distress: a double-blind trial of progesterone and placebo." Progesterone is no panacea for all the diagnoses which come under the umbrella of menstrual distress, including premenstrual exacerbations of symptoms present throughout the cycle, as well as spasmodic dysmenorrhoea (which responds to oestrogens and oral contraceptives) and endometriosis (which responds to progestogens).

Dr Clare also refers to the trial by Smith⁵; progesterone suppositories raise the plasma progesterone for 6-24 hours⁴ so medication is required at least once or twice daily and, on an adequate progesterone dosage, there is a cumulative effect during the first four days.⁴ Smith used a small dose of progesterone suppositories 200 mg on alternate days from day 19 until day 26; thus the progesterone was too late, too little, and too infrequent for this to be considered a trial. I would repeat that the common causes of failure with progesterone therapy are incorrect diagnosis and inadequate dosage.¹

K DALTON

London W1N 1AE

¹ Dalton K. *Premenstrual syndrome and progesterone therapy*. London: Heinemann Medical Books, 1977.

² Sampson G. *Br J Psychiat* 1979;135:208-15.

³ Dalton K. *Br J Psychiat* 1980;137:199.

⁴ Nillius SJ, Johansson EDB. *Am J Obstet Gynaec* 1971;110:470.

⁵ Smith SL. In Sachar EJ, ed. *Topics in psychoendocrinology*. New York: Grune and Stratton, 1975.

Gonorrhoea presenting as "sterile" pyuria

SIR,—Dr B Chattopadhyay and Mr I Hall draw attention in their paper (27 September, p 841) to the fact that gonorrhoea may occasionally present in men as "sterile" pyuria. In such circumstances urethral discharge is not noted by the patient (though careful examination after "milking" the anterior urethra will nearly always show evidence of purulent secretion).

The important clinical lesson to be drawn from their account is that symptoms of dysuria and frequency in young men should always be regarded as potentially serious conditions due either to sexually transmitted infections or to urinary tract infections secondary to some underlying abnormality. Among the common sexually transmitted infections, non-specific urethritis is often responsible for frequency and gonorrhoea for dysuria.

I would have thought that gonococcal infection in the female would be an extremely rare cause of "sterile" pyuria if a properly collected clean-catch specimen is sent to the laboratory. The short female urethra is usually adequately "rinsed" free of inflammatory cells by micturition with this technique.

J K OATES

Westminster Hospital,
London SW1P 2AP

SIR,—Dr B Chattopadhyay and Mr I Hall (27 September, p 841) are correct to add gonorrhoea to their list of causes of sterile pyuria in women, but the reason may be perverse. We were recently aided in making the diagnosis of gonorrhoea in a woman who presented complaining of haematuria by the finding of "sterile" pyuria in a midstream urine.

Two urine specimens received two days apart, and containing more than 20 white cells per high-

power field of a centrifuged deposit, showed no growth when cultured on CLED selective medium. Further incubation on non-selective blood agar in the presence of carbon dioxide failed to reveal the presence of significant numbers of fastidious organisms,¹ although no attempt was made to identify *Neisseria gonorrhoea*. Gram staining of the deposits revealed a mixed flora consistent with vaginal contamination. On being further questioned, the patient admitted to the recent onset of a vaginal discharge and *N gonorrhoea* was isolated from a cervical swab.

Women with vaginal discharges may frequently contaminate a midstream urine and the use of a vaginal pack inserted before collection has been recommended (Association of Clinical Pathologists Broadsheet 80). The finding of "sterile" pyuria in women may suggest a vaginal origin for these cells, and thus lead to a diagnosis of gonorrhoea.

M C KELSEY

Department of Microbiology

B DILLON

Department of Obstetrics and Gynaecology,
Barnet General Hospital,
Barnet, Herts EN5 3DJ

¹ Maskell R, Pead L, Allen J. *Lancet* 1979;i:1058-9.

Systematic review of the benzodiazepines

SIR,—The recommendations presented by the Committee on the Review of Medicines in its article "Systematic review of the benzodiazepines" (29 March, p 910) appropriately focuses concern about the use of these drugs. However, I would like to comment on one point that perhaps should be expanded on.

In the opening paragraphs the committee refers to the differences between the "long"-acting and the "short"-acting benzodiazepines, yet in the guidelines for lorazepam, oxazepam, etc, it mentions that paradoxical aggressive outbursts and uncovering of suicidal tendencies have been reported with the benzodiazepines. It should be noted that these reactions have been reported only in relation to the long-acting drugs—namely, diazepam,^{1,2} chlordiazepoxide,^{1,2} clorazepate,³ and flurazepam⁴ but not with oxazepam.^{2,5} In fact, oxazepam reduced anxiety scores in such patients and in this respect may be the drug of choice for the susceptible population. Furthermore, the uncovering of suicidal tendencies is probably a reference to the report by Hall and Joffe,⁶ which implicates only diazepam.

As the opinion of the committee will no doubt exert considerable influence on the labelling and use of benzodiazepines, I feel it would be appropriate to clarify this seeming inconsistency.

T R EINARSON

Pharmacy Department,
General and Marine Hospital,
Owen Sound, Ontario,
Canada N4K 5H3

¹ Anonymous. *Mass Gen Hosp Newsletter* 1978;1:38.

² Gardos G, DiMascio A, Salzman C, Shader RI. *Arch Gen Psychiatry* 1968;18:757-60.

³ Karch F. *Ann Int Med* 1979;91:61-2.

⁴ Einarson TR. *Drug Intell Clin Pharm* 1980;14:291-2.

⁵ Kochansky GE, Salzman C, Shader RI, Harmatz JS, Ogeltree AM. *Am J Psychiatry* 1975;132:861-3.

⁶ Hall RCW, Joffe JR. *Am J Psychiatry* 1972;129:738-42.

Heart rate variations in the Guillain-Barré syndrome

SIR,—We have read with interest the paper by Dr J C Frison and others (6 September,

p 649) reporting a reduction in cardiac beat-to-beat interval variation among patients with Guillain-Barré syndrome, which was taken to indicate a disorder of the autonomic innervation of the heart. We would like to point out that beat-to-beat variation, recorded as the standard deviation, is strongly dependent on both age and size of the mean R-R interval, so that these factors must be considered when comparisons are made between patients and normal groups.

Our measurements of beat-to-beat variation in normal subjects (to be published) show that the standard deviation declines with age and increases with the size of the mean R-R interval. Thus with a mean interval of 600 ms (or 100 beats/min) the standard deviation will average 45 ms at age 7 years but 24 ms at 50 years. Similarly, at age 33 years the predicted standard deviation will be 31 ms at a mean interval of 600 ms and 66 ms at a mean interval of 1000 ms (or 60 beats/min).

Thus although the two groups studied by Dr Frison and his colleagues were matched for age the difference in the size of the standard deviation between the two could be explained, at least in part, by a tachycardia in the Guillain-Barré patients. Since tachycardia is a common feature of the acute phase of the illness, its resolution during recovery should necessarily be accompanied by an increase in the size of the standard deviation.

In conclusion, we do not believe that the reduction in beat-to-beat variation noted by these authors can properly be ascribed to autonomic neuropathy in the absence of a consideration of resting heart rate.

S A SMITH

S E SMITH

Department of Pharmacology,
St Thomas's Hospital Medical
School,
London SE1 7EH

No to euthanasia

SIR,—Having read the statement on euthanasia (6 September, p 691), may I voice the opinion of a geriatric nearing 80 who has had a lengthy experience of hospitalisation in different medical and surgical wards (not strictly geriatric) for painful afflictions, which at times in my weakened state made me feel that I would be better off dead? Despite the almost unbearable pain I sometimes endured I am strongly opposed to the belief, expressed by EXIT in a recent broadcast on Radio 4, that euthanasia should be officially legalised. I find it difficult to appreciate the benefits (and what really are they?) which are claimed.

So far as those who are younger and normally able are concerned, it can seldom be needed, as most can—and in fact do—voluntarily provide their own euthanasia by overdoses of drugs, etc. With regard to the elderly, whether or not the illness is terminal—and indeed how can any doctor be quite sure?—there exists an emotional ebb and flow, with depression deepening more at some phases of the illness than at others. At such low levels the patient is most suggestible, and may quite well give a misconceived consent to euthanasia, whereas in a better phase he might have decided more reasonably otherwise. During this highly suggestible time there is some risk of exposure to the insidious persuasion of anyone who might have personal reasons for not wishing him or her to live longer. Under such circumstances distressed close relatives might reluctantly agree to give their consent, only to

regret it later after the grievous deed is done.

Apart from the fact that no doctor can be quite sure that the patient will not recover or at least partially recover, intractable pain can usually be relieved or eased by modern pain-killing drugs, without the need for overdoses to relieve suffering. Furthermore, if the patient is comatose, euthanasia would of course be unnecessary. And what a problem it would be for the doctor to decide. No—please never, never legalise euthanasia.

JOHN W FISHER

Paignton, South Devon

Computers for general practice

SIR,—In "Computers in general practice: feasibility study" (27 September, p 884) it is stated that "A small 'first-generation' computer system should be used by practice staff or the GP. . . ." Purely for the sake of accuracy, I should like to point out that the generations of computers are defined by the technology which was used to build them. Thus "first-generation" machines (mid-1940s) used valves and "second-generation" machines (mid-1950s) used transistors. The "third generation" uses integrated circuit hardware, and new software technology came in about the mid-1960s and is still with us.

The correct term to use in the context of the article is "microcomputer," as in recommendation (13), as compared with the larger and increasingly more sophisticated machines. The microcomputer is relatively cheap, small, easy to use, and (if we allow for its present shortcomings) could in my opinion be of enormous value to GPs and thus their patients. The reservations about choice, etc, are clearly set out in the recommendations and should be strongly heeded.

RONALD B WHITE

Flore, Northants NN7 4LU

Community medicine: a second chance?

SIR,—As your leading article states (27 September, p 826), there is a second chance to replan community medicine.

The exciting elements of community medicine, its preventive aspects, were destroyed by the reorganisation of the Health Service in 1974, and thus recruitment inevitably suffered. To these diminished preventive functions were added two quite separate activities—administrative medicine and certain services for the clinical care of children.

Preventive medicine does not need another eulogy. Every oration, every medicopolitical speech, every plan pays lip service to it. We now have an opportunity to act. We need departments of preventive medicine to serve each district. Located at a hospital, they would give a service to all those requiring advice, help, and support on preventive medicine—general practice, hospital practice, district local authorities, social services, voluntary services, etc. Each department of preventive medicine should be a depository of information on international and national data on the natural history of disease and should be a source of advice on the application of these data to each district. In collaboration with medical and other colleagues, it should initiate desirable preventive action locally. It should contribute to national research on preventive medicine. This is the department whose help

I need as a clinician. Job satisfaction in this important field would return and recruitment would be stimulated.

In the proposed new reorganisation we need administrative medicine at just three foci—at the Department of Health and Social Security, at regional health authority level, and at departmental level in hospitals. At this last level a consultant would undertake it by agreement with his colleagues and with the help of an administrative assistant; he would act as adviser in the local practice of that specialty directly to the district health committee and indirectly to the RHA and the Department.

The clinical care of children should be allocated where it belongs—to general and hospital practice. Individual day-to-day clinical care should go to the general practitioner and specialist clinical care to the paediatrician. Important screening services for infants and school health should be organised in one clinical preventive service based on general practice, or paediatrics, or both.

Community medicine is an ambiguous term invented to cover confusion. Let us face the reality of the situation. We need administrative medical officers and we need consultants in preventive medicine; the two fields are distinct and disparate specialties. One of the lessons learned from large-scale reorganisations is that they cover areas which are too large and produce errors which disrupt the whole service. Experiments on the lines described, either in one interested region or in a number of districts scattered throughout the country, would avoid past pitfalls and produce valuable guidelines for the future.

J G HOWELLS

Institute of Family Psychiatry,
Ipswich, Suffolk IP1 3TF

Women in medicine: training and appointment schedules

SIR,—There is an answer to the accommodation of women in the medical careers structure—namely, that appointments for both men and women should be based on five- or 10-year "tenures."

Let us assume that entry to medical school or basic science courses are so arranged that qualification occurs at the age of 25. The years 25-30 would then be spent in junior hospital posts or the GP training schemes, and the years 30-35 at senior registrar level. Thereafter consultancies for men might be divided into junior (35-45), middle (45-55), and senior grades (55-65). Once appointed a person would expect to retain his grading but might move from a peripheral consultancy (35-45) to a teaching post (45-55) and then on to an administrative post (55-65), or even at the senior level out to a more leisurely peripheral post. The same system would allow for a clinical research investigator grade (usually 35-45). It would also allow those who wish it actually to change specialty—for example, cardiology to chest medicine, metabolism or immunology to nephrology.

Remember that psychological studies show that those who keep on the move have higher-than-average intelligence and achievement motivation. Moreover, the system would ensure a fairer share of the cake and a fairer distribution of talent to peripheral posts, where the value of independence is so much the greater. Given the necessary flexibility,

and backed up by the computer, women should then be able to withdraw or become part-time for elective five-year tenures.

E N WARDLE

Newcastle upon Tyne NE3 3DE

Legionnaires' disease and the media

SIR,—Harvey Marcovitch is unjust to the doctors concerned in his review of the Thames Report programme on legionnaires' disease (4 October, p 939). The lack of information provided by the doctors on the programme was due rather to the editing than to the doctors taking part. It is hardly surprising that when an interview is compressed to less than half its original length important pieces of information, such as the retrospective nature of the diagnosis and the widespread occurrence of the organism in public water supplies, are omitted or appear garbled. These problems are compounded when those interviewed believe (perhaps naively) that they are contributing to an information programme rather than a witch hunt.

Dr Marcovitch appears surprised at the interviewees' lack of ease in front of the cameras. When the few minutes of interview shown in a finished programme are filmed in the course of a two-hour interrogation I think that even he, with his experience of the media, would have some difficulty appearing at ease and communicating in plain English.

JUDITH HILTON

London E17 9RX

Acquiring skills of facilitation

SIR,—The fact that my partners and I are not fully trained facilitators has evidently leaked from some data bank, and in consequence we have been invited to an advanced course facilitators workshop to be held in Windsor Great Park under the auspices of the British Postgraduate Medical Federation. "The objectives of this workshop is [sic] to enable doctors to acquire skills of facilitation to enable them to run advanced courses," we are told. "There will be consultation with participants but it is anticipated that the facilitators will describe and discuss educational and organisational aspects." We are also promised that "outside speakers who have recently gained such experience will help participants."

The blurb tells us neither what the courses that our skilled facilitation will enable us to run might be about, nor what it is that we shall describe and discuss educational aspects of, nor what the facilitators will consult the participants about, nor finally what the outside speakers have recently gained experience in. However, we should be consoled by the fact that "participants will be invited to produce and demonstrate implementation of plans."

I have unfortunately already committed myself to attending that week a refresher course (or is it a workshop?) at our local hospital, which it is anticipated will facilitate participation and implementation of the prosaic subject of surgery. So I shall probably never know what I have missed.

J R JAMES

Southsea PO4 0SU