A concentration of 1·5 μg/ml was arbitrarily taken as a level readily obtainable in the blood with both antibiotics. The 19 strains resistant to penicillin and tetracycline only were resistant to tetracycline in concentrations above 20 μg/ml. This resistance pattern occurs quite frequently in strains of *S.aph. aureus* isolated both from hospital patients and from the general community. It would appear therefore that any microbiological advantage which minocycline may exert over other tetracyclines is due to its superior activity against strains of *Staph. aureus* which are resistant to tetracycline.[4]

—I am, etc.,

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1 Frisk, A. R., and Tunevall, G., *Antimicrobial Agents and Chemotherapy*, 1968, **8**, 335.
2 Stegbigel, N. H., Reed, C. W., and Finland, M., *American Journal of the Medical Sciences*, 1968, **255**, 179.
3 Fedorko, J., Katz, S., and Allnoch, H., *American Journal of the Medical Sciences*, 1968, **255**, 252.
4 Klastersky, J., and Daneau, D., *International Journal of Clinical Pharmacology*, 1972, **6**, 324.

Delayed Drug-induced Dystonias

SIR,—I regret my delayed response to the correspondence following my original report (20 October, p. 174) and welcome the more general recognition that those very disturbing extrapyramidal spasms may be wrongly blamed on the patients, especially when they suffer from some personality disorder disagreeable to the examining physician or when the reaction occurs a day or more after the administration of the phenothiazine or butyrophenone responsible.

Dr. L. Rose (17 November, p. 424) should, however, not be so hasty in implying such breathtaking naivety on the part of his colleagues. At no point was it stated that these suicidal patients were managed with no more aid than one large dose of haloperidol. Both patients were receiving adequate and orthodox benzodiazepine sedation at the time and of course received appropriate antidepressant therapy afterwards, as needed. My report drew attention to the ill effects such single doses of butyrophenone could have and in no way suggested its adequacy in managing such cases.

I would like to record my thanks to Mr. Peter Richardson and Mr. Tom Pearson, who helped to bring this matter to my attention.

—I am, etc.,

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Strangulated Ovary and Tube in Inguinal Hernia in Infancy

SIR,—A girl one year old was admitted to this hospital with a history of three days' constipation. She had vomited only once two days previously. On examination a tense swelling was found in the left groin. No cough impulse was present and the mass was irreducible. Strangulated inguinal hernia was diagnosed. On exploration a mass was found protruding from the internal inguinal ring into the hernial sac, which contained altered blood and the left ovary and tube twisted clockwise. The gangrenous ovary and part of the tube were excised and the mesovarium and remainder of the tube were allowed to retract into the abdominal cavity. Herniotomy was performed. The postoperative period was uneventful. Section of the excised specimen confirmed that it consisted of a strangulated ovary with a portion of tube.

The first indication of the genital gland in the embryo is an area of thickened epithelium on the medial side of the mesonephric ridge. This medial genital fold enlarges and separates from the lateral part. The differentiation of gonads begins about the seventh week of intrauterine life. The medial aspect, the mesovarium, attaches the ovary to the mesonephric fold and by the inguinal fold to the abdominal wall. In the last fold the fibromuscular gubernaculum is developed and as it crosses the mesonephric fold it gains attachment to the cornu of the uterus. Later the mesonephric folds unite and form the genital cord, resulting in connexion of the ovary to the posterior layer of the broad ligament. These attachments stop the descent of the ovary farther through the canal of Nuck to the base of the labium major. The canal of Nuck is obliterated by the eighth fetal month and the ovary is then suspended between the cornu of the uterus and the internal inguinal ring. The adult position of the ovary is reached about the tenth year of life. If the canal of Nuck remains open the ovary may be forced into a congenital hernial sac[1] together with the tube and even the uterus.[2] Strangulation of the gonad and tube is a possible complication of this type of hernia in a female infant.

The occurence of such an anomaly was reported in the writings of the Greek physician Soramus of Ephesus about 97 A.D.[3] These cases do come to the general hospitals and sometimes are not diagnosed correctly unless one is aware of this condition. They occur mostly in baby girls under two years of age. An asymptomatic lesion of the infantile female genitalia would be more frequently missed than in a male infant. Manual reduction is not advisable in these cases and the need for surgical treatment is universally accepted.—I am, etc.,

J. KOTOWSKI

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1 Bancroft, P. M., *Journal of Pediatrics*, 1945, **26**, 489.
2 Graves, G. Y., McIlroy, D. B., and Hudson, G. W., *American Journal of Diseases of Children*, 1951, **81**, 256.
3 Watson, L. F., *Hernia*, 3rd edn. St. Louis, Mosby, 1948.

Vitamin C and the Common Cold

SIR,—In view of the reawakened interest in the use of vitamin C in common cold prophylaxis (inter alia) we should like to report the results of two small double-blind trials among adult employees of two industrial concerns between February and April 1973.

A dose of 1 g of ascorbic acid daily was used, given in one group as a single effervescent drink and in the other as one 0.5 g tablet twice daily. Anderson *et al.*[1] also used 1 g daily, though with a recommendation that up to 4 g daily be taken during an episode of upper respiratory tract infection. In our studies the same daily dose was maintained throughout.

A total of 295 men and women, with ages ranging from 18-60, completed 80 days of treatment, 153 on ascorbic acid and 142 on placebo. As with all trials of this kind in which subjects are required to record symptoms, definition of the cold episode was difficult. However, it was possible to identify four patterns of upper respiratory tract infection from six cardinal symptoms recorded: "sneezing," "running nose," "headache," "sore throat," "cough," and "fever" when cards became available for analysis. No significant differences between the ascorbic acid and control groups in respect of symptom-free days, days of illness, or any of the four patterns of defined "colds" were found. No attempt was made to assess severity of symptoms in this study and therefore no comment is possible on any difference in degree between sickness episodes in the two groups.

It is concluded that in this small number of adult volunteers taking ascorbic acid daily as a single 1 g dose or two 0·5 g doses had no effect on the incidence of the "common cold."

Our thanks are due to the medical and personnel staffs of Mullard, Southampton, and E. G. Gomme, High Wycombe, for their co-operation and valuable assistance in these studies.

—We are, etc.,

MICHAEL CARSON

Southampton

MARGARET CORBETT

Ealing

HUGH COX

High Wycombe

NORMAN POLLITT

Roche Products Ltd.,
Welwyn Garden City

1 Anderson, T. W., Reid, D. B. W., and Beaton, G. H., *Canadian Medical Association Journal*, 1972, **107**, 503.

Clonidine in Treatment of Dysmenorrhoea

SIR,—I have been considering for some time the problem of severe dysmenorrhoea accompanied by nausea and vomiting, with loss of time from work. Could this be a migraine variant? Migraine is considered to be due to a constriction of arteries followed by excessive dilatation causing congestion with sickening pain, nausea, and vomiting. Why should not this mechanism affect the uterine arteries at a time when there is an increased flow of blood through them?

With this in mind I have successfully treated 15 women suffering from severe dysmenorrhoea with clonidine 0·025 mg twice daily for 14 days before and throughout the period. The results have exceeded all my expectations. All 15 responded to the treatment; 11 required no additional treatment and four required an occasional paracetamol tablet. All 15 reported they had been able to continue their normal pursuits at the time of their period and had lost no time from work and that family relationships had shown a marked improvement.—I am, etc.,

LIONEL KENNETH LEVENS

Stoke-on-Trent, Staffs

Noisy Oxygen Therapy

SIR,—I certainly share Dr. J. M. Leigh's concern (15 December, p. 652) with noise in general but with regard to the 24% Ventimask I would make two points. Firstly, it does not have to be driven at 96 litres per minute but operates quite satisfactorily at half that rate when, I suspect, its noise is comparable with that of the 28% mask. Secondly, if a patient really needs 24% oxygen then the "irritating quality" of the noise is probably good for him.—I am, etc.,

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