hospitals. In some hospitals induction for growth retardation is performed only after antenatal cardiotocography has shown some abnormality of the fetal heart rate.³ As the oxytocin stress test becomes more routine, the risks of inadvertent induction of antepartum haemorrhage in unsuspected cases of placenta praevia increase. In view of the danger of producing haemorrhage it would be advantageous not to perform an oxytocin stress test on patients in whom placenta praevia is suspected.

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¹ Emmen, L., et al, *British Journal of Obstetrics and Gynaecology*, 1975, **82**, 353.

² Weingold, A B, et al, *American Journal of Obstetrics and Gynecology*, 1975, **123**, 466.

³ Simmons, S, in *Proceedings of Third Study Group of the Royal College of Obstetricians and Gynaecologists*, 1975, p 12.

Raynaud's disease and oral contraceptives

SIR,—The recent correspondence on this subject (17 July, p 156; 21 August, p 477) omits to mention the fact that patients with Raynaud's syndrome, either of an idiopathic nature or due to scleroderma, have raised plasma fibrinogen levels.^{1,2} Work in our laboratories (to be published) has confirmed previous workers' findings³ that the use of the contraceptive pill causes a significant elevation of plasma fibrinogen values. As raised fibrinogen levels increase whole-blood viscosity⁴ it would seem rational to encourage patients with Raynaud's syndrome not to take the contraceptive pill.

We have followed this policy in three cases of Raynaud's syndrome and have found that these patients, on ceasing to take the pill, have had a fall in fibrinogen levels and a noticeable symptomatic improvement. One patient was unwilling to change her form of contraception, but as progesterones have been shown not to increase fibrinogen levels⁵ her prescription was changed from a combined oestrogen/progesterone pill to a progesterone pill. After this her fibrinogen level fell and her hands felt warmer.

I would suggest that Raynaud's syndrome, whether of idiopathic causation or due to scleroderma, is indeed a contraindication to taking the combined oestrogen/progesterone contraceptive pill.

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¹ Jarrett, P E M, et al, *British Journal of Surgery*, 1975, **8**, 62.

² Pringle, R, Walder, D N, and Weaver, J P A, *Lancet*, 1965, **1**, 1086.

³ Brackman, P, and Astrup, T, *Lancet*, 1964, **2**, 10.

⁴ Weaver, J P A, Evans, A, and Walder, D N, *Clinical Science*, 1969, **36**, 1.

⁵ Poller, L, et al, *British Medical Journal*, 1969, **1**, 554.

Space phobia and the "3F syndrome"

SIR,—Could Drs I Marks and P Bebbington (7 August, p 345) be talking about a condition well known to physicians in geriatric medicine which I have called the "3F syndrome" (fear of further falling)¹ and which is extremely common in elderly women? Incidentally, by elderly I mean women over the age of 75; the

average age of Drs Marks and Bebbington's patients was 56.5 years.

Patients who have in the past experienced a fall become extremely frightened and anxious and I have always attributed this to the shock effect of discovering that their body, which has formerly behaved in a stable and predictable fashion, now unpredictably and literally "lets them down." The syndrome has two clinical accompaniments: the "3G syndrome" and the "3P syndrome." The former means "grabbing great-grandmother" (a further indication of the usual age distribution), while the latter refers to the "patient with precocious parking." The former term describes the apparently irresistible need of patients with this syndrome to clutch or grab on to any object, without regard to its value as a source of support or to its proximity, while the latter reminds us that these patients make major errors of judgment when approaching a chair and tend to reach for it in an attempt to sit down long before this is appropriate.

Other features found in association with the "3F syndrome" include: a tendency to stand with the arms extended, abducted, and supinated, which is very reminiscent of the Moro reflex in infants; a disturbance of the flexion synergy on rising from a chair, which is often replaced by a tendency to extend the arms, legs, and trunk and force the patient back into the chair; and the habit of repeatedly uttering the phrase "I am going to fall" when in a state of stability. Many of these symptoms are rapidly reversed by rehabilitation or by the provision of minimal support, and it seems as though the disturbance of visuospatial perception and movement pattern is aggravated by anxiety.

My colleagues and I are about to embark on a research project into falls in old age, in which, among other things, we will be attempting to relate this clinical picture to the patient's personality and to the pathological condition responsible for the falls.

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¹ Isaacs, B, *The Giants of Geriatrics*, Inaugural Lecture, University of Birmingham, 1976.

"The Forbidden Love"

SIR,—The patronising and dismissive allusions to what he supposes are the conclusions of the authors of "The Forbidden Love" which Dr Sydney Brandon makes in his review (28 August, p 533) hopelessly miss the point. There is no doubt from the text that they clearly mark off "care and respect" for children (p 89), as well as non-deviant unpleasantness to them (p 93), from deviant and manifestly erotic paedophilia, which was unequivocally seen as destructive and dangerous (p 127) as well as pathological (p 100).

So puzzled was I by the total lack of resemblance between the book and Dr Brandon's review of it that I was left wondering whether he could have read it at all; or if he had, whether it was with powerful prejudice; or otherwise whether he could have the necessary theoretical equipment to assess it critically. How otherwise could he fail to see the authors' intention to demonstrate the mechanisms that underlie paedophilia and the ways in which these may on the one hand be incorporated in a manner that is beneficial personally (p 92) and

ethologically (p 37) or on the other become perverted and so give rise to deviant behaviour (for example, pp 99-100)?

It is a pity that such a valuable study could not have received a less trifling notice which would have done justice to its merit as well as to the real, rather than fancied dismerits—its lurid cover, its sensationalist title, and its lack of a bibliography, for instance.

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Antibiotics for sore throats

SIR,—I was rather surprised by your expert's answer (19 June, p 1516) to the question of withholding antibiotics when treating sore throats. Is it now in fact established paediatric practice "to give oral penicillin at least to children because (a) it does no harm and (b) rheumatic fever and acute nephritis are occasionally seen, though increasingly rarely?"

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Folate deficiency and neurological disease

SIR,—Drs M Manzoor and J Runcie are to be commended for their simple and clear data presentation (15 May, p 1176). I would like to make some comments on their observations.

(1) In a paper dated January 1976¹ not referred to by the authors I described four women aged between 32 and 44 who had folate deficiency, signs of polyneuropathy, vibration sense impairment, mild depression, and subtotal villous atrophy in the jejunal mucosa. Only one patient had megaloblastosis, but two had low cerebrospinal fluid (CSF) folate levels.

(2) From all our studies¹⁻³ we fully agree with Drs Manzoor and Runcie's conclusions that a long-standing serum folate deficiency could induce neurological and mental disorders, but we have to stress the need for more complete investigations in such cases. CSF folate determinations are useful because a low serum folic acid concentration could induce minor neurological and mental symptoms, while a low or borderline CSF folate in addition could induce major neurological symptoms in spite of the presence of a normal erythrocyte folate level and in the absence of frank anaemia.^{2,3}

(3) I suggest the following precautions with respect to folate therapy. (a) We have confirmed a previous report⁴ that after 3-6 months of folic acid therapy there is a progressive fall of serum vitamin B₁₂ in some patients. In practice, after six months of folic acid therapy multi-vitamin supplements including vitamin B₁₂ have to be added.³ (b) High oral or even pharmacological doses of folic acid must be prescribed with great caution for epileptic patients.⁵ (c) In patients from whom carcinomas have been removed or who may have occult metaplasias folic acid administration in maintenance doses must also be limited because of its known stimulation of RNA and DNA metabolism and of cellular division. In such cases folic acid should be administered for 2-3 weeks only and then replaced by vitamin B₁₂,