Metabolism*, 1969, **29**, 179.

⁴ Newton, D A G, Bone, I, and Bonsor, G, *Thorax*, 1978, **33**, 684.

Treatment of ulcerative colitis

SIR,—I was interested to read of the use of thalidomide by Dr M F R Waters and his colleagues (24 March, p 792) for the treatment of chronic ulcerative colitis. Clofazimine is another drug used for treating leprosy and erythema nodosum leprosum and this agent has been claimed to be effective in cases of pyoderma gangrenosum.¹ Clofazimine has also been used in the treatment of Buruli ulcers, the necrotising skin lesions caused by *Mycobacterium ulcerans*, and I have heard anecdotally of the successful use of thalidomide in this condition.

Buruli ulcers and pyoderma gangrenosum may resemble each other closely. If further studies are to be carried out using thalidomide in patients with ulcerative colitis, then it might be interesting to concentrate on those cases which are associated with pyoderma gangrenosum.

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¹ Michaëlsson, G, *et al*, *Archives of Dermatology*, 1976, **112**, 344.

Drug eruption or psoriasis?

SIR,—In their article giving general principles for approaching the problem of a suspected drug eruption Drs R A Hardie and J A Savin (7 April, p 935) mention that antimalarials and lithium may worsen psoriasis. This association will usually be evident from the patient's history. We recently encountered a case in which a "toxic erythema" provoked by a sulphonamide evolved imperceptibly into erythrodermic psoriasis, presenting considerable diagnostic and therapeutic difficulties.

The patient was a 20-year-old black male with no past or family history of skin disease. He developed ulcerative colitis in July 1978 and was initially treated with sulphasalazine. There was a favourable response, but in October 1978 he developed an itchy symmetrical erythematous and later scaling eruption associated with fever and generalised lymphadenopathy. This subsided after