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Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

Post-pill amenorrhoea

SIR,—I was interested to read the article by Dr H S Jacobs and others (8 October, p 940) dealing with post-pill amenorrhoea. As the authors list four of my own articles among their 25 references and there are some aspects of the work they present that are subject to dispute a reply seems appropriate.

In my own articles I have always used a period of amenorrhoea of 12 months before diagnosing secondary amenorrhoea, whereas Dr Jacobs and his colleagues use a period of four months' amenorrhoea. Experience in this department¹ suggests that the spontaneous cure rate in amenorrhoea of this short duration is relatively high, so that we may, in fact, be dealing with groups of patients that are different in many ways.

Except for a suggestion in one paper,² since retracted,³ I have never claimed that there is a proved causal relationship between oral contraceptives and secondary amenorrhoea; rather that there should be a high index of suspicion. The analysis of Dr Jacobs and his colleagues is therefore of great interest.

I certainly share the authors' views that, irrespective of a history of oral contraceptive intake, full investigation is mandatory, mainly to exclude pituitary tumour.⁴ It is indeed worrying that in one recent series of patients with galactorrhoea and amenorrhoea 20 of 25 patients with proved pituitary adenomas gave a history of the use of oral contraceptives.⁵ If this finding is confirmed it would be very difficult to explain as a chance phenomenon.

I have had some difficulty with the classification of clinical groups used by the authors. "Clomiphene-responsive amenorrhoea" is a new classification that I find difficult to

interpret. My own experience with clomiphene suggests that patients responding to this drug represent such a heterogeneous group of disparate causes of anovulation that it does not help to group them together and could make a rational understanding of disease processes more difficult. Although the authors suggest that post-pill amenorrhoea is particularly responsive to clomiphene, this in fact is not generally true. In one of my articles cited in favour of this belief⁶ only six of 12 patients conceived—a much more finite end point than apparent ovulation. In a much larger group of patients with long-term follow-up^{7,8} only one-third of women treated with clomiphene had become pregnant. These results do not really support the views of Dr Jacobs's group that "the response of these patients to simple treatment with clomiphene is so good that it need not be a matter for serious clinical concern." In particular, it should be noted that amenorrhoea will persist in 30% of patients followed up for a period ranging from 18 months to 11 years³ when the entry definition has been 12 months' amenorrhoea at least.

While I agree that the authors are quite correct in advising caution in assuming that the pill may cause amenorrhoea, I do not agree that there is a clear case "that using oral contraceptives does not cause subsequent amenorrhoea." My own belief is that in the state of present knowledge the Scottish verdict of "not proven" is more appropriate than the English verdict of "not guilty." The authors' view that this problem is, in a therapeutic sense, trivial is certainly not borne out by careful study and follow-up of patients where the criteria for admission to the study are

perhaps more stringent than those used in the article under discussion.

RODNEY P SHEARMAN

Department of Obstetrics and
Gynaecology,
University of Sydney,
New South Wales

¹ Shearman, R P, in *Integrated Obstetrics and Gynaecology for Postgraduates*, ed C J Dewhurst, 2nd edn, p 62. Oxford, Blackwell, 1976.

² Shearman, R P, and Smith, I D, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1972, **79**, 654.

³ Shearman, R P, *Contraception*, 1975, **11**, 123.

⁴ Shearman, R P, and Fraser, I S, *Lancet*, 1977, **1**, 1195.

⁵ Chang, J R, et al, *American Journal of Obstetrics and Gynaecology*, 1977, **128**, 356.

⁶ Shearman, R P, *Lancet*, 1968, **1**, 325.

⁷ Shearman, R P, *Lancet*, 1971, **2**, 64.

The urethral syndrome

SIR,—The letter from Drs A J Splatt and D Weedon (29 October, p 1145) has served to highlight some of the points over which confusion exists about the symptom complex of frequency and dysuria in females. The term "urethral syndrome" is unhelpful, but if it is to be used at all it should be reserved for those patients who have been demonstrated to be abacteriuric. In eight of their 38 cases infection was demonstrated and it seems illogical to group together bacteriuric and abacteriuric patients in a single diagnostic category.

Unfortunately flow rate, residual urine volume, and the presence of trabeculation are inadequate criteria for diagnosing outflow obstruction. Flow rate in the absence of voiding pressure measurement may be misleading, in women residual urine volume has causes other than outflow obstruction, and trabeculation is a common finding in patients with instability but without outflow obstruction. Before postulating that outflow obstruction is an aetiological factor the urodynamic facts must be established beyond criticism. Previous controlled trials have failed to