very short-acting anticholinesterase drug; when it is given intravenously, myasthenic weakness improves in 30–40 seconds and the increase in strength lasts about five minutes. However, when it is injected into a patient in a cholinergic crisis there is temporary aggravation of the muscle weakness. This test probably has some value in differentiating the two types of crisis, but it may be difficult to evaluate the result owing to the very short action of the drug.

If a cholinergic crisis (due to overdosage of neostigmine) occurs, administration of the drug must be stopped temporarily, atropine should be given in a dose of 1/60 gr. (1 mg.) intramuscularly, and this dose repeated hourly until signs of atropinization occur. Measures must also be taken to treat weakness of bulbar and respiratory muscles, such as tracheal intubation, tracheotomy with positive-pressure respiration, or assisted breathing in a respirator, depending on the distribution of the muscle weakness.

Pyridostigmine

One of the main disadvantages of neostigmine is its short action, and pyridostigmine ("mestinon"), a pyridine analogue of neostigmine, was introduced in 1954 as it was said to have a rather longer action and was less apt to cause side-effects on the alimentary canal than neostigmine. A 60-mg. tablet of pyridostigmine by mouth corresponds to 15 mg. of neostigmine. The total dosage and timing of their administration is worked out as described for neostigmine. In general, pyridostigmine produces side-effects less frequently and is the more useful drug for the control of myasthenia gravis, but individual patients vary in their response and some prefer to continue with neostigmine. In others a combination of the two drugs gives the best results, neostigmine being used during the day and pyridostigmine for the last dose at night, as its rather longer action may obviate the need for a dose during the night in the more severe cases.

Other Drugs

Organic Phosphate Compounds.—During the past twelve years several long-acting choline esterase inhibitors have been tried in the treatment of myasthenia gravis; the best known are di-isopropyl fluorophosphate (D.F.P.), tetraethylpyrophosphate (T.E.P.T.), and octamethyl pyrophosphoramide (O.M.P.A.). These drugs were found to be uncertain in their action, and toxic effects were frequent and difficult to control. There does not seem to be any place for them in the routine treatment of the disease.

Ephedrine has some effect in increasing muscle power in myasthenia, but the mechanism of this is uncertain. It can be given in a dose of $\frac{1}{8}$ gr. (25 mg.) two or three times a day in addition to neostigmine or pyridostigmine. In my experience it has proved most useful in patients who wake during the night with choking and respiratory difficulty, and it seems likely here that its main value is from its bronchodilator effect.

Drugs to be Avoided

Quinine aggravates myasthenia, an effect opposite to that seen in myotonia, where the delayed relaxation of muscle is often relieved by quinine and aggravated by neostigmine. Myasthenic patients are very sensitive to curare, and this drug should not be administered in operations on patients with the disease unless this danger is realized and adequate provision made for assisted respiration until the effects of the curare have worn off. A.C.T.H. and cortisone have been given in the treatment of myasthenia, but they often exacerbate the disease after a few days; a remission sometimes occurs after the drug has been stopped. In view of this, great care should be taken in using these drugs for a coincidental disease in a myasthenic patient.

Treatment Apart from Drugs

About 12% of myasthenic patients have a neoplasm of the thymus. It can usually be shown radiologically by screening of the chest, antero-posterior and lateral pictures, and if necessary tomography. These patients should be given deep *x*-ray therapy to the tumour, and in some cases operative removal of the thymoma should be carried out at a later date. During deep *x*-ray treatment the necessary dosage of neostigmine may vary considerably from day to day and careful supervision of this is needed. The question of operative removal of the thymus in myasthenia patients who have not got a radiologically demonstrable thymoma has been discussed recently in a leading article in this *Journal* (1959). In general the operation should be carried out in patients under the age of 45–50 if the disease is becoming generalized, or progressively getting worse, and if the patient is needing increasing doses of neostigmine or pyridostigmine and notable remissions are not occurring. In exacerbations of the disease, when there is bulbar palsy or paralysis of the respiratory muscles, the patient needs treatment by methods similar to those used in poliomyelitis or acute infective polyneuritis—namely, postural drainage, physiotherapy to the chest, and in some cases tracheotomy and positive-pressure respiration.

REFERENCE

Brit. med. J., 1959, 1, 288.

REACTIONS OF CANCER PATIENTS ON BEING TOLD THEIR DIAGNOSIS

BY

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"I asked the doctor—I looked him straight in the face and I asked 'Is it cancer?' and he said, 'Yes.' Well, I'd rather know the truth—it's better than imagining all the time. I asked my own doctor in the first place, 'was it . . . ?' and I didn't get to say the word, and he said 'We don't know,' so naturally I thought it must be. If I'm ill I'd rather know what I'm suffering from, because you don't die any sooner for knowing about it."

Doctors and journalists sometimes discuss what the patient with serious disease should be told about his illness. The patient's own views are seldom heard. It is generally assumed that patients with cancer, even those with localized and curable conditions, prefer not to be told the diagnosis, and that silence or reassurance is the best solution to the patient's (and doctor's) anxiety. This policy has unfortunate repercussions for cancer education. It means that the only cancer patients

most people know are those with advanced disease who die. If the patient does well the condition, it is thought, cannot have been cancer. This masks the more optimistic side of cancer treatment and so encourages a fatalistic attitude, resulting in delay in seeking advice through fear.

The study analysed in this paper started with the premise that it was in the public interest for early cancer likely to be cured to be quite unemotionally and casually referred to as "cancer" from the beginning. In this way a nucleus of patients would be created with no doubt in their minds about what had been the disease. In the event, as will be seen later, the surprising finding was reached that in the large majority of cases such telling was what the patients themselves preferred. In all, consultants told, and recorded having told, 231 selected patients (Table I).

TABLE I

Site of Lesion	Male	Female
Skin or lip	79	53
Mouth or tongue	13	9
Uterus	—	63
Breast	—	11
Other	1	2
	93	138

Patients' Initial Reaction

Between a week and a month later, depending on the patient's availability, and in the course of an interview ostensibly centred on the medical history, one of us (J. A.-S.) tried to discover indirectly the nature of the patient's reaction to the consultant's explanation. Many interviews were recorded, always with the patient's knowledge. Towards the end of the inquiry it was decided to seek the family doctor's views (35 cases), and to interview as many patients as possible a second time. Those who were being followed up at distant clinics, who had been dismissed, or who were on written follow-up could not be seen again. In all, 41 were seen a second time from one to two and a half years after having been told, in order to learn what they then thought and if they had spoken of their condition as cancer to others. This last was an important factor if "telling the diagnosis" was to have any educational value.

Given an indirect approach, sympathetic listening, and some encouragement, it was hoped that patients would feel free to speak of any worries, as indeed many did. The results of the inquiry are summarized in Table II.

TABLE II.—*Patients' Initial Reaction*

Reaction	Male	Female
Approval	61	92
Denial that they had been told	23	21
Disapproval	0	17
Inconclusive*	9	8

* This group tended only to respond to direct questions, and no conclusions could be drawn about them.

Approval

1. "I think you go through your treatment better because you know it's a case of life or death with you. You couldn't get better without it, could you? That's why I wanted to know. I think it's very—wise—to know, yourself; it wouldn't do to tell anyone else. Though I think a lot of people here think they have got an abscess—well, it's just as well to let them think so." Later she said: "I think it's better to tell people, because I think it makes them fight better."

2. "I'm the worrying sort—that's just it. If I'd asked the doctor and he'd brushed me off it would have been worrying. I'd sooner he told me when he wanted me to go to Christie's. I would advise a doctor to be frank unless, of course, it's an internal one, and then I should be very, very careful, because it could come as a nasty shock and they've got to have the will to carry on. If he tells them when it's on the bladder or somewhere internal which means a serious operation, they might just—give up. But with these curable things I do think it's best to tell them what it is, and the seriousness of the treatment, so that they'll go in for it and do what they're told and not stray."

These two patients stress the practical value of knowing, suggesting that they submit to treatment in a different spirit if they know. Other patients make it clear that to be told nothing or to be reassured and yet to be treated at a cancer hospital is more worrying than to be told frankly what is wrong.

3. "It took the use of my legs when he told me. But I'd much prefer to know, and then you know what you're fighting. If they don't tell you you just keep worrying and wondering 'Have I got it?'; so it's much better to know. In my ward, of course, I'm the only one that's got it. They say 'What's the matter with you?' and I say 'I've got an early cancer of the womb, what's the matter with you?' and they say, 'Oh, I've got a growth, I've got an ulcer, I've got this and that.' Don't you think people can fight things better if they know?"

4. "If you know what's the matter you know what to expect, but if you're in the dark and they're treating you for this and that and you don't really know, it worries you more. I mean I wasn't shocked. It stunned me a little, but I wasn't really afraid. Of course, I was upset when I came in, but I'm not now." "What upset you?" "I think it was self-pity. When you've no one to talk to it worries you."

Patients are usually well aware that the truth is sometimes concealed from them.

5. "When we have this we always wonder how much is being kept back and how much is being told for our own good, you know."

6. "I would probably not have been reassured if the doctor had said it was nothing. But I know of people who have been reassured that it could be cured, and the doctor has told their relatives that nothing could be done. That worries me."

7. "I heard the doctor say it could be a small cancer—now, that was the first I knew, and it didn't cause any shock or worry or anything. You see, there's this way of looking at it. If a person knows the truth at the beginning it's a pleasant surprise if it's not so bad when the time comes, and it isn't a shock if it is. You're always capable—and maybe there's a chance—of hearing good news if the patient is told the truth. It's no good making a mystery of it, is there? A person worries more if it's a mystery. And people will never get to know that cancer is ever cured if they're never told what it is."

Most of these patients add that only those whose condition is curable should be told, in their opinion, and their thinking invariably stops at this point.

Denial

Denial that they have been told was the reaction of 19% of the patients, and of more men than women. After the patient had given all the information he meant to give freely without having mentioned cancer or what he was told, a direct question had to be asked about the possibility of the condition being cancer and if the consultant had said anything about this. Denial was therefore definite and not due to misunderstandings. Sometimes the patient would not use the word cancer

until after the interviewer had introduced it. In no case did the interviewer question the patient's claim not to have been told.

8. "The doctor didn't say it was cancer. He just said it was in an early stage and could be cured. I didn't ask, because if I don't know I won't worry, will I?"

9. "The doctor didn't say what it was. They don't tell you anything, and when they're so nice with you you don't like asking in case it seems cheeky."

10. "He said I had an ulcer on the neck of the womb, he said, and 'we can cure it.' So that made me feel better—yes, that made me very comfortable." To introduce the word the interviewer said: "You mean that coming to Christie's you had thought it must be cancer?" "Yes, I did. I asked him if it was a cancer" (at this point her eyes filled with tears), "but he said 'Not at all, it's just a small ulcer.'" In his letter to the family doctor the consultant had said that this patient had been told and that she had accepted the diagnosis quite happily.

Disapproval

Few give any indication that they disapprove of being told frankly the nature of their complaint—only 7%, and all women. Not all say so in so many words, because, after all, there is an element of self-esteem involved. Some are contradictory.

11. "I've died many deaths since he told me. I suppose I asked 'Is it cancer? having to go to Christie's,' and he said 'Yes, it is, but it is localized,' and I think he said it was early and that I had a fair chance or a good chance—I'm not sure which. I can tell you it was a shock—I nearly died. I think he was over-frank with me."

12. "My doctor told me it was an ulcer on the womb and that I needed treatment. I think it should have been left at that. There was no need to tell me what it was. It's the word that is so terrible."

13. "He said it was a simple cancer of the skin. It was a terrible shock—I went all dizzy. I had never thought of such a thing. Well, it is the *word*! I've had diarrhoea ever since and haven't slept at all, thinking about it and imagining things." "Would you rather the doctor had not told you?" "Yes, I would. It has upset me so much. He could have said it was a cyst or something."

Patients' Delayed Reactions

Of the 41 patients who had been seen one to two and a half years after the first interview, 35 had not changed their views, five had, and one who denied that she had been told now talked freely of her condition as cancer (Table III).

TABLE III.—*Patients' Delayed Reactions*

At First Interview	Total	At Second Interview			
		Approved	Disapproved	Denied	No Longer Denied
Approved ..	32	29	3		
Disapproved ..	5	2	3		
Denied	4			3	1
	41	31	6	3	1

Of the 37 who did not deny that they had cancer, 26 did not mind others knowing that they had had cancer, 10 had not let anyone know, and the attitude of one on this point was not clear.

14. The consultant noted: "When I disclosed the diagnosis to this patient she expressed more horror than any other patient I have seen so far. 'It is that awful word!' In the end she seemed glad to know, especially since I could reassure her as to cure." The patient's story was: "He told me what it was—a skin cancer like spinners get. Terrible, terrible! I was terribly upset. But I have every confidence in him." "Because he told you so frankly?" "No, because of the way he looked at me—so kind. I just stared at him when he told me—I seemed calm when I left the hospital, but inside—!" "Were you upset because you thought it couldn't be cured?" "No, I wasn't worried about that. It just seemed such a terrible thing to be carrying around with me. I'm glad he told me, because I've known to take care of it, and I might not have bothered if I'd thought it was nothing." About two and a half years later she still approved of having been told. "I think the most valuable part of knowing about it is that if you have anything similar you know how to pay attention to it." She had persuaded a relative to seek advice for a similar lesion, and he had also been treated at this hospital. "I don't mind people knowing," she said. "I would tell anyone."

15. This patient described herself as "one of a well-known family" in her village, "and things soon get around there." She had never heard of cancer being cured, so it had been a great shock when the consultant told her she had an early cancer of the womb. "With the cases I'd known I'd given myself up." Two years later she was in again, cheerful and chatty. "I had given myself up," she said. "When he said I was to come in for two weeks I thought 'They'll say anything to get you in.'" "You didn't believe him when he said it could be cured?" "No, I didn't really. But I thought it's either kill or cure and I'd better go." She still thought it better for the doctor to be frank. "Yes, I do; otherwise I might not have gone. And I look at it like this—it helps other people too. I'm a talkative sort—well, you can see I am—and I tell people about my experience, and it helps them if they're frightened about Christie's. I belong to an old folks' club and we get talking there, and when I sit in the park I talk to the people on the same seat, as old people do, and I tell them, and I think it helps."

16. Seen two years later, another patient said that, looking back, she would rather not have known. "Not with them at [referring] hospital telling me it was a cyst. Then to come here and be told it was a cancer made me lose faith in doctors speaking the truth at all. If they reassure me about anything again I just wouldn't believe them." Later she said: "It wouldn't be fair to the hospital not to tell everyone what I've had. But they can hardly believe me."

Two points are repeated by many of the patients. They are aware of the educational effect of what they say. "I think it's only right to tell other people," said one. "It's only fair to the hospital when they've cured me of cancer," said another. Then they say how sceptical their friends are about their having had cancer at all. "She didn't believe me—she said they'd never tell you. I said 'Well, I wouldn't make it up, because it's not a nice thing to have had.'" Another said: "I said to one lady what I'd had, and she said that wasn't cancer—it was a growth, perhaps. She was really indignant about it. People are funny. Another lady I mentioned it to could hardly credit it." Another said: "They think I'm romancing." Such is the popular conviction that doctors do not tell the truth to patients with cancer.

Ten patients seen a second time had not spoken of it to their friends.

17. An old woman thought it was all right to be told so long as the condition could be cured. "If you're not told and do get to know it comes as more of a shock." After treatment she did not tell her sister or the people she lived with about it. "I'll see how I go on," she thought, "people are funny." A year later she said she had still kept it to herself. "Well, you see, love, I thought they might shun me."

18. Another did not really believe that she was cured. Asked if she had never heard of anyone cured of cancer, she said very positively: "*Never* in my life, and I can't

really think it can be. . . . Well, the doctor said it was a cure. I said, 'Are you sure, doctor?' and he said 'Yes.' And yet I can't convince myself that nobody can get cured." Speaking of having been afraid, when in hospital a year before, that her friends would get to know that it was the Christie Hospital, she said: "Well, I am now . . . well, I'm like this. If I hear of anyone talking of this place I say I know a friend and they've done well for her—and it's myself all the time. No, I'm too sensitive. I wouldn't like them to think I've had anything like that."

The Family Doctor's Point of View

In 35 cases, after the patient had returned home after treatment, the family doctor was sent a questionary asking: (1) Did the patient discuss with you the diagnosis he was given here? (2) What was his reaction? (3) Your comments.

The majority of patients who, according to our classification, approved of being told the diagnosis did discuss it with their doctor. Four out of five who denied to the interviewer that they were told did not discuss it with their doctor either. In reply to "What was his reaction?" the doctors made such comments as: "Not worried," "Sensible," "Quite philosophic about the whole thing," "Grateful for the information." In no case did the family doctor report an unfavourable reaction to being told. Their comments were: "I feel in this case everything has been gained and nothing lost by telling the patient the exact nature of the lesion." "This patient took the diagnosis well. She will not in future hide any symptoms, and I should think would be less alarmed by any proposed treatment than before." "I approve the policy adopted in early cases like this patient." "I think it a good idea, certainly from the G.P.'s point of view. Most patients of mine who have known the truth have been far easier to deal with and happier."

The Problem of Telling

So far we have been analysing the patients' reactions to having been told. A short comment is also indicated on the experience of the consultants who told these patients their diagnosis.

Medical men are not endowed with special courage, and they have not themselves been insulated from the accumulation of human experience on which the fear of cancer is based. There is therefore a reluctance, variously rationalized, to talk freely to patients about cancer, even when cure presents little problem. However, fortified by the motive of public education, frankness with these patients has become progressively easier with each case, and indeed the customary atmosphere of "therapeutic deception" has been replaced by a refreshing honesty, advantageous to doctor and patient alike.

It was an essential feature of this experiment to tell the patient his diagnosis in the most matter-of-fact way possible, indicating almost in passing that cure was taken for granted. "This ulcer on your tongue, Mr. —, is quite a typical and straightforward cancer, a cancer of the tongue. It's a small one, of course, so we can easily get rid of it for you. Permanent cure of this sort of cancer is not difficult—because you were a very wise man to consult your doctor while the cancer was still so early." Some discussion of treatment follows—how, when, and where.

The immediate reactions of these patients in the out-patient department, where most of them were told their diagnosis, were remarkably placid and forthright, whatever the ultimate finding at the later interview. Some asked for further reassurance as to cure, some about infection of others, or about heredity. Only one or two patients in the entire series reacted there and then with emotional instability. This type of patient can sometimes be spotted beforehand, and would probably be better left in ignorance.

Discussion

There is no doubt that in this country the word cancer connotes incurable disease with distressing and inevitable death. This fact must surely have its origin in experience, and only new experience rather than exhortation and reassurance will alter this conviction. It has long been British medical practice to conceal from patients that they have cancer, with the consequence that the only diseases known as cancers were uncured or untreated ones. The cured cases were scrupulously labelled as anything other than cancer. The effect of this "heads-I-win, tails-you-lose" policy is evident from the incredulity of patients' friends when told the truth. This general ignorance of the very possibility of cure was also shown by an opinion survey in the Manchester area (Paterson and Aitken-Swan, 1954), when 64% of those interviewed did not know that cancer could be cured.

It would seem, therefore, to be an essential part of successful public education on cancer, and in the general interest, that some patients with the more curable types of growth should be told the diagnosis. By the same reasoning those already cured should likewise have the facts presented to them, but by then the effect is much less. If frankness of this sort could be shown, however, to have unexpected and undesirable sequelae then such a policy would have to be abandoned, however good the motive may seem for its continuance. The contrary seems to have been established.

Lack of space limits the full evidence being presented, but extracts have been selected to represent all points of view. So far as can be discovered, two-thirds of the group preferred to know what was wrong. This proportion, naturally, may only measure the success of the consultants' judgment in deciding whom to tell, but the fact remains that they seemed genuinely glad to know. In some cases "telling the diagnosis" had the effect of calming fears, the patient having interpreted silence or reassurance, while being referred to a cancer-treating hospital, as meaning that his case was hopeless. Others felt that to know the truth helped them to fight better, it gave them additional resources to call on, they submitted to treatment in a different spirit, and they worried less.

In a different category are those 7% who claimed to have been upset by the knowledge of their diagnosis. Some of those who denied they were told may also come into this category. In some cases it was said that the frank use of "the word" was what shocked them, rather than fear that they had an incurable disease, which is, of course, of itself indicative of an unhealthy state of public opinion. Some admitted that they would have preferred a lie. Not enough were interviewed later to draw any conclusions about how these patients eventually adjusted to their knowledge, but it seems reasonable to hope that what the word symbolizes to them, and the element of stigma apparently attaching to it, may be modified in time as they continue well and pain-free. From what patients have said, there is clearly more to this reaction than the inability to accept

the consultant's assurance that the condition is curable. Interviewing on a less superficial level would be required in order to learn more about why this group of patients with curable cancers found the knowledge of their diagnosis emotionally intolerable.

The denial reaction merits further study and follow-up. Patients who deny that they were told may be doing so because they did not "take in" what the consultant said. They at least could have had no undue reaction to the unsuccessful offer of truth. They may, on the other hand, have had a shock and not wish to be reminded of it, in which case they are merely denying to the interviewer that they were told. But in some cases they seem to be denying it to themselves as well—the same defensive denial encountered in some patients discussing their delay in seeking advice (Aitken-Swan and Paterson, 1955).

In basing these results upon the patient's own description of his reaction we are very conscious of the deficiencies of the evidence. What is said at an interview is inevitably the product of that particular situation and of the interpersonal relationship achieved by those two people. A low "disapproval" rate could in part measure the interviewer's failure to create the kind of atmosphere in which a diffident patient feels free to speak frankly. Also, misinterpretation is possible in the interviewer's attempt to sense the truth of the emotions behind the patient's words.

Throughout, the emphasis of the study has been on the patient's own words. We have had to omit from our quotations all that does not pertain to the subject under discussion, with a resulting appearance of over-simplification. But the interviews were, in fact, lengthy, and one part added to the understanding of another. Most important, perhaps, patients did not know that we were specially interested in what they had been told, and their freedom in expressing their reactions to this is some measure of success in establishing a friendly atmosphere. Finally, in those cases where the family doctor also reported, it was encouraging to see that, with few exceptions, his comments supported the impression that had already been formed.

Conclusion

It would of course be nonsense in the present state of British public opinion to expect all patients to approve the policy of being told their true diagnosis. If the given figures are accepted what must now be decided is whether a 7% disapproval rate is low enough to justify continuing this practice. Having regard to the very great advantages shown to be gained, both in the medical management of these patients and in public education on cancer, it is considered that 7% is a small premium to pay. It must be remembered, too, that this small group of patients, however critical they may be of the consultant's frankness, have almost certainly had their cancers cured. Moreover, it seems likely that this figure will fall still lower than 7% as public experience grows and public opinion changes.

To conclude, our results find striking support in the words of Dr. V. R. Khanolkar, speaking recently on British television. Discussing the problem of what patients with cancer should be told, he said: "Much against our expectations, shall we say, my colleagues and I were surprised that when the disease is more or less curable the patient has co-operated much more

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willingly when we have told him what the disease is, that something can be done for it, and that there is every hope of it being cured. . . . That is because I believe there is a very large fund of courage and resolution in human minds which we have not accounted for in the past."

Summary

A study is presented of the reactions of 231 selected patients who were told they had curable cancer. Two-thirds said they were glad to know the truth, 19% denied they had been told, while only 7% (all women) resented the consultant's frankness. The family doctors of 35 patients reported no untoward effects of this knowledge and none opposed the general policy of telling such patients their diagnosis.

It is concluded that since a sufficiently large majority of patients are able to accept the truth, and benefit from the knowledge, all patients with the more curable cancers, unless obviously unstable, should be told their diagnosis. This is considered an essential part of public education on cancer, aiming at earlier treatment and higher cure rates.

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To-day's Drugs

With the help of expert contributors we publish below notes on a selection of drugs in current use.

Brontyl (Lloyd-Hamol).—This is 7-(2-β-hydroxypropyl)-theophylline. Tablets of 120 mg. and ampoules of 300 mg. in 2 ml. are available.

The drug has been introduced to overcome the disadvantages of existing theophylline preparations, which arise because of the poor solubility of theophylline in water; this has necessitated administration of theophylline in the form of salts, such as the ethylenediamine salt (aminophylline). Ethylenediamine is itself toxic; moreover, free theophylline is precipitated from such compounds by the stomach acid, causing severe gastric irritation and preventing absorption. The hydroxypropyl derivative dissolves in water to give concentrated heat-stable solutions which are almost neutral. They are less painful when injected, and theophylline is not precipitated in the stomach. Brontyl may be used like theophylline as a bronchodilator, coronary vasodilator, and diuretic. One to four 120-mg. tablets are given 3–4 times a day. The ampoules are intended for intramuscular or intravenous injection in emergencies.

N.H.S. basic price: 100 tabs., 13s. 8d.; 5 ampoules, 6s. 6d.

Secrosteron (British Drug Houses).—This is dimethisterone), or 6α:21-dimethylethisterone, and is supplied in 5-mg. tablets. It is an orally active progestogen which, in comparisons made by animal experiments, has been found to be about twelve times as potent as ethisterone. Its relative potency in the human subject has not yet been accurately determined, and, since some other agents found to be highly active in animals proved to be only weak progestogens in humans, the place of dimethisterone in clinical practice remains to be shown. The manufacturers suggest that the indications for dimethisterone are the usual ones for progestogen therapy, and recommend a dosage of 1–3 tablets daily. However, it is best to review this in the light of any published reports.

N.H.S. basic price: 100 tabs., 75s.