BRITISH MEDICAL JOURNAL

SATURDAY 6 AUGUST 1983

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SUPPLEMENT

NO 6389 BRITISH MEDICAL JOURNAL 1983 VOLUME 287 375-442
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.
WEEKLY. ISSN 0007-1447
ASTM CODEN: BMJOAE 287 (6389) 375-442 (1983)

CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.

Compliance of patients and physicians: experience and lessons from tuberculosis

SIR,—After the recent papers by Dr Wallace Fox on treatment compliance in tuberculosis (2 July, p 33; 9 July, p 101) the following data from our work on control of tuberculosis in refugee camps in Somalia may be of interest. The control of tuberculosis raises certain dilemmas in drug treatment. Because the populations of refugee camps are potentially transient, short course chemotherapy would give more chance of the course being completed in the limited time in which the control services are accessible to the refugees. Against this are: (*a*) the high cost of short course chemotherapy using rifampicin; and (*b*) the need to keep treatment programmes in refugee camps similar to the national programme of the host country.

A standard treatment regimen of a three month intensive phase of streptomycin, isoniazid, and thiacetazone (these last two in the combined drug TB1) followed by a nine month maintenance phase of TB1 was used in the camps. A review of the programme at one year indicated that more than half of 600 patients started on treatment had been lost to follow up, and of those still attending 70 were attending irregularly—12 in the intensive phase, and the remainder in the maintenance phase. Defaulting was defined as missing more than three consecutive days in the intensive phase or more than one week in the maintenance phase.

Drug compliance was investigated in patients regularly collecting their drugs; spot checks were made to determine the number of drugs remaining at a certain day of the weekly cycle. Although 77% of adult patients were correct to within two days, only 43% of children had less than three days' error in drug usage; 27% of children had tablets in their possession indicating more than seven days' error in treatment compliance.

Discussions with medical officers in other refugee camps in Somalia suggested that this dismal picture was common. On the basis of these findings, two different approaches were taken to attempt to increase the effectiveness of the programme, one based on alternative drug regimens, the other on increasing community participation in the programme. The alternative drug regimen was supervised intermittent ambulatory treatment,[1] using biweekly streptomycin and isoniazid. Provisional assessment of progress so far shows little improvement in the effectiveness of the modified programmes.

There clearly do seem to be positive arguments in favour of short course chemotherapy, particularly when even non-defaulters may leave the refugee camp after a limited time. The problems of cost and of relation to the host country's programme of control of tuberculosis will remain constant but may not be insuperable.

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[1] Fox W. The chemotherapy of pulmonary tuberculosis. *Chest* 1979;**765**:7855-965.

Climacteric flushing in a man

SIR,—Hot flushes in men with testicular insufficiency have been well described,[1] as Dr Jean Ginsburg and Ms Barbara O'Reilly point out (23 July, p 262), although they do not mention data that androgen insensitive male pseudohermaphrodites also flush after orchidectomy unless oestrogen treatment is started.[2] Similarly, withdrawal of oestrogen treatment for prostatic carcinoma is associated with hot flushes.[3] This, together with the better known data that women with gonadal dysgenesis and their associated low oestrogen and high gonadotrophin concentrations flush only if oestrogen is given and later stopped,[2] provides strong evidence for climacteric flushing as a sex hormone withdrawal phenomenon.

I recently saw a 35 year old man who presented with flushing secondary to hypothalamic-pituitary rather than primary testicular dysfunction. He had an 18 month history of hot flushes that occurred up to 10 times a day and subjectively lasted about five minutes. They were of classic menopausal nature—sudden onset of a feeling of warmth over the upper body, flushing of the face, and sweating. At the same time the patient had noticed a diminution of libido and loss of spontaneous or stimulated erections. He had also started to lose body hair and noticed diminished growth of his beard.

On examination he had evidence of hypogonadism with loss of pubic and axillary hair and very soft testes that were 12 ml in volume. Endocrine investigation confirmed his hypogonadism with a testosterone concentration of 8·9 nmol/l (2·5 ng/ml), and inappropriately low gonadotrophin concentrations: luteinising hormone 1·0 U/l, follicle stimulating hormone 0·5 U/l. There was also a poor luteinising hormone response to 100 μg luteinising hormone releasing