of course, complained of two or even more symptoms, but one in three complained of none at all. Of interest also is that the incidence of monilial vaginitis corresponded closely with that occurring in women in general,[2] though the impression was that (as with loss of libido, headaches, etc.) it occurred much more often in women taking the pill.

When I related to age group and parity (1) the number of patients complaining of no symptoms and (2) the number discontinuing the method because of symptomes the latter generally began to exceed the former after the age of 30, especially in patients with more than one child. These findings equate with the common experience that oral contraceptives seem to suit the yound nullipara better than the older multipara.—I am, etc.,

M. J. V. BULL

Oxford

1 Herzberg, B. N., Draper, K. C., Johnson, A. L., and Nicol, G. C., *British Medical Journal*, 1971, 3, 495.
2 Morris, C. A., *Journal of Clinical Pathology*, 1969, 22, 488.

Corticosteroid Withdrawal in Asthma

SIR,—Beclomethasone dipropionate aerosol has recently been introduced as an alternative to corticosteroids or corticotrophin in patients with asthma. We wish to report two cases which illustrate the possible dangers involved in transferring asthmatics from systemic corticosteroids to the beclomethasone aerosol. One patient was admitted in status asthmaticus and the other developed symptoms of acute adrenal insufficiency.

Case 1.—A woman aged 47 with extrinsic asthma for nine years had been treated with corticotrophin 10-20 units daily for the past two years. She was grossly Cushingoid. Before starting treatment with beclomethasone her plasma cortisol was 11 μg/100 ml and after tetracosactrin stimulation it was more than 30 μg/100 ml. Her asthma was well controlled by beclomethasone and the corticotrophin was withdrawn. Six weeks later she began to wheeze. She had been advised to take her reserve supply of prednisone under these circumstances but she did not do so, as she feared the return of her Cushingoid appearance. Three days later she was admitted, grossly cyanosed, in status asthmaticus; her arterial Po_2 was 24 mm Hg. She had no signs of adrenal failure. After treatment with intravenous hydrocortisone and aminophylline together with antibiotics and oral prednisone she made a slow recovery.

Case 2.—A man aged 23 had had extrinsic asthma for 20 years. He had received prednisone 10 mg daily for eight years. His asthma was satisfactorily controlled on beclomethasone and his prednisone was gradually reduced. While still taking prednisone 10 mg daily his plasma cortisol was 2 μg/100 ml, and after tetracosactrin stimulation it was 3 μg/100 ml. Four weeks after prednisone had been withdrawn he developed a cold. He did not have purulent sputum but he became weak and drowsy. He complained of abdominal discomfort and vomited. On admission to hospital he was confused and had gross muscular weakness. He had no wheeze and his peak flow was unchanged at 400 l./min. He had no abdominal signs. His blood pressure was 110/70 mm Hg (previous readings had been 130/90 mm Hg). His serum sodium was 126 mEq/l. and serum potassium 3·5 mEq/l. His plasma cortisol was 7 μg/100 ml. He received intravenous hydrocortisone and saline and recovered fully within 12 hours.

This report emphasizes the potential problems arising when long-term corticosteroid therapy is discontinued. Our patients receiving beclomethasone are given a reserve supply of prednisone with instructions to use it and contact their doctor immediately if their asthma deteriorates or they feel unwell. In addition, they are told to continue to carry their steroid card together with a letter which mentions the risk of status asthmaticus and adrenal insufficiency. We have also warned their general practitioners that these patients are at special risk.—We are, etc.,

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Paralytic Ileus in Strongyloidiasis

SIR,—It was with great interest I read the account by Dr. J. B. Cookson and others (30 December, p. 771) of a case of strongyloidiasis, though I felt there were some inconsistencies in their report. Although the infestation may well have produced a paralytic (adynamic) obstruction as an end result (as the barium meal and laparotomy findings suggest) it seems that the obstruction was initially dynamic in nature since the patient complained of abdominal pain, and bowel sounds were heard on abdominal auscultation. Clinically, therefore, it would appear that the obstruction was initially dynamic—an enteric paralysis resulting from myenteric fatigue. This is the end-stage of dynamic obstruction of any origin and possibly not a specific immediate effect of strongyloidiasis, as the title of this paper would suggest.—I am, etc.,

M. J. WORLD

Stevenage, Herts

Colleagues in Africa

SIR,—The letter from Dr. A. Barlovatz (16 December, p. 670), who writes after a lifetime of service in Zaire prompts me, a newcomer to the Zairois scene to point out that the picture he gives is certainly *not* uniform throughout the country. His figures underline the grave shortage of medical personnel and the very great need for expatriate doctors for many years to come, and I am sure that no Zairois, whether medical or lay, would like the impression to be given that expatriate doctors are no longer welcome.

Unlike the situation in England, a large proportion of doctors in Zaire work in administrative posts, and it is not surprising that all these should go to national personnel. However, there are many areas like the one served by this Hospital, where I am the only doctor along a 150-mile (240-km) stretch of road with a population of 100,000 people who would "fête" any doctor of whatever nationality willing to serve them. Many such hospitals are now without even *one* doctor (a similar population in England has 150 doctors)—as this one will be unless a replacement is soon found for my furlough.

Of course, there are many problems confronting a foreigner in a newly independent state, even in a mission hospital (the church, too, is newly independent!). However, I can say that never has any Zairois interfered with a clinical decision of mine and not often in a policy decision either. The county authorities have generally been very helpful and only today I received a letter thanking me for the new work we are undertaking against leprosy. The two nearest Zairois doctors have both stayed in our house and there is a cordial relationship. I have also been asked twice to organize elective periods for final-year students from the national medical school, though this has unfortunately not been possible owing to pressure of other commitments.

Zaire cannot offer you a lifetime's career in medicine. Such prospects now must obviously go to Zairois doctors. BUT she *does* offer, in hundreds of places, challenging opportunities to do worthwhile work, immeasurably appreciated by the local population, for short and medium terms and innumerable opportunities for "Burkitt-type" research too. You don't have to publish in Zaire itself!—I am, etc.,

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Toxicity of Benorylate

SIR,—Recently a new antirheumatic medicine, Benoral, was produced and widely advertised as useful for arthritis and allied forms of rheumatism. It contains 40% w/v of benorylate (4-acetamidophenyl O-acetylsalicylate). I prescribed a course in the recommended dosage for 11 of my patients, of whom eight were unable to persist with the treatment because of toxic symptoms. One of three who completed the course derived some benefit from it. The toxic symptoms included a dramatic loss of hearing, tinnitus, nausea, and a feeling of disorientation. These are the classical symptoms of salicylate toxicity and are remarkable only because of the speed with which they occurred and the acute form in which they presented. Several of the patients developed the symptoms after the second dose of Benoral and few could take more than four doses. After they had recovered from their symptoms (in about 48 hours) I persuaded several of them to resume on half doses but all had to stop because of deafness or tinnitus.

I have reported these cases to the manufacturers. It would be valuable to know if others using this preparation have had a similar experience.—I am, etc.,

R. EDGAR HOPE-SIMPSON

Cirencester, Glos.

Cervical Carcinoma in Young Women

SIR,—I would like to report two cases of cervical carcinoma in situ found on routine testing of young women in the past three months in a general practice of 4,000. This high incidence is contrary to the official view that cervical carcinoma is a disease of middle age.

The women are aged 27 and 21 respectively, both are on "the pill," and the first reports showed non-specific inflammation. Although no repeat smear was recommended by the pathologist this was done six months later and carcinoma in situ was reported.