

with a glass of water and no harm results. One man is reported to have taken one tablet with water four times a day for several weeks without ill effect.¹ However, should oesophageal hold-up occur for more than a few seconds, localized thermal and caustic burning occurs as the tablet effervesces. Of 16 cases of Clinitest tablet ingestion reported in the literature, 13 were followed up; strictures developed in 11 of these, five of them in young children. Some were treated by repeated oesophageal bouginage, while others required segmental resection.^{2,3}

To prevent accidental ingestion of Clinitest tablets I suggest that patients should be advised to keep their urine-testing tablets away from medications and out of the reach of children. It is important that the prescriber inform diabetics with poor vision who cannot read identifying labels that a Clinitest bottle is easily recognized by the ridges palpable in its surface. These ridges indicate that the contents are poison.—I am, etc.,

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- ¹ Tomsovic, E. J., and David H., *Journal of Pediatrics*, 1958, 53, 608.
² Danzig, L. S., and Loebel, A. S., *Journal of the American Medical Association*, 1965, 192, 1092.
³ Genesier, N., and Becker, M., *Clinical Pediatrics*, 1969, 8, 17A.

Side Effects of the Pill

SIR,—Your recent articles on the association between "the pill," carcinogenicity, thromboembolism, and infertility prompt me to write to you regarding the frequency with which side effects of the pill are seen in general practice. Hardly a day goes by without a young woman attending the surgery suffering from some side effect of the "combined" preparation. She may be worried by "breakthrough bleeding," loss of libido, depression, headache, or amenorrhoea.

I think it is true to say that the pill is probably as common a cause of amenorrhoea as is pregnancy. The amenorrhoea caused by a "weak" pill such as Ortho-Novin 1/50, Norinyl-1, or Minovlar or a strongly progestogenic pill such as Anovlar can be worrying for a woman and confusing for her doctor. Secondary amenorrhoea caused by disturbance of the hypothalamic-pituitary axis after cessation of oral contraception can be a disaster to the woman wishing to conceive again, as pointed out by Mr. K. Vernon Bailey (25 November, p. 492). As a general practitioner working in a relatively young population, I have never seen a case of thromboembolism due to the pill. Dramatic and disastrous as it may be, it is relatively rare. Amenorrhoea, on the other hand, is a side effect seen probably weekly.

But the two most overwhelming side effects of the pill are surely loss of libido and headaches. Since becoming aware of these I have made a practice of inquiring about them when my female patients come for routine examination or repeat prescriptions. To my astonishment I have found that probably 50% of women admit to a complete loss of libido while they are on the pill. A decrease in libido might be considered acceptable, but a complete loss of sexual interest is surely a quite unacceptable side effect. Because of their fear of pregnancy many women will unhappily tolerate this state of affairs. In the past few months,

however, women have been asking more frequently to stop the "combined" pill because of loss of libido, and I have even "cured" a case of secondary impotence in a male by removing the pill from his wife.

Probably 5-10% of women on the pill suffer from what I term "withdrawal" headaches. These are unilateral, severe, and often accompanied by nausea and a compulsion to lie down. They usually occur on the second, third, or fourth day after stopping the pill to allow cyclical "menstruation." Most women seem to put up with them and to be unaware of their association with the oral contraceptive. In my experience changing pills may lead to a temporary improvement in the headaches, but after several cycles they usually recur. Clonidine may be of some benefit, but it seems illogical to me to give a patient iatrogenic headaches and then to treat her with an equally powerful drug which has side effects of its own.

It will be interesting to see what side effects the "progestogen only" pills will produce. They may be unlikely to cause thromboembolism;¹ they are more likely to cause "breakthrough bleeding" and contraceptive failure. Unless they reduce the incidence of loss of libido and of headache their place in the family planning armamentarium must be questionable.

An almost universal panacea the pill may be, and we all use it; an ideal contraceptive it most certainly is not.—I am, etc.,

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- ¹ *British Medical Journal*, 1972, 4, 378

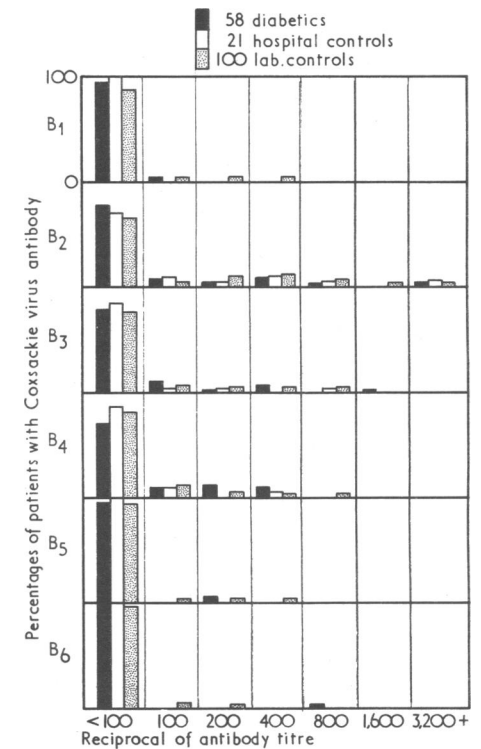
Coxsackie B Virus and Diabetes

SIR,—Gamble *et al.*^{1,2} reported a possible relationship between Coxsackie group B viruses and the onset of insulin-dependent diabetes. To prove an association between a virus infection and the onset of diabetes mellitus it would be necessary: (1) to isolate the same virus from a number of patients at the time of onset of their diabetes, or (2) to show a rising titre of viral antibody in patients' sera at this time, or (3) to show an epidemiological association between a virus epidemic and the onset of diabetes, or (4) to demonstrate a high viral antibody titre in patients' sera above the "background" level observed in the same population at the same time.

Because the onset of clinical diabetes may appear some time after a possible viral infection we considered that it was practicable to investigate only the third and fourth of the above criteria in relation to Coxsackie group B viruses. Fifty-eight newly diagnosed diabetic patients (whose clinical symptoms of the disease were severe enough to warrant admission to hospital) and 21 hospital patients in the same ward and matched for age by decade, who were not diabetic and whose blood sample was taken on the same day as from the diabetic patient, were investigated. We have also compared the results with those from 100 patients referred from medical outpatient departments to the virus laboratory with indefinite symptoms thought possibly to have a viral aetiology over the same period.

The diabetic patients comprised 34 who subsequently required insulin therapy, 9 who could be controlled by dietary restriction

alone, and 15 who received an oral hypoglycaemic agent in addition to dietary advice. Twenty-eight of these patients were under the age of 40.



Comparison of Coxsackie group B virus neutralizing antibody titres in three groups of patients.

During the period of investigation no one Coxsackie group B virus predominated in Northern Ireland and a seasonal incidence of onset of new cases of diabetes was not present.

Neutralizing antibody to the six Coxsackie group B viruses was measured by mixing doubling dilutions of inactivated patients' sera with equal volumes of 200 TCD₅₀ of virus and allowing the virus-serum mixtures to neutralize for three hours at 37°C before inoculation into cell cultures.

The distribution of neutralization titres is shown in the figure. There was no significant difference between the three groups; consideration of only those who required insulin treatment or were below the age of 40 did not alter this negative conclusion.

We have not been able to find any evidence to associate Coxsackie group B virus infection and the clinical onset of diabetes mellitus.

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- ¹ Gamble, D. R., Kinsley, M. L., Fitzgerald, M. G., Bolton, R., and Taylor, K. W., *British Medical Journal*, 1969, 3, 627.
² Gamble, D. R., and Taylor, K. W., *British Medical Journal*, 1969, 3, 631.

Making Hospital Geriatrics Work

SIR,—The success of Drs. H. M. Hodkinson and P. M. Jefferys (2 December, p. 536) in abolishing a geriatric waiting list merits congratulations. It is important to emphasize some of the circumstances in which this has been achieved.