operation. The tea goes into the drainage bag, but the pleasure of it going down is not lightly to be dismissed. Total cystectomy, which in my experience is followed by at least 4-5 days ileus, is now my most common reason for gastrostomy. To have a tube down your nose for so long is intolerable, and if removed prematurely it must be replaced. With a gastrostomy the nurse has only to empty the bag when full and measure the contents and to insert or remove a spigot. Ward sisters always say a gastrostomy causes less work.

I have seen no complication clearly and directly attributable to gastrostomy. I believe gastrostomy increases safety by efficiently and quickly removing swallowed air which would otherwise pass into the small bowel. The advantages here are obvious—particularly when a bad aerophagist is seen blowing up the bag like a balloon. I am aware of three disadvantages to gastrostomy. Firstly, though it can be performed under local anaesthetic at any time it is preferable to insert the tube at the time of operation. Thus gastrostomy may be used more often than is strictly necessary. Secondly, I prefer to leave the tube in situ for 10 days. This means that the patient could spend an extra day or two in hospital. Thirdly, if the patient drinks large amounts immediately after operation there may be a fairly large loss of potassium. This has to be borne in mind when planning the intravenous therapy.

I believe that there is no longer any case for adding nasogastric aspiration to the discomforts of operation.—I am, etc.,

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Dangerous Patients

SIR,—There is little doubt that it is that part of the Mental Health Act, 1959, dealing with restricted patients which causes psychiatrists working in conventional hospitals most trouble and concern. Doctors treating mentally disturbed offenders have an intense dislike of restriction orders and it is a truism that these orders restrict doctors as well as their patients.

In your forthright and perceptive leading article (3 February, p. 247) on the Aarvold Report,[1] you imply that all patients subjected to special restrictions as imposed by sections 60/65 are dangerous. In fact this is not always so. Indeed, one of my patients was placed on a restriction order, without limit of time, as the result of being found guilty of a minor offence of theft. This man was classified as severely subnormal and was very simple and quiet, but was rather gullible and had been induced by his co-offenders to stand watch while they actually stole some material. However, he had been convicted by the same court on two previous occasions and one can only assume that he was placed on a restriction order because the court thought him to be a nuisance to society rather than a menace. This in practice is becoming so commonplace that one is reluctant to recommend a section 60 order in certain cases because of the fear that the court will add on a section 65 order. It should therefore be possible for the doctor to state in his report to the court whether or not he is prepared to treat the offender in his hospital under section 65, and also he should be able to advise the judge as to the length of time the restriction order should remain in force, if the court feels that a restriction order is essential for the protection of the public.

With regard to patients granted conditional discharge, the position can become quite ludicrous. For instance, one of my patients classified as subnormal was placed on conditional discharge in September 1971. In November 1972 he pleaded guilty to various offences and was sentenced to 12 months imprisonment. Both I and the prison medical officer reported to the court that he could no longer be considered to be subnormal within the meaning of the Mental Health Act, and he was consequently dealt with by the normal processes of law. However, this man is still on conditional discharge and so after he has served his sentence he could be returned to hospital. We shall then have the ridiculous position of the responsible medical officer having to treat a person as subnormal in spite of the fact that he has previously reported that he is no longer suffering from this condition. In cases such as this, I believe that the conditionally discharged patient should be discharged absolutely.

Last year I drew attention[2] to the divergence of opinion with regard to the interpretation of a part of the Mental Health Act. In this letter I have pointed out further aspects of the working of the Act which require clarification. No doubt other psychiatrists will have formed their own views about sections of the Mental Health Act which require alteration. I therefore feel that now is an opportune time for a complete review of the Mental Health Act.—I am, etc.,

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1 Home Office *Report on the Review of Procedures for the Discharge and Supervision of Psychiatric Patients Subject to Special Restrictions*, Cmnd. 5191. London, H.M.S.O., 1973.
2 Roith, A. I., *Lancet*, 1972, **1**, 1389.

Working of the Mental Health Act

SIR,—The letter from Mr. J. A. Cooke (3 February, p. 292) is not clear on all details, and I wonder if I might put the following points, which I would consider axiomatic.

(1) Though the four specific types of mental disorder described in section 4 of the Mental Health Act 1959 and used for orders under section 26 are separate and distinguishable, there is nothing to stop a clinician using any two of them at the same time. Indeed, clinicians regularly combine "subnormality" and "psychopathic disorder" —not only for the purpose of section 26 but also for that of section 60.

(2) Ever since the Act came into being clinicians have regarded mental disorder resulting from organic disease of the brain, including brain damage, as constituting "mental illness," a term which, as Mr. Cooke says, is undefined in the Act and therefore designed to be pliable.

(3) If this condition secondary to brain damage or other organic disease is mainly manifested by "seriously irresponsible conduct," I can see no reason why the section 26 or section 60 medical recommendation should not be on the ground of "mental illness combined with psychopathic disorder." The order would indicate that the patient had been made mentally ill by the organic disease but that his illness was mainly appearing in the form of a disturbance of personality rather than as notable dementia.

I am sure in fact that no mental disorder secondary to such organic disease can occur without there being a degree of dementia which would make the use of the term "mental illness" still more justifiable.

(4) Provided that the diagnosis of "mental illness" preceded that of "psychopathic disorder" on the recommendation, the clause under "psychopathic disorder" whereby a person cannot be detained beyond the age of 21 would not apply.

I hope that what I am saying is in accord with the rather obscure last paragraph of Mr. Cooke's letter. Indeed, I think it could be argued that a simple classification of "mental illness" in the sort of case in question could not be used without the addition of the words "or psychopathic disorder," even when personality disturbance was the main feature of the condition. If, however, the clinician has doubts, I cannot see why he need stop using both. In this connexion, I have just seen a woman in her late sixties who, after a stroke, has become an alcoholic, a compulsive stealer of drugs and generally disinhibited in behaviour, grossly egocentric, and quite insouciant. It is likely that she will soon need to be in hospital under section 26 of the Act and I have no doubt that the classification of "mental illness" will properly apply to her.—I am, etc.,

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Myocardial Infarction and Pulmonary Thromboembolism

SIR,—Dr. Helen H. Tucker and her colleagues (6 January, p. 10) report a low clinical incidence of pulmonary embolism in their group of patients who were mobilized in the first few days after their myocardial infarction. Their reported incidence is probably an underestimate.[1] Immobility is the commonest single cause of venous thrombosis.[2] While early mobilization would be expected to reduce the incidence of this condition, it has been well documented[3] that most thrombotic episodes occur during the first few hours of immobility.

In Dr. Tucker's series, as in others, there was a high mortality rate in patients who developed atrial fibrillation after myocardial infarction. This may be because a pulmonary embolus caused the arrhythmia. A cardiac arrhythmia may be the only manifestation of pulmonary embolization.[4] We have studied six patients whose principal objective abnormality was a cardiac arrhythmia and in whom the presence of pulmonary embolism was demonstrated angiographically.

Unexplained dyspnoea is used as an indication for the treatment of cardiac failure by Dr. Tucker and her colleagues. It is likely that at least in some of these cases pulmonary embolism accounts for this symptom. It is well known that pulmonary emboli do not necessarily cause any radiographic or electrocardiographic abnormality and that the clinical diagnosis of venous thrombosis is very inaccurate.

There is a tendency to attribute any cardiorespiratory abnormality occurring in