In our experience, a single intramuscular injection of 150 mg medroxyprogesterone acetate administered during the early puerperium is a highly efficacious contraceptive measure, which in that period offers the extra advantages of not affecting lactation or predisposing the woman to thromboembolic complications. Therefore injectable hormones provide a rational approach for doctors wishing to give a contraceptive that will bridge the first postpartum trimester with optimal efficacy. However, as Dr Murphy clearly stresses, when initiated soon after birth (or abortion or miscarriage) the medroxyprogesterone treatment involves the risk of protracting vaginal bleeding without significantly affecting uterine involution. We also found, albeit more or less by chance, that in practice this sign appears to be highly distressing for some women.

For many years it has been our routine practice to delay surgical tubal sterilisation until the first postpartum menstrual period has occurred, at least in non-lactating women. To provide effective contraception during this interval we recommended an intramuscular injection of medroxyprogesterone administered at the time of hospital discharge. However, the results of the psychological evaluation conducted three and 12 months after voluntary sterilisation of 115 females and 70 males (185 couples) showed that the depot injection had led in some of the women to negative reactions which became manifest during the post-operative assimilation process. Even after active counselling and support, several women persisted in attributing their altered bleeding pattern to the sterilisation instead of to the contraceptive treatment. In a few of these women, who bled more or less continuously for more than six months, the concern about the metrorrhagia became pathological to a degree requiring psychiatric care. Consequently, we no longer recommend medroxyprogesterone for contraception in such cases, and though some of our patients in the puerperium still ask for it we delay the first injection until a menstrual period has occurred. If administered no later than on day 8 of the second postpartum cycle, this method has proved to be effective and the bleeding pattern does not differ from that usually observed with interval administration of this depot preparation.

A more recent psychological evaluation of a new series of women sterilised according to the same technique but not given medroxyprogesterone while awaiting partial tubectomy has shown that the adverse psychological reaction and the concomitant difficulties in assimilating the effects of the operation have no longer occurred.

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Cutaneous manifestations of hydrallazine toxicity

SIR,—We read with interest recent reports by Dr M W Kissin and Professor R C N Williamson (24 November, p 1330) and Dr R M Bernstein and others (19 January, p 156) of cutaneous manifestations of late toxicity to

hydrallazine, and wish to report a case currently under our care.

A 58-year-old man with severe hypertension had a bypass vein graft for left renal artery stenosis in May 1976 and commenced hydrallazine. The maximum dose was 150 mg daily, with a total dose to date of 150 g. In November 1978 he complained of polyarthralgia; the latex test for rheumatoid factor gave negative results. He presented in December 1979 with malaise, fever, bilateral pleuritic chest pains, haemoptysis, and mouth and penile ulcers. In addition he had vasculitic lesions on the buttocks, forearms, and hands, and a deep ulcer over the metacarpophalangeal joint of the right index finger. These have begun to heal since hydrallazine has been withdrawn and adrenocorticotrophic hormone started. At this time he was anaemic (Hb 8.3 g/dl) and had a raised sedimentation rate (114 mm in the first hour, Westergren) and increasing uraemia, with haematuria and albuminuria. The antinuclear antibody test is positive at > 1 in 400 (homogeneous staining), having been 1 in 10 in 1976.

This case fulfils several of the criteria of patients at risk of developing late toxicity to hydrallazine¹ including initial accelerated hypertension, a previously positive antinuclear antibody test, a cumulative dose of more than 100 g, and coexistent autoimmune disease (he has antibody-positive primary hypothyroidism). The cutaneous manifestations in this patient were widespread. With increasing use of hydrallazine, even at low doses, we must be vigilant for the sensitisation effects of such toxicity.

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¹ Perry HM jun. *Am J Med* 1973;54:58-72.

SIR,—Following the article of Dr M W Kissin and Professor R C N Williamson (24 November, p 1330), we would like to report on a case of the hydrallazine-related lupus erythematosus (LE) cell syndrome associated with extensive ulceration.

In 1971, when she was 21, this patient developed malignant phase hypertension with a blood pressure of 220/160 mm Hg, early papilloedema, and haematuria. Blood pressure control was difficult because of frequent postural hypotension and she was eventually controlled in 1976 on a regimen of 640 mg propranolol, 200 mg hydrallazine, and 10 mg bendrofluzide daily. In 1979 she came under the care of this hospital. After four miscarriages she was pregnant for the fifth time and was admitted for Shirodkar suture. For a few days prior to admission she had had irritation over the left arm and right leg and had small tender areas of purpura. The operation was performed uneventfully. The purpuric rash persisted and the LE cell test was found to be positive. Antinuclear factor was present, but antibodies to DNA were absent. Urea, electrolytes, and blood count were normal, and her hypertension was well controlled. Hydrallazine was discontinued, but her rash became very extensive and painful, and within five days started to vesiculate. Treatment with prednisolone was started at this stage. The rash did not extend any further; but the areas of confluent purpura and vesiculation became necrotic and extensive shallow ulceration developed over the whole affected area, requiring skin grafting. It finally healed completely after three months. The steroid was reduced abruptly at the time of the skin grafting and this precipitated an episode of pericarditis, with a friction rub and cardiographic changes. This settled as soon as the dose of steroid was increased. The blood pressure remained well controlled on 500 mg methyldopa and 10 mg bendrofluzide and the patient was delivered of a

Extensive ulceration associated with hydrallazine.

normal infant at 34 weeks. The LE cell test remained positive for three months after delivery but has now become negative, and her legs remain well healed. Her blood pressure is tending to rise and she requires a larger dose of methyldopa for control.

The remarkable feature about this woman's illness was the rapidity with which the purpura extended and became confluent. There was presumably an extensive underlying arteritis because these areas immediately became necrotic and gradually sloughed. Prednisolone appeared to prevent further extension of the purpura and it is possible that starting it as soon as the diagnosis was made may have prevented so much ulceration from occurring.

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Phenobarbitone and epilepsy

SIR,—We have recently learnt that it is official BMA policy to support the proposed legislation to include all 5,5-disubstituted barbiturates within the schedules of the Misuse of Drugs Act. We would like to comment on the effect that this would have on the prescription of phenobarbitone for the treatment of epilepsy.

Although the necessity to prescribe phenobarbitone has been reduced by more modern antiepileptic drugs, there are still a large number of people whose epilepsy is satisfactorily controlled by this drug. We feel that the inclusion of phenobarbitone within the provisions of the Act would expose many people with epilepsy to unnecessary inconvenience and possibly hazard. Many doctors would feel disinclined to comply with the extra demands of writing a prescription for a controlled drug and would attempt to withdraw phenobarbitone. The fact that many chemists would stop stocking the drug would increase the difficulty in obtaining it and would therefore encourage non-compliance. Furthermore, the concern of the patient over being