

Correspondence

Letters to the Editor should not exceed 500 words.

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Treatment of the Phobic Anxiety State

SIR,—The large number of patients involved and the severely incapacitating nature of their illness make your recent articles on phobic anxiety state welcome and valuable (22 February, p. 489; 1 March, p. 559; and 8 March, p. 619). I doubt, however, whether it is fully realized how many patients continue to suffer anything from 10 to 40 years with these distressing symptoms. Until recently there was little hope of relief by ordinary psychotherapy and social treatment methods. Fortunately the whole outlook regarding treatment has changed for the better since the introduction of monoamine-oxidase inhibitor drugs¹ and the advent of behaviour therapy, both of which are considered favourably in these articles. I feel, however, that the authors can be criticized for making the whole subject of treatment unnecessarily complicated.

On going through our hospital and other records, my colleagues and I at St. Thomas's and elsewhere find that we have treated between us over 450 patients with phobic anxiety states in the last few years. Most have been treated with monoamine-oxidase inhibitor drugs. What started as a trickle of patients has now become a veritable torrent. They are apparently being sent by fellow sufferers who have themselves received relief, or by doctors who have seen other patients get better with, but are themselves nervous about, prescribing the monoamine-oxidase inhibitor drugs.

We hope to publish shortly a detailed analysis of over 200 of these patients who have been followed up for a year or more. About 80% of them are improved, and this includes some who had been ill for between 20 and 30 years. If the anxiety states are accompanied by normal sleep pattern only monoamine-oxidase inhibitor drugs are required, and occasionally chlordiazepoxide. If the patient's sleep is impaired, speci-

ally by early morning waking, then we consider that monoamine-oxidase inhibitor drugs should be given during the day and a tricyclic antidepressant should also be given in the evening to try and get a return to normal sleep pattern. Very little psychotherapy has been required.

The patients, however, must be strongly encouraged to tackle the phobic situations while the somatic effects of anxiety are being damped down by the monoamine-oxidase inhibitor drugs. Treatment with drugs may also have to be continued for up to five years or more in some of these patients. But as they may be ill for over 30 years without them this fact must be seen in the proper clinical treatment perspective. As already emphasized by Frommer^{2,3} children with phobic anxiety states seem to respond to the monoamine-oxidase inhibitor drugs just as well as adults, and because of their obsessional natures are often more careful than adults about not taking cheese, etc. No problems have arisen in the skilled use of the monoamine-oxidase inhibitor drugs in children, and we have over 50 of them helped in our series to be published shortly.

Despite what the writers of these articles say, we continue to find it safe to combine a monoamine-oxidase inhibitor drug during the day with a tricyclic drug at night in properly adjusted dosages. And if this only is done many more patients are helped. In fact, if a lot more monoamine-oxidase inhibitor drugs with added tricyclics were to be given to these severely suffering and incapacitated patients with phobic anxiety states, and much less potentially addictive and dangerous sedatives, hundreds of patients all over the country could be helped by ordinary general practitioners with very little need for all the other treatments mentioned in these three articles. There will, however, be a number of patients with specific phobias, and much less free-floating anxiety, who will be greatly helped by the additional use of behaviour therapy. But the monoamine-

oxidase-inhibitor drugs should be tried first as they are so much simpler to use.—I am, etc.,

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- Frommer, E. A., *British Medical Journal*, 1967, 1, 729.

Nature of Osteopetrosis

SIR,—I have read with interest your article on the management of metabolic bone disease (8 March, p. 621). I would like to comment on the statements concerning generalized osteosclerosis (osteopetrosis). These have over the years been repeated almost word for word from one book or article to another, and are quite incorrect. During the last few years I have had the opportunity of examining histological sections from a number of cases in Britain, as well as the collection available at the Armed Forces Institute of Pathology in Washington.

As stated in your article, bone formation is normal, but in so far as cell behaviour is concerned bone resorption and remodelling are also normal. The cortical bone, owing to a hindered blood supply, is often somewhat porotic, so that frequently a larger number of osteoclasts than normal may be observed. The lesion is in the organic intercellular matrix of the growth cartilage. This becomes more heavily calcified than normal, and the calcified cartilage then resists all normal resorption processes, remains permanently in the bone, and so causes morphological disturbances. It is the presence of this excess

of calcified cartilage together with somewhat porotic bone that causes these bones to be rather more brittle than usual. The contrast between the abnormal enchondral ossification and normal periosteal ossification has been demonstrated on a number of occasions in radiographs of the spine, where vertical sectors of vertebrae are formed by the enchondral and lateral sectors by the periosteal mechanism.

Since the underlying biochemical defect is in the organic matrix of the growth cartilage, this is unaffected by a diet severely restricted in calcium, although patients may suffer other metabolic disturbances as a result of the unbalanced diet.—I am, etc.,

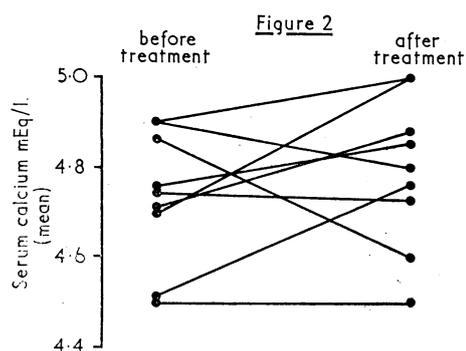
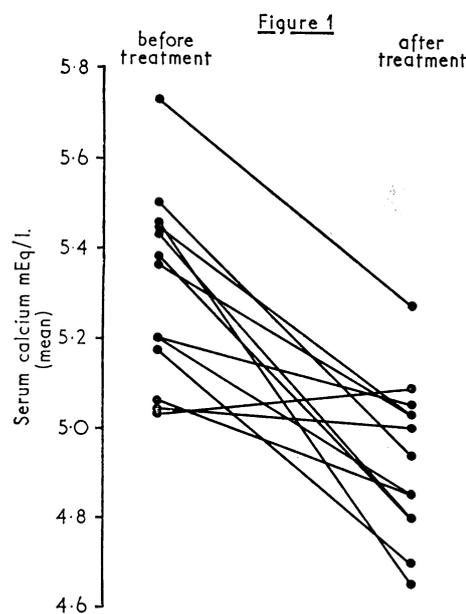
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Calcium Metabolism in Acromegaly

SIR,—After reading the paper by Dr. A. Nadarajah and colleagues on calcium metabolism in acromegaly (28 December, p. 797), we reviewed the records of 29 acromegalics evaluated in our hospitals.

Twenty-two patients had serum calcium determinations at variable times before and after therapy (radiation, cryohypophysectomy, or surgical hypophysectomy). Of the 13 patients who had a mean serum calcium above 5 mEq/l., all but one showed a decrease after therapy (Fig. 1). The decrease was greater than 0.2 mEq/l.



in all but two patients. The nine patients who had mean serum calciums less than 5 mEq/l. showed no consistent change after therapy (Fig. 2). Serum phosphate showed no consistent pattern in either group. Because of the small number of patients in each group, no attempt was made to separate those that had a good response to treatment from those that did not respond. A rough estimate of the duration of acromegaly in all 29 patients was made by calculating the length of time any symptoms attributable to acromegaly were present prior to diagnosis. In the group with calcium above 5 mEq/l. the mean duration was 10 years and in the other it was 5.5 years. A non-paired *t* test revealed $P < 0.1$.

We feel that a likely explanation for these results is that excess growth hormone secretion in some patients causes parathyroid hyperplasia and possibly adenoma formation. Their glands secrete excess parathyroid hormone, resulting in high normal or even elevated serum calcium levels. Serum phosphate is variable because of the opposing effects of growth hormone and parathyroid hormone on renal phosphate excretion. Successful treatment of acromegaly may result in a fall in serum calcium levels which were high normal or greater before therapy, and may be another useful index of response to treatment. Duration of the disease along with severity probably are the main factors which influence calcium metabolism in acromegaly.—We are, etc.,

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Scientific Terminology

SIR,—The undersigned members of the Council of the British Veterinary Zoological Society would like to make a plea to medical graduates and all other scientific workers to use in publications the internationally accepted scientific names of animals and plants. It is rarely essential to use these names, which are normally derived from Latin or Greek, when referring to man and domestic animals, but very important when referring to exotic laboratory animals and wild species.

Many medical and veterinary schools fail to make known to students the importance of the systematic scientific classification of animals and plants which was originally devised by Linnaeus, the famous Swedish naturalist, in 1758. The result is that most members of both professions are unaware of the principles and conventions of taxonomy. In publications they frequently fail to identify accurately the host and use only the common name such as "mouse," "bat," etc., although they may be scrupulous in quoting the scientific names of bacteria or other parasites infecting the animal. This use of the vernacular names only is to be deplored. The practice is unscientific and leads to a great deal of confusion, especially when foreigners endeavour to translate a language with which they are unfamiliar. Frequently there is more than one vernacular name for a species, and often several species may share the same common

name. The officers of this society would like to recommend that in all medical publications the scientific names of species or groups of animals should be given and included in the title wherever necessary.

In conclusion, we should like to draw the attention of the profession to the publication entitled *International Code of Zoological Nomenclature Adopted by the XVth International Congress of Zoology*, by Stoll *et al.*¹—We are, etc.,

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REFERENCE

- ¹ Stoll, N. R., Dollfus, R. Ph., Forest, J., Riley, N. D., Sabrosky, C. W., Wright, C. W., and Melville, R. V., *International Code of Zoological Nomenclature adopted by the XVth International Congress of Zoology, 1964*. London, The International Commission of Zoological Nomenclature by the International Trust for Zoological Nomenclature.

Abortion Act in Practice

SIR,—The Abortion Act 1967 is permissive in that what was previously an offence is no longer so when two registered medical practitioners in good faith decide that an abortion is justified according to the criteria laid down in the Act. It does not allow abortion, as your correspondent Dr. J. H. Hughes (8 March, p. 637) states, because women "become pregnant at the wrong time." This interpretation may well be contrary to acting "in good faith," which, in the medical sense—and it can only be in the medical sense—means a thorough appraisal of the situation, a knowledge of the literature on the subject, and an awareness of improvements in medical treatment and social measures which could influence the decision. It does not mean acting in wilful ignorance.

The Act does not give Dr. Hughes the right to castigate those psychiatrists who, acting "in good faith," are seriously in doubt as to whether an abortion is justified, and for good reasons know that support and treatment would be at least as effective as abortion in dealing with the problem be it social or medical. They have ample clinical evidence to support the "good faith" of their decisions and the law does not even require them to attest. It would be of great interest to see what factual evidence could be produced to support the many decisions to abort under the present Act. Those who advocate abortion and who ignore the massive evidence on what happens when the pregnancy is allowed to continue may not be challenged, because in this country a doctor's "good faith" is rarely questioned. It could be questioned if doctors who perform the abortions have their services advertised, accept uncritically all the certificates sent to them, and charge fees. Similarly the doctor who signs the original