However, a careful history revealed that mild symptoms of endocrine dyscrasia existed before the development of a full-blown hypopituitarism. Menarche at 15 was followed by sporadic bleedings of varying duration (from a few hours to 14 days), always with scanty flow. Frequent spells of depression were explained by the family physician as a "minor defect self-correctable by marriage." Marriage at 22 somewhat regularized oligomenorrhoeic menses. Married life, however, was unsatisfactory. She experienced no orgasms and coitus was regarded only as a necessity for reproduction. After marriage, the "moody" spells became more frequent and alternated with mild euphoria.

After prolonged therapy with chorionic gonadotropins the patient achieved pregnancy in the sixth year of marriage. The uneventful pregnancy ended by low-forces delivery. However, a mild haemorrhage followed the manual removal of the retained placenta. A complete absence of milk prohibited breast-feeding.

Menses never returned after birth of the child. The spells of deep depressions with periodic psychomotor outbursts required institutionalization. Several courses of insulin and electric shock therapy over a five-year period did not alter the course of the disease. Eventually the endocrinological work-up established the true picture of the metabolic derangement.

Physical examination revealed a short and obese female with peri-orbital oedema, scanty pubic and axillary hair, B.P. 90/60, pulse 58, slow tendon reflexes, and no clitoral and vaginal reflexes.

Laboratory studies: urinalysis normal; complete blood count showed mild hypochromic anaemia; syphilis serology negative; blood creatinine 0.6 mg./100 ml.; uric acid 6.8 mg./100 ml.; insulin tolerance test ended in an acute hypoglycaemic reaction with 20 mg./100 ml. glycaemia. Glucose tolerance test also ended in hypoglycaemic reaction at 35 mg./100 ml. glycaemia. P.B.I. 1.8 µg./100 ml. rose to 6.8 µg./100 ml. after stimulation with 10 units T.S.H.; radioactive I^{131} uptake was 7% with the conversion ratio 5%; sedated basal metabolic rate minus 46% and minus 48%; urinary gonadotropins reduced; 17-ketosteroids in 24-hour urine = 3.7 mg.; 17-hydroxysteroids = 0.1 mg.; pregnanediol and pregnanetriol were absent; E.C.G. showed low voltage in all leads, otherwise normal; x-ray of the skeleton unremarkable; vaginal epithelium showed poor cornification.

The diagnosis was established as pan-hypopituitarism with accompanying syndromes of hypothyroidism, hypocorticism, and hypo-ovarium.

Replacement therapy consisted of tri-iodothyronine with tetra-iodothyronine, prednisolone, and oestrogens supplemented with thyroid, adrenal, and ovarian tropic hormones (T.S.H., A.C.T.H., F.S.H.). A complete remission with an establishment of a regular menstrual cycle occurred within six months.

In the other two patients with Sheehan's syndrome several spontaneous abortions preceded the critical pregnancy, which was followed by the development of acute pan-hypopituitarism.

In appraising these three patients it is important to note that all possessed a mild hypothalamic inadequacy with poor contractility of uterine muscle leading to the delayed expulsion of the foetus and/or detachment of the placenta, and atonic haemorrhage. In other words, the

dramatic events of the delivery in the form of haemorrhage are the result of a hormonal insufficiency brought about by pre-existing disease in the hypothalamus and/or hypophysis. The symptoms then became more pronounced after the post-partum haemorrhage and so have led to an erroneous interpretation of the exact nature of the disease.—I am, etc.,

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Z. Z. GODLOWSKI.

Penicillin in Milk

SIR,—Two years ago I reported the case of a woman who developed dermatitis which proved to be a hypersensitivity reaction to the minute amounts of penicillin in normal bulked milk supplies.¹ Two attempts at desensitization had failed. Subsequently she was treated by adding penicillinase to her milk. When she had remained free of her eruption for 14 months a further attempt was made to desensitize her, which was entirely successful. Soluble penicillin G was given by mouth, beginning with 0.1 unit daily and increasing over a period of five months to 15,000 units a day. Over the final two months the addition of penicillinase to her milk was gradually discontinued. She has now remained completely well for a year on a full normal diet.—I am, etc.,

London W.1.

P. BORRIE.

REFERENCE

- ¹ Borrie, P., and Barrett, J., *Brit. med. J.*, 1961, 267.

Ingrowing Toenails

SIR,—Mr. A. W. Fowler in his letter (November 2, p. 1131) has, I am sure, explained why toenail surgery remains in the doldrums. I am less certain that he has suggested the correct cure. Our thesis¹ is that the conservative management of ingrowing toenails can be carried out by the patients themselves, under the supervision of their own general practitioner, the casualty department of any hospital, or under the care of a chiropodist.

It cannot be denied that very variable results have been obtained with all methods of nail-bed ablation, including the method described originally by Quenu,² in which the germinal matrix alone is excised. I would agree with Mr. Fowler that this operation can give excellent results, but it requires interest, a meticulous technique, and experience. If, therefore, toenail surgery is to be lifted from the doldrums, I am convinced that this can only be achieved by supervision and teaching of those who carry out any form of operation on the nail bed.

Until nail-bed ablation becomes a more universally satisfactory technique I am convinced that the ingrowing toenail should be treated energetically by conservative means, and any patient requiring nail-bed ablation, for which there are

undoubted specific indications, should have a carefully planned and carried out operation, and hence a good end-result.—I am, etc.,

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REFERENCES

- ¹ Lloyd-Davies, R. W., and Brill, G. C., *Brit. J. Surg.*, 1963, 50, 592.
² Fowler, A. W., *ibid.*, 1958, 45, 382.

Training for General Practice

SIR,—In a recent monograph entitled *Doctor and Patient. Ethics, Morale, Government*¹ and given prominent publicity in *The Times*, Sir Robert Platt has drawn attention to the necessary post-graduate training prior to entry into general practice. He suggests a period of three, and preferably five, years' post-graduate training, whereby "the whole status of general practice would improve and the public have direct access to a higher quality of medical care."

There must be many of us who agree with Sir Robert Platt, but has adequate consideration or encouragement really been given to those who would wish to embark upon such a course? Granted the fact that the first year's pre-registration post should be treated very much as a provisional period, what of the following years? A midwifery appointment is essential; a casualty, paediatric, and further medical appointments are certainly desirable, to say nothing of psychiatry and the "minor specialities," all important in general practice.

One has therefore to exist on, at the most, £1,200 per annum (senior house officer grade), or if the job is particularly good and therefore receives many applications, £980 (house officer grade). If one is married, a separate home for wife and perhaps family has to be provided out of this income. Added to that, one is often doing work or taking decisions that one feels general practitioners would have taken had they been similarly trained.

Why, therefore, penalize so heavily those who wish to provide in the future what is at present described as "the best form of general practice"? Can one wonder that one's contemporaries seek the relative security of general practice at the earliest possible opportunity?—I am, etc.,

JEREMY BARTLETT

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Plymouth, Devon.

REFERENCE

- ¹ Platt, R., *Doctor and Patient. Ethics, Morale, Government*, 1963. The Rock Carling Fellowship Lecture. Nuffield Provincial Hospitals Trust, London.

Mental Retardation

SIR,—The correspondence about appropriate terms to describe individuals with intelligence less than "normal" implies that there is agreement in the United States about the use of the term "mental retardation." This is not reflected by the