the headings "Danger of overreaction" and "Two sides of the coin" he ends by white-washing one of the worst abuses of our century by comparing, with some sympathy, the dilemma of the Soviet government in its abuse of psychiatry with that of the Catholic church in dealing with heretics or the Romans in dealing with the early Christians. Surely that is the point, that we are now faced with an evil of similar dimensions which should be vigorously condemned, not minimised because brutal suppression by the establishment has occurred before.

In his first paragraph Dr Hare infers that oppression in modern Russia is merely a continuation of that under the Tsars. Yet has he really taken into account the sheer scale of terror in Russia since the communist régime came to power?

We should avoid doublespeak and condemn oppression unequivocally wherever it occurs.

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Pneumoconiosis and chronic bronchitis

SIR,—We regret that in our recent paper "Pneumoconiosis and chronic bronchitis" (13 August, p 424) we wrongly attributed to Hart and Aslett¹ the suggestion that chronic bronchitis might protect against pneumoconiosis. In fact they mentioned the equally pertinent but contrary hypothesis, that bronchitis might impede dust elimination, but were unable to reach definite conclusions on this from the data available. Our paper showed no interaction either way.

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¹ Hart, P D'A, and Aslett, E A, *Chronic Pulmonary Disease in South Wales Coalminers*, Special Report Series No 243. London, Medical Research Council, 1942.

Oestrogens for menopausal flushing

SIR,—Since our study¹ has been quoted in the controversy between Mulley *et al*^{2,3} and Campbell *et al*⁴ may we be allowed to comment on some points of difference between our trial and that of Campbell *et al*?⁵

We did not separate our patients into "mild" and "severe" groups; patients were selected who complained of symptoms listed in the Kuppermann Index⁷ and included some women with a few flushes and three with none. Dilution of the group of severe cases by these milder ones would cause an apparent reduction in the difference between oestrogen and placebo. However, after excluding the three patients with no flushes the proportional reduction in mean flushes on oestrogen compared with placebo reached significance ($P < 0.05$).

Campbell informed his patients that "their tablets would be of different strengths"; ours were told that they would receive either an inert preparation or oestrogen for three months each. Campbell found a similar placebo effect whether it was given before or after Premarin. We found a significant difference: patients changing to placebo after oestrogen complained of flushes which were often more

severe than at the start of the trial. This informed them that they had stopped taking oestrogen and the trial became no longer "blind" in this group. Consequently for analytical purposes placebo in the first three months only was compared with oestrogen in the first or the second periods.

We conclude that oestrogens are highly effective in relieving severe menopausal flushing and that placebos are effective for mild cases only if given *de novo* because of the "rebound phenomenon" of severe flushes in women who go on to take placebo after three months on oestrogen.

A cautious approach to long-term therapy is justified on the grounds of economy in prescribing and also to prevent heavy expenditure of scarce time and money on medical supervision and regular curettage in patients at risk of endometrial cancer. Short-term therapy is helpful and safe particularly in hysterectomised patients.

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¹ Coope, J, Thompson, J M, and Poller, L, *British Medical Journal*, 1975, **4**, 139.

² Mulley, G, and Mitchell, J R A, *Lancet*, 1976, **1**, 1397.

³ Mulley, G, and Mitchell, J R A, *British Medical Journal*, 1977, **2**, 766.

⁴ Campbell, S, and Whitehead, M J, *British Medical Journal*, 1977, **1**, 104.

⁵ Campbell, S, *et al*, *British Medical Journal*, 1977, **2**, 1218.

⁶ Campbell, S, *et al*, in *Management of the Menopause and Post-Menopausal Years*, ed S Campbell, p 149. Lancaster, Medical and Technical Publishing, 1976.

⁷ Kuppermann, U S, Blatt, M U G, and Wiesbaden, U, *Journal of Clinical Endocrinology*, 1953, **13**, 88.

Ischaemic colitis and drug abuse

SIR,—Mr A R Turnbull and Dr P Isaacson (15 October, p 1000) rightly stress the role of hypotension in the development of bowel necrosis in young adults. We have seen a similar case of necrotising colitis after self-poisoning.

A 27-year-old woman attempted suicide by taking approximately 75 tablets of Distalgic (dextropropoxyphene and paracetamol). She was found unconscious and developed fits and apnoea. Her blood pressure was unrecordable on admission and remained below 80 mm Hg (systolic) for the next 20 hours. In addition to routine measures she required intermittent positive pressure ventilation and she was haemodialysed. She was also given nalorphine and, to control fits, intravenous diazepam. She regained consciousness and apparent wellbeing within eight hours of admission.

Twenty-four hours later she complained of lower abdominal pain. This became worse, she developed generalised peritonitis, and laparotomy was performed. Patchy gangrene was found in the caecum and ascending, transverse, and proximal part of the descending colon. There was a small amount of free gas. The main vascular supply of the colon was quite normal and the vascular arcades were pulsating. The gangrenous colon was excised and ileosigmoid anastomosis was carried out.

Histological examination of the excised colon showed necrosis of the whole bowel wall, with inflammatory infiltration and arteritis of small vessels. The larger vessels were normal. No clostridial organisms were seen.

Necrosis of the colon without vascular obstruction was termed necrotising colitis in 1961.¹ The aetiology has been attributed to *Clostridium welchii* organisms found in the lumen of the large bowel and invading the muscularis of the colon.² However, it is clear

that in our patient the cause was prolonged hypotension consequent on a drug overdose.

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¹ Killingback, M J, and Lloyd Williams, K, *British Journal of Surgery*, 1961, **49**, 175.

² Tate, G T, Thompson, H, and Willis, A T, *British Journal of Surgery*, 1965, **52**, 194.

ECT and the media

SIR,—May we comment briefly on Mr K Sabbagh's letter (5 November, p 1215)?

That he has to produce excerpts in favour of ECT from a single programme is surely evidence of the bias he denies. It has become fashionable for the media to focus on only one aspect of a problem or to present only one side of the argument. We know the programme lamenting the fate of the thousands languishing in mental hospitals will be followed by one criticising the policy of discharging schizophrenic patients into the community, and the programme attacking social workers who failed to protect battered children will be followed by one deploring their readiness to use compulsory powers.

Mr Sabbagh may feel that his need to "worry" people justifies such a loaded approach to society's problems, but if the BBC has come to believe that there are no absolute values and no ultimate truths it would at least be more honest and responsible to present conflicting views in the same programme.

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Susceptibility of bacteroides to noxythiolin

SIR,—We were interested in the report by Dr B Chattopadhyay (29 October, p 1121) of noxythiolin-resistant *Pseudomonas aeruginosa* in which he emphasises the importance of checking the sensitivity of pathogenic organisms before using this preparation.

Noxythiolin is widely used for peritoneal lavage and instillation into other sites which may be infected with *Bacteroides fragilis*. Despite an extensive literature search including the work of Haler and Aebi,¹ which is incorrectly cited in the list of references given by Dr Chattopadhyay, we have been unable to find a report of the susceptibility of this organism. We present here the results of our own studies.

Fifty-one clinical isolates of *B. fragilis* from different patients were tested by an agar dilution technique on DST agar (Oxoid) with 5% lysed horse blood using an inoculum of approximately 10⁶ organisms. Plates were incubated overnight in Gaspak jars (Baltimore Biological Ltd) at 37°C and the minimum inhibitory concentration (MIC) recorded. The minimum bactericidal concentration (MBC) was determined by replica plating on to antibiotic-free medium and reincubating. The MIC was 0.125 g/l for 18 isolates, 0.25 g/l for 28 isolates, and 0.5 g/l for the remaining five. The MBC was four times the value of the MIC.

The rate of killing was also determined on three isolates by a method similar to that described by Dr Chattopadhyay but using doubling dilutions from 20 g/l to 1.25 g/l and also including a