deemed adequate, without definition of the circumstances, which might be, for all one can tell, during attendance as an out-patient. It does seem strange that, during such a "rigidly designed and strictly controlled" trial, one of the control group should have "died suddenly at home before completion of treatment"; or that histological confirmation of the disease at biopsy has not been offered in either the control or treatment group.

Objective serum-enzyme assay can scarcely be replaced by muscle-strength measurements, admittedly crude and subjective, and even then with no attempt to assess the pelvic girdle musculature so characteristically affected in this condition. Nor can these findings be submitted for valid statistical analysis, since the authors have confounded the type of treatment with the mode of administration, the latter implying obvious immobility for intravenous infusion in one group but not for the oral placebo in the other, physical differences additionally capable of influencing muscle power in the dystrophic child. Invocation of Bradford Hill's approval[11] of the M.R.C. Streptomycin Trial cannot restore double-blind status, since here the question of five-day intravenous infusions never arose; nor can dressings on an intact arm suddenly confer all the variables such an infusion must introduce, to say nothing of the extra variables on muscle-strength testing due to differences in the dressings themselves. Further, in a disease capable of much ill-defined individual variation, a control group of ten is much too small a sample for adequate statistical treatment. It is surely more scientific to avoid these numerous pitfalls by realizing that in some diseases the use of multiple objective parameters with the patient as his own control has proved accurate, valid, and rewarding in therapeutic and metabolic investigations.[12]—I am, etc.,

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Addiction to Dextromoramide

SIR,—I wish to report a case of addiction to Palfium (dextromoramide), which I believe to be of rare occurrence.

A male patient, aged 61, developed severe pain in back and down the left sciatic nerve in January 1963. *X*-ray showed gross narrowing of L 5–S 1 disk space, with some narrowing of other lumbar disk spaces also. Paracetamol tablets were prescribed for analgesia but failed to ease the pain and Palfium tablets were prescribed. He reached the stage of taking 50 Palfium tablets per week, and had been doing so from June 1963 until April 1964, when he found himself quite unable to stop his tablets for more than a few hours. I then tackled him about this large dose and told him he was addicted to them and that he must cease taking them. He stated that he wished to be helped and was prepared to co-operate fully. I referred him to the Bethlem Royal Hospital and the Maudsley Hospital and he was admitted on 10 May 1964, where the dextromoramide tablets were stopped abruptly and he was heavily sedated with chlorpromazine 200 mg. tablets and sodium amytal 3 gr. (192 mg.) every four hours. He developed quite severe withdrawal symptoms. Within a few hours he became extremely agitated and tense, complaining of "twitchings" in all four limbs and pacing restlessly up and down, smoking continuously. He remained extremely miserable for 24 hours, but his symptoms had largely subsided within 48 hours and did not recur even when all his sedatives were stopped. He was discharged home on 29 May. He has not required any tablets since and has remained symptom-free and is delighted that he is no longer an addict.

—I am, etc.,

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Propranolol for Angina

SIR,—Dr. R. Mulcahy (10 October, p. 942) seems to attribute to us a more sanguine view of our findings of the effect of propranolol (19 September, p. 720) than expressed in our summary, in which we state "this study suggests that beta-adrenergic blockade may be helpful in angina pectoris." In planning the trial we considered the possibility of a "second wind" effect leading to an increase in exercise tolerance, as suggested by Dr. Mulcahy. However, we felt that an interval of from 30 to 50 minutes between the exercise tests was sufficient to preclude this type of response.

We were led to report our results by the finding that any striking increase in exercise tolerance was confined to the patients limited by angina during the test. The absence of major improvement in other patients suggested that any favourable effect from the therapeutic suggestion of an intravenous injection was outweighed by the effort required to exercise to the limit of tolerance for a second time within an hour. In these circumstances we feel that our tentative conclusions as to the possibility of benefit from the drug were justified.

Subsequent work in seven patients with seriously impaired exercise tolerance has, in fact, shown that a saline injection is followed by an average increase in exercise tolerance of only 6%, a response similar to that found after propranolol in patients who were not limited by angina.—We are, etc.,

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Sarcoidosis of the Parotid

SIR,—I have recently had occasion to review our experience of inflammatory conditions of the parotid in the department of surgical studies at the Middlesex Hospital, and I was therefore particularly interested in the article by Dr. G. Greenberg and others (3 October, p. 861) on enlargement of the parotid gland due to sarcoidosis. In an analysis of 120 cases we found two examples of sarcoid, one presenting as a lump simulating a tumour, the true diagnosis not being suspected until a routine pre-operative chest *x*-ray was taken, the other being an incidental histological finding in the wall of a cyst removed by operation. Neither showed the clinical features of inflammation, and so much is this our experience that we warn against a common tendency to raise the diagnosis of sarcoid too readily as a cause of parotitis. It would be interesting to know in how many of Dr. Greenberg and her colleagues' patients the parotid was the primary presenting condition, and in how many of these the clinical symptoms were inflammatory rather than the development of a diffuse or localized inert swelling.—I am, etc.,

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Professional Patients

SIR,—The term professional patient requires elaboration. The patients described by Dr. T. L. Dunn (3 October, p. 879) share some features in common with cases of hospital addiction. This is a well-documented condition in the medical[1-4] and lay press.

In his concept of "Illness as a Hobby," Dr. Richard Asher (who introduced the term Munchausen syndrome[5]) has proposed a spectacular but realistic practical classification of some of the commoner types of perennial patients[6]:

(1) *The "serious self-student"*: not necessarily a hypochondriac; e.g., the T.B. patient knowledgeable about pneumoperitoneums, artificial pneumothoraxes, and phrenic crushes.

(2) *The rich hypochondriac*: grand-tour type who consults eminent specialists throughout the world.

(3) *The poor hypochondriac*: perpetual out-patient.

(4) *The pharmaceutical collector.*

(5) *The faddist apostolic*: visits a "little man" who is "just off" some street seeking royal jelly,[7] acupuncture, wholemeal, etc.

(6) *The lonely person*: chat with doctor plus glass of medicine (equivalent to chat with landlord plus glass of beer).

(7) *Sufferers from chronic autogenous disease*: e.g., anorexia nervosa, dermatitis artefacta, and Munchausen syndrome.

(8) *Genuine malingerers.*

The alleged increasing abuse of psychiatric services by professional patients is a problem requiring cautious interpretation, for it may be more apparent than real. Furthermore, all the above types of patients are world-wide and existed long before 1948, which precludes them from being merely "products of the extension of social and psychiatric services under the National Health Service." The patients Dr. Dunn describes are undoubtedly true malingerers; the implications of this are that we should make our psychiatric hospitals less comfortable and less attractive than at present and less freely available, to discourage those people from taking advantage of us. This is obviously unthinkable. I suspect, however, that the majority are motivated by more subtle considerations and fall into the categories 1–7.

The alleged increasing abuse of psychiatric services by professional patients is a problem

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