from the G.M.C.'s registrar to the B.M.A. that the annual retention fee would have to go up—by an amount unspecified—failed to provoke the brisk reaction that might have been expected. No doubt inflation psychology had effected the representatives because they also accepted a rise in the B.M.A. subscription to £21 with barely a murmur.

In a responsible debate on medical confidentiality the speakers tried to stick to principles, and after the platform had repelled several amendments the Council's advice to doctors that they should respect the patient's wishes on confidentiality was approved. The relationship between doctors and social workers on confidentiality of patients' medical records is at present worrying the profession, and this too was debated. This matter will require careful consideration by both groups if patients' interests are not to be adversely affected.

The contribution the B.M.A. makes to scientific and social medicine was reflected in the wide range of the debate on the activities of the Board of Science and Education, a part of the meeting which, as always, attracted much press interest. Euthanasia was once again rejected, the board's proposals to reduce smoking supported, and an inquiry into A.I.D. agreed upon. Sir Ronald Tunbridge spoke about the Board's recent report on abortion and its much publicized reference to the age of consent, and he emphasized that it was not B.M.A. policy that the age should be changed. The meeting decided that the prescribing of amphetamines should not be compulsorily banned nor that these drugs should be available only from hospital pharmacists. However, a recommendation to include barbiturates under the Misuse of Drugs Bill was approved.

The Special Representative Meeting, which followed the A.R.M., broadly approved the Council's reports[2] on the Industrial Relations Bill and on N.H.S. reorganization. On the first subject Dr. Ronald Gibson reported the B.M.A.'s success in persuading the Government to make special provision for the professions in the new legislation, and the Council was given a free hand by the S.R.M. to apply for the B.M.A.'s admission to the special register under the Industrial Relations Act at the appropriate time. This can now be done without change in the B.M.A.'s status or character, and it seems likely that negotiations for doctors in the N.H.S. will continue along established and well-tried channels.

There were no real surprises in the debate on N.H.S. reform, the Representative Body strengthening the Council's proposals here and there but not altering the main lines of policy. On the subject of finance, the S.R.M. wanted the Government to provide "large amounts of extra money forthwith" to rectify some of the Service's more "glaring defects." The representatives deplored the absence from the Consultative Document of any reference to improving the standard of care of the patient. As in the Council and its standing committees the emphasis on management caused much anxiety among speakers, and this understandably prompted the request for full professional representation in the regional and area health authorities and for strong statutory professional advisory machinery at these levels.

The timetable set by the Government for receiving comments on its proposals was criticized, but Sir Keith Joseph had assured the B.M.A., Dr. Gibson said, that the views of the Representative Body would be "taken fully into account" in preparing a White Paper.

[1] *British Medical Journal Supplement*, 1971, 1, 55.
[2] *British Medical Journal Supplement*, 1971, 3, 1.

Temporal Lobe Epilepsy

Though the term temporal lobe epilepsy was first used by W. G. Lennox,[1] it was derived from Kinnear Wilson's earlier concept of "temporal epilepsy".[2] The temporal lobe is the part of the brain which lies below the Sylvian fissure, and its most medial and deep portion includes the hippocampal region with the uncus, the hippocampus itself (Ammon's horn), and the amygdala. This area is concerned not only with smell but also with the autonomic nervous system, visceral sensation and motor activity, and possibly certain aspects of memory. S. Currie and his colleagues[3] at the London Hospital have recently reviewed a relatively unselected group of no fewer than 666 patients with temporal lobe epilepsy followed for an average of seven years. Since our knowledge of the natural history of this illness is scanty, this thorough study is particularly welcome.

Currie and his colleagues found that attacks with nocturnal fits—which is often thought to be characteristic of temporal lobe epilepsy—occurred in only 5%. Viscereal symptoms were the commonest type, occurring in 40%, while déjà vu was reported in only 14%. Though it is often held that abnormal sensations of smell and taste are common in this condition, they found that visual (18% of all cases) and auditory (16%) symptoms occurred much more frequently than olfactory (12%) or gustatory (3%) symptoms. Moreover, there was also a relatively low incidence of psychiatric disorders compared with other series[4-6]—probably reflecting the relatively unselected nature of their series. Abnormal physical signs occurred in only 3% of patients; 92% had definite foci on the electroencephalogram and 6% ill-defined foci. Finally, 11% had a family history of epilepsy, 7% a history of a birth injury or an abnormal birth, and 5% had had seizures in infancy.

The London Hospital group's conclusion that temporal lobe epilepsy is a disorder with a later age of onset (average 28 years) than has previously been recorded is probably influenced by the fact that very few children were referred to them. In their series those whose epilepsy began under the age of 10 years were not seen for the first time until an average of 15 years later, and when epilepsy began between 10 and 15 the first attendance was not until roughly 10 years later. This is important as children may have epilepsy for several years before the attacks become typical of temporal lobe epilepsy and before the electroencephalogram shows a definite focus in the temporal lobe.[5 7 8]

Follow-up of the 666 patients showed that 73% had improved and that 40% were free from attacks. Of those of working age, 88% were in employment, while most of the remainder had psychiatric disorders and were not disabled by epilepsy. Hence Currie and his colleagues concluded that temporal lobe epilepsy has a relatively good prognosis. Moreover, their findings suggest that surgery is not often needed for this type of epilepsy because the main indication for surgery is the failure to control the attacks by medical means sufficiently for the patient to lead a relatively normal life. In fact, only 62 patients underwent lobectomy, most of whom had had epilepsy from before the age of 15. Fifty-four of the 666 patients died; in 42 death was related to the epilepsy, being due to an underlying cerebral tumour in 30 patients, but only seven died during or as a direct result of a seizure.

It is of special interest that only one patient examined at necropsy had mesial temporal sclerosis (that is, loss of nerve cells and glial scarring affecting not only Ammon's horn but

also the rest of the hippocampal region[9]), whereas this lesion was found in 18 out of 62 undergoing surgery; a high incidence at operation has also been reported by J. R. Green[10] and M. A. Falconer and colleagues.[12] A tumour is the second commonest lesion found at operation. This was present in 18% of the patients studied by Currie and his colleagues,[3 11] a similar proportion to that in other series.[10 12] Usually these tumours are small (or "cryptic") and produce no focal clinical signs. They consist of small glial malformations, slowly growing gliomas, or occasionally angiomas.

The outcome of surgical treatment in temporal lobe epilepsy is best when mesial temporal sclerosis is present. J. H. Margerison and J. A. N. Corsellis[13] found a very strong correlation between clinical temporal lobe epilepsy, a temporal lobe focus on the electroencephalogram, and mesial temporal sclerosis. The cause of mesial temporal sclerosis is not known for certain, but any theory of its origin has to explain the known familial incidence of epilepsy. It is known, however, that children with a family history of epilepsy are much more liable to suffer from status epilepticus or a febrile convulsion in childhood, and possibly the consequent anoxia and hyperthermia might lead to mesial temporal sclerosis.[7 10] This theory has received some experimental support from the production of mesial temporal sclerosis in guinea-pigs under conditions of hypoxia and hyperthermia.[14]

Hence, though a few patients with temporal lobe epilepsy are disabled (more often by psychiatric problems than by epilepsy), for the majority the prognosis is good. In selected patients, moreover, surgery can often produce a definite improvement.

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[6] James, I. P., *Journal of Mental Science*, 1960, **106**, 543.
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[11] Northfield, D. W. C., in *Second Symposium on Advanced Medicine*, ed. J. R. Trounce, p. 161. London, Pitman Medical, 1966.
[12] Falconer, M. A., Serafetinides, E. A., and Corsellis, J. A. N., *Archives of Neurology*, 1964, **10**, 233.
[13] Margerison, J. H., and Corsellis, J. A. N., *Brain*, 1966, **89**, 499.
[14] McLardy, T., *Nature*, 1969, **221**, 877.

Transatlantic Debate on Addiction

The British and the Americans have for long taken an interest in each other's drug problems.[1-5] At times cousinly comment has been distinctly acerbic. As long ago as 1920, when the Dangerous Drugs Act was first introduced, Captain Walter Elliot commented during the course of a Parliamentary debate that to follow the American model of narcotics prohibition would be to court disaster. He went on to stigmatize the Americans as "barbarians". "I do not think that it is too strong a phrase to use of people who have such an extraordinary savage idea of stamping out all people who happen to disagree with their particular views."[6]

The traffic in tart comment has been two-way. D. P. Ausubel, in curtly dismissing the relevance of British experience to the American scene, denounced the practice of legalized prescribing of heroin as "the epitome of amoral expediency".[7] The most recent contribution in this genre has come from the U.S. Attorney General,[8] who denounced the British approach as "surrender."

A thoughtful American contribution to serious debate now comes from F. B. Glaser and J. C. Ball.[9] They suggest that a simple historical reason for the United States having chosen a style of response characterized by emphasis on enforcement policies, while Britain in contrast chose to permit legalized prescribing of heroin and left much in the hands of the doctors, lay in the relative size of the narcotic problems in the two countries 50 or so years ago. They state that in 1913 the U.S.A. had some 782,118 addicts[10] and contend that the corresponding prevalence in the U.K. was in comparison "negligible." Surprisingly, no one seems in fact ever to have attempted the task of historical reconstruction which would be involved in providing an estimate of the United Kingdom's prevalence at the comparable period. Perhaps Glaser and Ball's contention will set some scholar to work. The general assertion that this country's problem was in the early part of this century smaller than America's would probably in the event be amply substantiated, and yet in the nineteenth century opium addiction was endemic in some parts of Britain.[11]

Glaser and Ball then describe the workings of the present British system, and are perhaps being a little too arbitrary when they state that the system is a "myth." A system which leaves much to the individual doctor, which leaves many matters undefined, is as much a system as one which is based on tightly defined legislative controls. To suggest then as these authors do that "the British . . . have moved in a direction similar to the United States" is an incomplete interpretation of recent developments, and one which incidentally invites us to overlook what are still profound differences in emphasis. To suppose that the British prescribing system was discredited by the alarming growth in heroin addiction in the 1960s,[12 13] and thereafter abandoned, would be a considerable misreading of history. The same essential policy is being maintained as heretofore, with the difference that prescribing is limited to specially approved doctors operating from specified clinics and with notification now compulsory.[14] This issue should not be clouded. The British response still permits the prescribing of heroin and still gives central responsibility to the individual physician. And without undue complacency it may be claimed that this policy seems to have had some real success in containing what threatened to be an explosive epidemic.

Glaser and Ball then go on to discuss the British system for "registration", or notification, of narcotic addicts. They look on this feature of our response with particular favour, and see it as the one certain transferable lesson. American policies have always been hampered by inability to monitor impact of legislation on prevalence of addiction. Home Office records in Britain have provided a useful if somewhat rough-and-ready basis for framing and monitoring policy decisions. The American commentators must here find themselves in something of a dilemma, for the prescribing clinics provide the essential basis for the recording system. However, the weakness of our records is overlooked. We are without adequate information on the prevalence of barbiturate or amphetamine injection, and in an era