tion, some menstrual relief, and recurrence of the symptoms shortly after the period ceases? Were Dr Dalton to be really strict and confine the diagnosis of premenstrual syndrome to those women who experience symptoms only during the premenstrual week then the situation might be clearer. But were she to do this she would have to revise drastically downwards her estimate that 50% of actively menstruating women are premenstrual sufferers.²

The symptoms which go to make up the syndrome (tension, anxiety, headache, backache, irritability, depression) are not uncommon; indeed, a recent epidemiological study suggests that they are relatively ubiquitous in women in the age groups studied by Dr Dalton.^{3,4} An additional problem is that to find a woman who is absolutely free of such symptoms at times other than premenstruum can be quite difficult. In the circumstances Dr Dalton's distinction, while of possible theoretical importance, tends to break down in the clinical setting.

Dr Dalton once again reiterates her claim concerning the efficacy of progesterone in the treatment of premenstrual symptoms, despite the fact that two double-blind controlled trials^{5,6} have failed to establish its superiority over placebo. She claims a success rate of 83%; but it should be remembered that other workers have claimed similar rates of success in this condition using substances as diverse as meprobamate, bromocriptine, lithium, and pyridoxine.⁷ Double-blind studies of the efficacy of these substances, however, have also failed to establish their supremacy over placebo. Given that the placebo response rate in the premenstrual syndrome is itself reasonably high, this is a reason not for pessimism, merely for humility.

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³ Banks MH, Beresford SAA. *J Psychosomatic Res* 1979;23:307-13.

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Health education to improve rubella immunisation in schools

SIR,—Recently I was a school doctor in a girls' comprehensive school of about 800 girls in the borough of Islington. I was shocked to discover that the uptake of rubella immunisation was only 68%. I decided to give a talk to the 150 11-year-olds on the same day as they were given their forms to take home for parental consent to immunisation for rubella. The talk was short—less than 10 minutes. I was gratified by the result—the increase was from 68% to 86%. I was therefore extremely interested in the article by Dr S A M Jones (6 September, p 649) and would agree from my limited experience that it is the children rather than their parents who should be approached about this.

There are four points that I would like to add to her conclusions. (1) The talk to the girls should be the same day as the forms are taken home for parental consent. This will mean the girls will go home full of enthusiasm and less likely to lose the forms. (2) The girls who have consent and are absent on the immunisation day should be immunised at a

medical session later in the term. (3) Girls who failed the previous year should be invited to attend the talk the next year and be given another form. (4) Teachers should be invited to the talk: firstly, to encourage the girls; and secondly, for their own benefit. In this school in two years 10 teachers were suitably impressed by the talk and came to have their blood tested for antibodies.

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Symptoms in middle life and the menopause

SIR,—I was surprised to read Mr J Wilbush's criticism (23 August, p 563) of the masterly survey of symptoms in middle life by Dr G T Bungay and others (19 July, p 181). He is disappointed by "their neglect of basic features of their subject matter." What basic features?

The menopause is a physiological event, like the menarche. It is not a disease and has no known pathology. Certain changes occur in laboratory tests such as vaginal cytology and follicle stimulating hormone (FSH) concentrations in serum, which reflect the changing balance between various endocrine glands, but these are only approximately related to symptomatology. They do not in themselves constitute a disease state and few doctors would be prepared to treat, for instance, a raised FSH concentration in the absence of menopausal symptoms. Symptoms are the basic feature of a menopausal syndrome.

"Symptoms vary with the situational factors obtaining at the meeting between patient and doctor." The transactional nature of the medical consultation has been widely recognised. Some women who regard hormone replacement therapy as desirable following its promotion in the lay press, knowing that it is often prescribed for flushes, may complain of flushes to a sympathetic doctor in order to put pressure on him to prescribe hormones. The doctor may be aware of this; but this does not mean that he can ignore the patient's symptoms, which are his chief guide to her clinical needs.

"What do these studies prove?" They show that both men and women in the Oxford area complain of such symptoms as headache, loss of interest in sex, frequency of micturition, low backache, difficulty in sleeping, and crawling and tingling sensations in the skin. They show that these symptoms are not particularly related to the menopause, although some of them have previously been described as "menopausal."¹ They confirm the association of vasomotor symptoms with the menopause,² and the premenopausal peak of minor mental symptoms described by other workers.³

W H Utian carried out a single-blind placebo controlled study of oestrogen therapy in menopausal patients and found that the only symptoms to respond to oestrogen better than placebo were those related to hot flushes and atrophic vaginitis.⁴ In a double-blind placebo controlled trial of conjugated equine oestrogens we found that only hot flushes and vaginal cytology showed a significant improvement on oestrogen compared with placebo. All the other symptoms tested (headache, insomnia, arthralgia, depression, etc), did not show a greater improvement on oestrogen than on placebo.⁵ In a further double-blind placebo controlled trial of piperazine oestrone sulphate in the treat-

ment of menopausal depression and flushing, we found that flushes responded significantly on oestrogen compared with placebo, but depression showed no greater improvement on oestrogen than on placebo, when measured by the Beck Depression Inventory.⁶

The prescription of hormone therapy for "menopausal" symptoms should be limited to those symptoms which have been shown to be menopausal and oestrogen-responsive by epidemiological surveys and controlled trials.

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Progestogens before and after the menopause

SIR,—In your leading article on oestrogen-replacement therapy in old age (30 August, p 572) you refer to the evidence from Meade and his colleagues¹ that the progestogen component in combined oral contraceptives may be associated with the increased risk of arterial disease in pill users. It was unfortunate that similar evidence from the Royal College of General Practitioners' Oral Contraception Study² was in press at about the same time, so that neither paper was able to draw attention to the value of the confirmation of the observation from two independent data sets.

You rightly suggest the possibility that the addition of progestogen to an oestrogen regimen in climacteric women might also increase the risk of arterial disease. I have also expressed that view.³ I believe, however, it is important not to assume too readily that observations in premenopausal women can be applied to postmenopausal women, particularly when the treatment is somewhat different. A recent report by Weiss and Sayvetz⁴ identifies one mechanism that may be the same during the reproductive and postreproductive periods. They showed that oral contraceptive users have a reduced incidence of endometrial carcinoma when compared to non-users, and they attribute this benefit to the progestogen component, an effect which is well established in postmenopausal hormone therapy.

In our own data, eight cases of endometrial cancer have been reported. Six of these have occurred in the control subjects who have never used oral contraceptives, two in former users, and none in current users. The associated periods of observation are 129 593 person-years in the control group, 78 142 in the ex-user group, and 98 551 person-years in the current-user group.

Only one case (Vessey, personal communication) has been reported in the Oxford/FPA Study.⁵ This patient entered the study while using a diaphragm and had not used the pill at any time when endometrial cancer was diagnosed six years later. The associated periods of observation among women entering the study while using the pill, the diaphragm, and the intrauterine device are currently 73 382, 33 521, and 24 049 women-years respectively.

In both studies the subjects have predominantly used the combined oral contra-

ceptives. While neither set of data would by itself be large enough to justify publication, they do support the observations of Weiss and Sayvetz that combined oral contraceptives may be associated with a reduced incidence of endometrial carcinoma.

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¹ Meade TW, Greenberg G, Thompson SG. *Br Med J* 1980;280:1157-61.

² Kay CR. *J Roy Coll Gen Pract* 1980;30:8-19.

³ Kay CR. *Postgrad Med J* 1978;54 suppl 2:99.

⁴ Weiss NS, Sayvetz TA. *New Engl J Med* 1980;302:551-4.

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Spending to save money

SIR,—Minerva's personal experience of tetanus prophylaxis in a casualty department (9 August, p 461) again draws attention to how badly this subject is managed. With the wide availability of human antitoxin (as opposed to horse antitetanus serum) the appropriate (safe) regimens for prophylaxis in individuals with varying susceptibility to tetanus are well established, but are often used inappropriately, occasionally with disastrous results. Tetanus is potentially a fatal disease and should be entirely preventable by correct prophylaxis. It should have been for this reason (rather than "wasted time and money in giving unnecessary injections to be on the safe side") that Minerva documented her experience. The cost of three weeks in an intensive care unit for even a single patient with tetanus would fund many "unnecessary injections."

In similarly misguided cost-conscious fashion Minerva goes on to criticise the decision to circulate all NHS doctors with the excellent *Drug and Therapeutics Bulletin*. I am sure it is not widely appreciated that (for example) the cost of 60 days' treatment of hypertension with Slow-Trasacor or with Sotacor is £28.60 and £7.30 respectively, as the August bulletin points out. Apart from being an unbiased, conservative, up-to-date authority on topical therapeutics it may actually save money.

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The revised consultant contract

SIR,—The long, long lament from Lerwick, Mr R P Cumming's special pleading on behalf of Scottish whole-time consultants (6 September, p 686), can be answered simply and, I believe, fairly.

Firstly, both the financial provision for medical services and the consultant establishment in almost all specialties per unit of population are about 25% higher in Scotland, which makes it highly unlikely that the Scottish consultant works any harder for the NHS than his counterpart in England and Wales.

Secondly, I understand that the ratio of unfilled vacancies to established consultant posts has long been lower in Scotland, which suggests that the working environment for Scottish consultants is seen to have some advantages over the rest of the UK.

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Advertisement from group of homosexual doctors

SIR,—I wish to protest in the strongest possible terms at the refusal of the *BMJ* to publish an advertisement for a minority group of respectable members of the medical profession. I can only assume that the reason you have allowed publication of Dr M R Farrell's letter (30 August, p 622) is because the *BMJ* recognises it has no right to censor its members' views.

The BMA claims to represent all aspects of the medical profession. If it does not wish to recognise and represent certain minority groups, whether it be on the basis of sex, race, religion or marital status, or sexual orientation, then a clear policy statement is immediately required.

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SIR,—Dr M R Hamilton Farrell (30 August, p 622) of Addenbrooke's seems to have missed completely the point about the debate on homosexual doctors which took place at Newcastle. The debate took place on the motion, not on the topics discussed in Dr Farrell's letter. The motion asked the meeting to regret the action of the Editor. The existence of and the problems experienced by homosexual doctors are a perfectly proper subject of debate and of correspondence in the columns of the *BMJ*, as the appearance of Dr Farrell's letter shows.

What the Editor had to do, however, was to decide whether it was an appropriate subject for an advertisement in the *BMJ*. The publication of an advertisement might have been taken as indicating some kind of attitude on the part of the Editor to the topic of the advertisement, whereas the published letter contains its own arguments. It was the right of the Editor to make such decisions which was at stake, not the Association's attitude to homosexual doctors.

If Dr Farrell would like the ARM to discuss homosexuality among doctors then he should arrange for a motion on that topic to be put before it. I would agree with his view that the ARM would be better informed if the protagonists of such a motion were to stand up and speak, which they singularly failed to do at the ARM. It really is not reasonable to castigate the ARM for allegedly having a particular attitude to a subject when the people involved seem to have the same attitude themselves, that is they are ashamed to speak about it in public.

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Thai initiatives in Kampuchean refugee camps

SIR,—Professor Neil R M Buist's perspective from Khao-I-Dang refugee camp (5 July, p 36) is a chilling one. I am an Asian doctor who has worked in Thailand on a number of occasions. Professor Buist is right in bringing out the problems that the Kampuchean refugees pose for Thailand. When I visited Khao-I-Dang, I was aware of the tensions between some of the foreign volunteers (Volags) and Thai workers. I would like to report on one successful and exciting initiative that the Thais themselves have taken.

An organisation of Thai nationals called Community Based Emergency Relief Services (CBERS) is making many important inputs. Whereas foreign agencies have often concentrated on curative medicine, the Thais instinctively turn to prevention. CBERS has improved the sanitary arrangements, constructed latrines, organised parasite control among the children, and is even paying a few pence for every bag of flies that the children can go out and kill. This kind of action is needed when more than 120 000 people are crowded into a small place with no drains. CBERS has also tried to meet some of the social and emotional needs of the people by setting up a Khmer Cultural Centre where some traditional arts such as basket weaving are encouraged.

One of the innumerable tragedies of Cambodia has been that everyone who could speak English or French was murdered. Since, however, many of the Thai volunteers speak Khmer and can communicate easily with the refugees, they may have greater insight into the problems facing the refugees than specialist doctors who are flown in from the United States, New Zealand, and Europe. For example, because Western doctors are unfamiliar with tropical diseases, the Volags often had to wait for laboratory confirmation of common medical conditions that any Asian doctor would treat on clinical diagnosis.

While every refugee family has invariably lost relatives and children, in my experience, most women in the refugee camps do not wish to become pregnant at the present time. It is interesting that none of the foreign medical groups attempted to tackle this important human problem; indeed, some were critical of the work of CBERS. This organisation launched a large-scale voluntary family planning programme that has been well received by thousands of women.

On the very first day that family planning services were offered, 4709 women came for contraceptive advice. Within the first few months, 65% of the eligible couples were using some form of contraception.

CBERS made several methods of family planning available, but the most popular was the injectable contraceptive Depo-Provera, which is widely used in Thailand. With their unparalleled experience with this form of contraception, the Thai doctors feel confident in its use both for their own women and for those refugees who choose it. I did not meet a single Cambodian couple who was not grateful for these services. Even though their numbers have been drastically decimated, this is a time of great uncertainty in the refugees' lives; few women would want to be pregnant under such adverse conditions.

One of the many lessons of the tragedy of the South-east Asian refugees must surely be that Asians themselves are forming mature, effective, humanely motivated non-governmental groups who can work as equal partners with Western agencies in helping refugees. As with so much of international development, there are likely to be differences of emphasis and different judgments on technology. It is essential that there be mutual respect in these areas between both the Asian and Western agencies.

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