antagonists in its ability to reverse the effects of pentazocine (Fortral)."³

Finally, I would point out that the data sheet for Fortral which is contained in the readily available *ABPI Data Sheet Compendium 1977* refers to respiratory depression both following normal dosage and following overdosage. The text referring to overdosage goes on to describe the appropriate treatment of such respiratory depression. This information would be supplied to any doctor who responds to the statement in the advertisement that "full prescribing information is available from Winthrop Laboratories."

J B SPOONER

Winthrop Laboratories,
Surbiton, Surrey

¹ Davie, I, *et al*, *British Journal of Anaesthesia*, 1970, **42**, 113.

² Evans, L E J, *et al*, *Lancet*, 1973, **1**, 452.

³ Advertisement, *British Journal of Anaesthesia*, 1977, **49**, xx.

Why I hate the BMJ

SIR,—Having fallen behind with my review of journals I now face a large pile of volumes to be read. I receive many other weekly, monthly, and quarterly publications so that even to scan the titles is a time-consuming task. However, none compares with the *BMJ* in its relentlessly abundant flow of clinically relevant articles. Compelled to read, I can seldom glance and file away. I offer my reluctant congratulations on this double-edged achievement.

JAMES R PHILP

Department of Medicine,
Bowman Gray School of Medicine,
Wake Forest University,
Winston-Salem,
North Carolina

The reprint game

SIR,—Having retired in 1961, having published many papers since then, and having usually had no departmental help in complying with reprint requests, I can add some comments on this chore to those of your correspondents. None of them has mentioned that, although photocopiers can reproduce text, their idea of a photograph is only a faint wraith. Authors of papers in which illustrations are important should therefore regard these requests with special tolerance. Among other deserving categories are those from friends and others who are known to be interested in the subject of the paper, those in the form of personal letters, those bearing detachable stickers with the return address or attractive postage stamps, and those occasioning mirth. These are rare, but I include two, from well known institutions in Washington and Chicago, evidently sent by secretaries who took the name of the little road in which I then lived for an abbreviation and addressed me at "2 Cross Pathology."

Categories of less deserving requests are, alas, far more numerous. Some are for publications of which one has no reprints, ranging from trivial letters in one of the weeklies to entire chapters in books. Some bear only illegible signatures (does one address the man as "Squiggle" or cut his signature off and glue it to the envelope?) or a name and address applied with a rubber stamp so parsimoniously inked as to give a barely legible impression. Unexplained requests for two or

more reprints I resent; I have been asked for as many as seven. When stocks are low one tends to favour MDs in preference to members of some paramedical departments who seem unlikely fully to understand one's subject (according to the letters after their names such correspondents in the United States are often either able seamen or bachelors of surgery). Lastly, a plea on behalf of those who have to address hundreds of envelopes themselves; *please* simplify your address. I have recently been faced with one of seven lines, the second and third being:

Department of Pharmaceutics—School of
Pharmacy, Pharmacokinetics,
Clinical Pharmacokinetics Laboratory.
Could tautology go further?

LAWRENCE P GARROD

Wokingham, Berks

SIR,—I have just received from Finland a printed postcard request for a reprint of my "article" "The reprint game" (22 January, p 231) and any other reprints of a similar nature.

JOHN W TODD

Frimley Park Hospital,
Frimley, Surrey

Atrial fibrillation in the elderly

SIR,—There still remains considerable confusion about the management of atrial fibrillation in the elderly and Dr E B Grogono (12 February, p 444) is quite right to question the role of digoxin in the treatment of this dysrhythmia.

Much of the confusion exists because of failure to understand the underlying pathology of atrial fibrillation and its natural history in the elderly. It has been known for a very long time that atrial fibrillation may be associated with both rheumatic heart disease and thyrotoxicosis—indeed, in the latter condition atrial fibrillation is almost invariably present in those over 70 years of age. But by far the commonest cause of atrial fibrillation in the elderly is degenerative change in the sinoatrial node, and in its natural history and management this condition is altogether different from atrial fibrillation occurring in younger people and associated with other conditions.

The onset of "degenerative" atrial fibrillation may be quite symptomless and in the early stages is frequently intermittent. About 5% of people over 70 in the community have atrial fibrillation when screened by 12-lead electrocardiograms (ECGs) and about 10% of these can clearly be shown to have intermittent atrial fibrillation.¹ It is likely that the true incidence of intermittent atrial fibrillation is very much higher than this in the elderly, and this could be shown by 24-h ECG monitoring tapes.

Many patients with atrial fibrillation have a slow ventricular rate, and this probably is the case in at least a third of all elderly fibrillators; these require no treatment. If the ventricular rate is rapid, then treatment is indicated. If cardiac failure is present diuretics together with small doses of digoxin should be given, and in many patients this drug can be tailed off after the heart rate has been controlled and any intercurrent illness treated.² If there is no evidence of heart failure digoxin is not essential and beta-blocking agents can be used, occasionally with a diuretic. Other anti-

arrhythmic agents may also be tried if beta-blocking drugs are unsuccessful, but I would certainly not advise the use of direct current shock for the treatment of paroxysmal atrial fibrillation as suggested by your expert (1 January, p 42). There is no reason to believe that atrial fibrillation in the elderly is harmful¹ or indeed permanently reversible, and all that require treatment are episodes of heart failure and tachycardia. The dangers of digoxin are so great in the elderly that its use must be very carefully reviewed.

ANTHONY MARTIN

Horsham Hospital,
Horsham, Sussex

¹ Martin, A, MD Thesis, University of London, 1974.

² Dall, J L C, *British Medical Journal*, 1970, **1**, 705.

Anergy in Crohn's disease

SIR,—We were gratified by the attention given in your leading article (29 January, p 253) to the general subject of anergy in Crohn's disease and to the work of our Mount Sinai group in particular. It seems to us, however, that several points in that article require comment and clarification.

Firstly, the "rediscovery" by Mitchell *et al* of Kveim reactivity in Crohn's disease has not been reproduced by most other laboratories¹⁻³ and is considered in many quarters to be an artefact of contaminated reagent.⁴

Secondly, the "thoughtful study from Stockholm" which reported normal lymphocyte transformation in Crohn's disease failed to construct dose-response curves with varying concentrations of phytohaemagglutinin (PHA), and hence cannot be considered entirely valid.⁵⁻⁷ This same problem was manifested in the "larger and well-controlled study of 38 patients from Vermont," although even in that study the impairment of lymphocyte transformation seen in three-day cultures from patients with Crohn's disease was statistically highly significant. Indeed, almost all of the "reports of normal PHA responsiveness [that] have outnumbered the earlier, abnormal ones" have suffered from similar technical or statistical difficulties, as noted by us and others.⁷⁻⁹ Likewise the failure of the Vermont group to demonstrate dinitrochlorobenzene (DNCB) anergy could be related to their failure to require induration as a necessary criterion for a positive skin test.¹⁰

Thirdly, the study you cite from Rhode Island appears to show "no reduction" in T-lymphocytes only if comparison between group means is allowed to obscure the observation, noted both by Thayer *et al* and by you, that nearly one-third of the Crohn's disease patients had subnormal T-cell levels. The existence of this large immunologically deficient subpopulation in Crohn's disease is, in fact, the very heart of the matter.⁸⁻⁹ Moreover, other laboratories have also confirmed this phenomenon of T-cell reduction in Crohn's disease.¹¹

Finally, and most important, we are puzzled by your reference to "small, unrepresentative, and poorly classified groups of patients." For our part, we have over the past four years reported studies of cellular immunity in 172 meticulously classified patients representing every variety of inflammatory bowel disease, as well as in 55 of their relatives. Our observations have consistently demonstrated impaired lymphocyte responsiveness,⁸ depressed proportions and absolute counts of T-lymphocytes,¹²⁻¹³

and cutaneous anergy to DNCB¹²⁻¹⁵ in a substantial proportion of patients with inflammatory bowel disease, Crohn's disease, and ulcerative colitis alike. We have also noted that in ulcerative colitis the anergy appears to reverse after colectomy, whereas in Crohn's disease it persists despite surgical resection.^{14 15}

These facts should help provide a clear and definitive answer to your rhetorical "fact or fiction" question. The establishment of anergy as a feature of Crohn's disease may not be a "breakthrough," but it certainly is a fact.

DAVID B SACHAR
SAMUEL MEYERS
HENRY D JANOWITZ

Department of Medicine,
Mount Sinai School of Medicine,
New York

¹ Siltzbach, L. E., *et al*, *Lancet*, 1971, 2, 634.

² Williams, W. J., *Lancet*, 1971, 2, 926.

³ Hannuksela, M., Alkio, H., and Selroos, O., *Lancet*, 1971, 2, 974.

⁴ *Lancet*, 1972, 1, 188.

⁵ Fitzgerald, M. G., *Clinical and Experimental Immunology*, 1971, 8, 421.

⁶ Bull, D. M., *Gastroenterology*, 1974, 67, 1071.

⁷ Sachar, D. B., and Taub, R. N., *Gastroenterology*, 1975, 68, 1328.

⁸ Sachar, D. B., *et al*, *Gastroenterology*, 1973, 64, 203.

⁹ Watson, D. W., and Shorter, R. G., in *Inflammatory Bowel Disease*, ed J. B. Kirsner and R. G. Shorter, p. 81. Philadelphia, Lea and Febiger, 1975.

¹⁰ Catalana, W. J., *et al*, *New England Journal of Medicine*, 1972, 286, 399.

¹¹ Strickland, R. G., *et al*, *Gastroenterology*, 1974, 67, 569.

¹² Sachar, D. B., *et al*, *Annals of the New York Academy of Sciences*, 1976, 278, 565.

¹³ Meyers, S., *et al*, *Gut*, 1976, 17, 911.

¹⁴ Meyers, S., Sachar, D. B., and Taub, R. N., *Clinical Research*, 1976, 24, 628A.

¹⁵ Meyers, S., *et al*, *Gastroenterology*. In press.

Contraceptive information and promiscuity

SIR,—With reference to the commendable attempt by Dr Max Elstein and others at a "self audit" from within the profession of the sexual knowledge and attitudes of general practitioners (5 February, p 369) we question whether in fact the statement that "the possession of contraceptives information is often an incitement to promiscuity" can so readily be consigned to the category of myth as the authors assume. The statement, of course, defies absolute proof either way. Nevertheless, it does appear that there is enough considered opinion and related statistics to suggest that the generalised and widespread increase in contraceptive information has accompanied an increase in the results of promiscuity. Whereas contraceptive practice has reduced the fertility of married women among all age groups, it has had no definable effect on the number of illegitimate births to women under the age of 20, while during the same period premarital conception has declined.¹ Cases of venereal diseases (treated in clinics) have increased from 80 000 in 1949 to 282 000 in 1973.² Further, despite the increase in sex education in schools, the number of abortions among girls of 18 and under has increased by over 90% from 11 311 in 1970 to 21 764 in 1975.³ The report on "Unplanned Pregnancy" by the Royal College of Obstetricians and Gynaecologists⁴ states:

"Practically nothing is known about the effects of sex education programmes, either in regard to the future health and happiness of the individual children or in relation to unplanned pregnancy. It was suggested that wrongly orientated sex education could be having a result which was the exact opposite of what it was desired to achieve, in that it was arousing curiosity and the desire to experiment. The rapidly rising incidence of un-

planned pregnancies in the young age-groups gives some support of this idea."

Then again, in a recent leading article (4 September 1976, p 545) you observed that discussion in schools on contraceptive methods carries the implication of the children being expected to be sexually active. Advice was then given that knowledge of contraceptive methods needs to be strongly supported by moral persuasion to discourage sexual indulgence even in the light of knowing how to prevent the immediate complications of such irresponsibility. Indeed, it would appear that the most reliable method of contraception misses the attention of many who give sex education. This method, for which there is ample support in terms of evidence, reason, and technique, is simply—"No!"

M E DENYER
R K M SANDERS

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¹ *Population Trends*, 1976, No 5, p. 8.

² *Social Trends*, 1974, No 5, p. 147.

³ *The Times*, 13 December 1976.

⁴ Royal College of Obstetricians and Gynaecologists, *Unplanned Pregnancy*. London, RCOG, 1972.

D-Penicillamine and obliterative bronchiolitis

SIR,—We were interested in Dr D A Brewerton's letter (18 December, p 1507) on obliterative bronchiolitis in adult patients treated with D-penicillamine. We thought that we might be able to contribute to the "extensive inquiries . . . being conducted throughout Britain and elsewhere to learn whether there have been other examples of obliterative bronchiolitis in patients treated with D-penicillamine."

During the outbreak of methylmercury poisoning in Iraq in the winter of 1971-2¹ we gave short and sometimes repeated courses of D-penicillamine and N-acetyl-DL-penicillamine as mercury-binding agents to 12 and 7 patients respectively. Their ages ranged between 2 and 48 years and the daily dose from 30 to 60 mg/kg body weight. Each course lasted either 15 or 30 days. Some patients had two or three courses with an interval of two weeks in between. Our patients were closely observed daily for any manifestation that might be attributable to the medication. None of them developed the clinical syndrome of obliterative bronchiolitis.

LAMAM AMIN-ZAKI
SALEM AL-DAMLUJI

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Medicine,
Medical College,
Baghdad University,
Baghdad, Iraq

¹ *British Medical Journal*, 1972, 2, 605.

Missing tails

SIR,—We read with interest Mr John Frampton's letter (12 February, p 445) and note that he is advocating not one but two radiographs in addition to uterine sounds in order to locate an intrauterine contraceptive device (IUCD). As he rightly indicates, there are three questions to be answered in a patient with "missing tails" and a radiograph will answer only one of these.

It is our practice to employ diagnostic ultrasound on these patients. Our results

suggest that this procedure invariably demonstrates the IUCD if it is within the uterine cavity and will correctly diagnose pregnancy within four weeks of conception. Ultrasound is also very quick, hazard-free, and much less expensive than the procedure advocated by Mr Frampton, and is surely to be preferred. In a recent case, we correctly located an IUCD which had been shown by radiography to lie in the right iliac fossa. Ultrasound revealed a pelvic mass (and correctly suggested a diagnosis of lymphoma) and demonstrated a normally placed IUCD in the cavity of a displaced uterus.

It is our opinion that with the current availability of ultrasound in some 300 centres in Britain radiography is not indicated for patients with this clinical problem.

H B MEIRE
P RENTON

Department of Diagnostic Radiology,
Northwick Park Hospital and
Clinical Research Centre,
Harrow, Middx

SIR,—I agree with Mr J Frampton (12 February, p 445) that the common causes of disappearance of the thread of an intrauterine contraceptive device (IUCD) are too short a length of the thread, occurrence of an intra-uterine pregnancy, expulsion or extrauterine position of the IUCD, and occasionally detachment of the thread during attempted removal of the device. I wish to suggest some alternatives to the methods of management described in such excellent detail by the author.

Provided that a coexistent pregnancy can be ruled out a lateral x-ray of the pelvis is taken. If the IUCD is not seen in the lateral film, only then is a posteroanterior view of the abdomen (including the upper abdomen) requested. If the device appears to be above the pelvic brim it is visualised and removed through the laparoscope. Only occasionally is a laparotomy necessary for this purpose, especially if the device is embedded in the omentum or other organs.

If the lateral x-ray of the pelvis shows the IUCD to be below the pelvic brim this usually indicates an intrauterine position of the device. Presumably an IUCD that is outside the uterus tends to settle high in the abdominal cavity rather than remain within the pouch of Douglas. I cannot agree with Mr Frampton that "no further action need be taken" when the device is thought to be intrauterine. Disappearance of the thread denotes absence of a clinical sign indicative of the correct placement of the device—a sign that can be demonstrated by the patient or the medical attendant. There is the possibility of subsequent expulsion or, rarely, of extra-uterine placement of the device, which may have medicolegal implications. Among patients I have examined weeks after alleged disappearance of the thread reported by a general practitioner or family planning doctor I have so far not encountered any instance of "reappearance of the thread" suggested by Mr Frampton.

H K BASU

West Hill Hospital,
Dartford, Kent

SIR,—Mr John Frampton asked questions relating to the location of "lost" intrauterine contraceptive devices (IUCDs) (12 February, p 445). While agreeing with the points made,