It is interesting to examine some of the techniques of the attackers. An example is Miss Monica Furlong in the *Daily Mail* of 6 March. There are the usual querulous references to "moralists," calculated to deter those who believe in the normally accepted standards of behaviour from speaking out. There is typically the constant talk of the new moralists of "love," as if it were the only factor that mattered in human relationships. Chastity is again having to take a back seat to a false concept of charity, whereas in fact chastity is a part of true charity. And most significantly of all there is the assumption that sexual aberration is something that people can do nothing about.

Miss Furlong writes, "... promiscuity is essentially a *neurotic* form of behaviour, and as such it is not a simple matter of self-control." She blames the doctors for not having listened more carefully to their psychiatric colleagues. She misses the point that in any neurotic form of behaviour the individual can and has to do something about it, the psychiatrist's role being to help him to see more clearly what to do.

The medical profession in this country may have a key position in the re-establishment of standards of sexual morality, following the lead given recently by the 140 Swedish doctors. It is to be hoped that the extraordinary publicity given to the statements of a few doctors and clerics condoning immorality is a temporary phenomenon, perhaps related to the infancy of television. These statements are not typical of the sound thinking of the great majority, and in the long run it is the voice of reason that will be heard.—I am, etc.,

G. G. DALLAS.

P. LINDEN.

W. H. CRAWFORD.

Bangor,
Co. Down.

SIR,—I read the B.M.A. report and your leader thereon (7 March, p. 575) with great interest. From this study, in my opinion, one could draw (amongst others) the following general conclusions: (a) Appeals to avoid promiscuity, based on moral or religious teaching, are in present social conditions largely valueless; (b) an enormous amount of promiscuity develops as a result of "gang pressure"; (c) no general agreement seems to exist as to what is "sex education," or when or by whom the latter should be given.

In view of these findings, I think it is incumbent on the medical profession to evolve agreed principles on sex education (especially stressing the psychological aspects) for the various age groups. In such a presentation I would suggest that emphasis should be laid on the "psychological warping" (almost entirely overlooked in the above publication) so likely to result from irregular sex, even in the absence of such tragedies as venereal disease or illegitimate pregnancy. (In my experience of such talks, I have found this approach very helpful.) Some preparation of children and adolescents to fortify them against "gang pressure" should be given both in the home and in schools.

The lack of development of the altruistic sentiments in promiscuous adolescents is, in my opinion, perhaps even more important than their sexual ignorance. The basis of these sentiments should of course be laid in the home from the early years of childhood onwards.—I am, etc.,

Pinner, Middlesex.

ROBERT THOMPSON.

SIR,—It appears from the above report that there is an increasing incidence of venereal diseases in the young. It is somewhat surprising that we in our practice have not seen a case of venereal disease during the past two or three years although we have had some cases of pregnancy in 15-year-olds.

I personally have some doubt about whether the young are any worse now than they have always been. It is difficult to compare different ages, but there are some well-authenticated cases of precocious sex in the past.

In the year A.D. 39 Messalina was married to Claudius the Emperor of the Romans when she was only 15 and already experienced in sex. The Empress Theodora (A.D. 525) began her sex life at 12 or earlier as a prostitute in Constantinople before she gave up this life and married Justinian the Emperor.

About this time, too, St. Benedict fell in love with a married woman when he was only 13: in order to avoid sin he became a hermit and founded the Benedictine Monastery.

Emma, Lady Hamilton, began her career at 15 as the mistress of Charles Greville, married his uncle, Sir William Hamilton, at the age of 26, and met Lord Nelson and became his mistress at the age of 33 (their daughter Horatia was born two years later).

These examples illustrate how little things have changed over the centuries.—I am, etc.,

Blackpool, Lancs.

J. A. FORREST.

SIR,—I have read with great interest your leader on the B.M.A. Committee's report on Venereal Diseases and Young People (7 March, p. 575).

I was especially pleased with the strong defence of sexual morality adopted by the Committee, and the need for application of religious faith. Having 14 grandchildren, I feel that every encouragement should be given to these young people to live a clean, healthy, and disciplined way of life of which the greatest would be our own example.—I am, etc.,

London S.W.19.

G. R. E. G. MACKAY.

SIR,—I have shown this leading article (7 March, p. 573) to a fair number of teenagers. They were most impressed by it, and several of them suggested that all pupils in the fifth and sixth forms should receive a reprint of it. The majority of them suddenly appreciated the danger of a promiscuous life.—I am, etc.,

London W.1.

LEO RAU.

SIR,—I read in my newspaper last week that the police report that crimes of violence have increased since 1952 to nearly three times what they were.

I look at a book in my public library taken quite haphazardly. I find at first glance words printed therein that my mother would have described as "thieves' den talk" and certainly in those days nobody would have dreamt of uttering them, still less of writing them had they wished to have any claims to be considered cultured or good living.

How can people in the face of this say that we are not regressing spiritually and morally? Let's get our diagnosis right even if we cannot agree about prognosis and treatment.

Again, it seems to me that these advocates of the "new morality" seem largely unaware of the facts of sexual physiology. They seem to imply that, with enlightenment, sexual acts will take place with the calm, clinical, and aseptic atmosphere of a well-conducted operating theatre. Well, they won't.

That is the reason that precautions against venereal disease and unwanted pregnancy will largely fail, and therefore hope for the future only exists by a return to the Christian virtues of chastity and continency.—I am, etc.,

Penzance, Cornwall.

D. C. CLARK.

SIR,—Our profession tends, I think, to pontificate too much on sexual behaviour; and, unfortunately, it frequently gets quoted on this subject in the non-medical press. "Unfortunately" because so many people imagine that a doctor has by virtue of his training and experience special knowledge of sexual relationships. He has not, of course.

One—anybody—can attack the first and third letters on "Venereal Disease and Young People" (21 March, p. 766) on so many grounds. It is, for instance, both heart-breaking and funny to hear people recommending religious belief (presumably Christian?) to members of a nation who frequently do not even know the essential dogmas of this religion, and who could not accept them if they did. Although, of course, I really should say "these religions."

However, it is much more heartbreaking and not at all funny when older people arrogantly or piously condemn the attempts made by their juniors to become adjusted to the social conditions they have inherited. I think the older generation has (if it is not too ignorant) a duty to explain to the young that sexual intercourse need be followed by neither venereal disease nor unwanted pregnancy; and to indicate how these disasters may be avoided. They may also point out that the risks of failure compare favourably with those of most other human activities.

Everything else may be left to the judgment of the persons concerned. There is so little in the sexual histories of most of us to entitle us to say more than, "I did so-and-so. At least try to avoid *that* mistake."—I am, etc.,

Cardiff.

F. L. D. STEEL.

Hypertension with Monoamine Oxidase Inhibitors

SIR,—In your leader of 7 March (p. 578) the estimated mortality from E.C.T. is given as 0.03%. I would like to know (a) from which source this figure is derived, and (b) what is actually implied by it.

The mortality rate from E.C.T. has been variously estimated by different American authorities at 0.05%,¹ 0.8%,² 0.1%,³ and 0.4%.⁴ Assuming these figures refer to the same thing the average E.C.T. fatality rate is 0.3%, which is 10 times higher than the figure you mention and might therefore suggest that E.C.T. is more than 100 times more dangerous to life than tranlycypromine, which has an estimated mortality rate of 0.001%. There is, of course, an important discrepancy here. This refers to the death rate per number of patients receiving E.C.T. (patient-

fatality rate) and the mortality rate per number of individual electrical treatments given (treatment-fatality rate).

Using a questionnaire, Barker⁵ and Baker⁶ investigated retrospectively nine deaths which had occurred over a two-year period in 55 hospitals as a result of E.C.T. These deaths were distributed over more than a quarter of a million treatments. Amongst the conclusions from this study (which must be one of the largest in existence) was that the E.C.T. mortality rate was extremely low—one death per 28,000 treatments, which is equivalent to a treatment-fatality rate of 0.003%. This might imply that the mortality rates from E.C.T. and that arising from tranlycypromine are of approximately the same order (0.003% as opposed to 0.001%), whereas it is of course impossible to compare the incidence of death resulting from tranlycypromine against a mortality which is expressed according to the number of E.C.T. treatments which have been administered.

Also it would seem inappropriate to compare the fatality rate resulting from a monoamine oxidase inhibitor taken several times a day, alone or in combination with other powerful psychotropic drugs, over a period of several months or years, with that resulting from E.C.T., which may also be given alone or in conjunction with drugs (usually 2 or 3 times a week for much shorter periods). Too many variables are introduced. For instance, among many other considerations the age of the patient may be much more important in relation to the E.C.T. fatality rate than to the incidence of death associated with tranlycypromine.

Far more information about this subject is required before any lasting conclusions may be drawn. The position of the elusive decimal point is, however, of considerable importance.—I am, etc.,

Shelton Hospital,
Shrewsbury.

J. C. BARKER.

REFERENCES

- Kolb, L., and Vogel, V. H., *Amer. J. Psychiat.*, 1942, 99, 90.
- Impastato, D. J., and Almansi, R., *N.Y. State J. Med.*, 1943, 43, 2057.
- Alexander, S. P., Gahagan, L. H., and Lewis, W. H., *J. Amer. med. Ass.*, 1956, 161, 577.
- Gaitz, C. M., Pokorny, A. D., and Mills, M., *Arch. Neurol. Psychiat.*, 1956, 75, 493.
- Barker, J. C., and Baker, A. A., *J. ment. Sci.*, 1959, 105, 339.
- *Lancet*, 1959, 2, 793.

Attempted Suicide with Cheese

SIR,—Many reports have appeared lately dealing with possible side-effects of "par-nate" (tranlycypromine).

So far, however, I have not heard of a similar case to that of a depressed young woman recently admitted to this hospital. Prior to admission she was having tranlycypromine, and had been naturally warned about the risks of cheese concurrently with that drug. Unfortunately she suffered an acute deterioration of her illness and attempted suicide by swallowing some tablets of tranlycypromine. A few days after her admission she confessed to the staff that she had not only taken the tablets but also a "chunk of cheese." Nothing happened to her.—I am, etc.,

Stone House Hospital,
Dartford, Kent.

J. ASENSIO.

Ampicillin in Typhoid Fever

SIR,—Your leading article on ampicillin (18 January, p. 132) states that since the discovery of ampicillin (alpha-amino benzyl penicillin, "penbritin") in 1961¹ no full-scale results of clinical trials of ampicillin in typhoid fever have been reported. I would like to draw attention to a controlled trial of ampicillin treatment in typhoid fever carried out at the Mulago Hospital, Kampala, the results of which I presented at the Third International Chemotherapy Conference held in Stuttgart, West Germany, in July 1963² and which will be published in the proceedings of that meeting. The trial was controlled in that patients were allocated to treatment with ampicillin or chloramphenicol on a random basis. The criterion for the final diagnosis and inclusion in this trial was a positive blood culture of *Salmonella typhi*. Fifty patients were studied, 25 in each group. Both drugs were given orally. Ampicillin was given in the dose of 2.25 g. per day, and chloramphenicol 3.0 g. per day, till the pyrexia subsided. Thereafter ampicillin dosage was reduced to 1.5 g. per day, and chloramphenicol to 2.0 g. per day, and this was continued for one week. Children under 10 years of age were given half the adult dose. The series consisted of 36 males and 14 females. The age range was from 8 to 50 years.

In the patients treated with ampicillin the duration of illness before the start of the treatment had great effect on the response to the drug; the early cases responded much better than the late cases. On the other hand the response to chloramphenicol was uniformly good, regardless of the duration of illness before treatment. In nine patients who were ill for less than seven days before the start of the treatment the response to ampicillin therapy was good, and the average duration of fever was five days. This was noted in all patients irrespective of the severity of the illness. In 16 patients who were ill for more than seven days the response to ampicillin therapy was slow, and the average duration of fever after the start of treatment was nine days. The average duration of fever after the start of chloramphenicol was 5.5 days, regardless of the severity or duration of the illness.

In the ampicillin-treated group nine patients responded satisfactorily; the response was slow in 13 patients and poor in three. These three all did well on chloramphenicol. Blood culture of one of these patients showed *S. typhi* resistant to ampicillin and sensitive to chloramphenicol. One patient had a relapse and responded well to another course of ampicillin. One patient died of intestinal haemorrhage. In the chloramphenicol-treated group, the response to therapy was considered good in 21 cases, slow in three, and poor in one. The blood culture of the patient who showed the poor response grew *S. typhi* organisms which were found to be resistant to chloramphenicol and sensitive to ampicillin; he subsequently did well on ampicillin.³ Two patients relapsed, but responded well to second courses of chloramphenicol. Two patients had intestinal haemorrhage, and this was fatal in one. One other patient died of intestinal perforation. Four further cases of typhoid fever were treated with the bigger dose (4.0 g. per day) of ampicillin. No improvement in the response was noted.

There were no manifestations of hypersensitivity reactions noted during the administration of ampicillin. This is at variance with the experience of W. P. U. Kennedy and his colleagues,⁴ who encountered a high incidence of hypersensitivity reactions to ampicillin.—I am, etc.,

KANTI M. PATEL.

Makerere University College
Medical School,
Mulago Hospital,
Kampala, Uganda.

REFERENCES

- Rolinson, G. N., and Stevens, S., *Brit. med. J.*, 1961, 2, 191.
- Proceedings of the Third International Chemotherapy Conference (in press).
- Patel, K. M., *Lancet*, 1963, 1, 1378.
- Kennedy, W. P. U., Wallace, A. T., and Murdoch, J. McC., *Brit. med. J.*, 1963, 2, 962.

Trial of Oxethazaine

SIR,—The findings of Dr. G. V. Balmforth and his colleagues (8 February, p. 355) do not surprise me, for I have had some experience of the mixture of the local anaesthetic oxethazaine in a gel of aluminium and magnesium hydroxide ("mucaine"). They found that the local anaesthetic added no benefit to the plain gel in patients with a duodenal ulcer. On the other hand they also showed that the local anaesthetic mixture was no worse.

In a double-blind trial I found that mucaine was significantly superior to the same gel without the local anaesthetic in cases of heartburn of pregnancy. Since that trial ended I have used this mixture in over 50 similar cases and rarely found it not to satisfy my patient. I have also found mucaine to be useful as a symptomatic treatment of heartburn due to other causes, usually hiatus hernia, though the number of such cases in my practice is not sufficiently great to prove anything statistically. Patients with a duodenal ulcer do not often get a reflux oesophagitis and rarely complain of heartburn, so I would not expect a local anaesthetic to add any benefit to the plain gel in these cases.

The enthusiastic response new drugs sometimes evoke should not cause us to condemn them if they fail to come up to every expectation. Safe symptomatic remedies have a place in the therapeutic armamentarium of all physicians.—I am, etc.,

London W.12.

STUART J. CARNE.

Fluoridation Falsified

SIR,—I am now told by Mr. W. Stewart Ross (21 March, p. 766) "that 1½ g. of sodium fluoride would have to be ingested in water containing 1 part per million sodium fluoride" for toxicity, and that this volume of fluid cannot be drunk. The second part of this is true; the first I believe to be untrue. I cannot concede his "elementary point" until he explains why he chose two and a half bathfuls of water, rather than (say) two, as the minimum daily amount that will provide a toxic amount of fluoride. Will he please give the evidence for this figure? His 1½ g. of NaF is about 700 mg. of F; the B.D.A. states that 20 mg. of F causes chronic poisoning, and this is contained in 20 l. (about 35