the press, the journals, and the vaccine manufacturers with the approach of the Hong Kong strain to inoculate high-risk groups, institutions, etc.

I am now in my eleventh year of egg albumen sensitivity following that inoculation. Coping with an egg allergy is a perpetual problem, and eggless cookery is a trial for any wife. The new Hong Kong vaccine is also grown on eggs.—I am, etc.,

East Malling, Kent. N. NAUNTON DAVIES.

Pain in the Face

SIR,—Mr. Julien C. Taylor's dismissal of partial trigeminal root section as a significant measure in the treatment of trigeminal neuralgia (5 October, p. 55) cannot be allowed to pass unchallenged. He objects to Professor Henry Miller's description of the recurrence rate after this operation as "small." A review of the voluminous literature on the results of partial trigeminal root section by the temporal approach shows that the recurrence rate is between 3%[1] and 8.5%.[2] Even Mr. Taylor's contention that alcohol injection of the sensory root has no mortality is not supported by Dr. J. Penman's statement (24 August, p. 498) that "injection has a very small death rate." Rowbotham[3] reported 250 cases of trigeminal root section with no mortality and Olivecrona[2] had a mortality rate of 0.9% in a series of 445 cases.

In most therapeutic situations sweeping statements are out of place, and in this particular case it would be difficult to improve on Henderson's[4] opinion that "There is no single treatment for all cases of trigeminal neuralgia. Some patients will not tolerate injection and others are afraid of operation. There are individual considerations in every case, and the best treatment may be operation, or Gasserian injection, or peripheral-nerve injection, or tablets; all have a place in proper management and all should be considered by the surgeon who has experience of all methods and is familiar with the Gasserian region."—We are, etc.,

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2 Olivecrona, H., *Acta psychiat. scand., Suppl.*, 1947, No. 46, p. 268.
3 Rowbotham, G. F., *Lancet*, 1954, **1**, 796.
4 Henderson, W. R., *Brit. med. J.*, 1967, **1**, 7.

Tobacco Habit

SIR,—Six years of propaganda have proved the universally lethal effects of tobacco beyond statistical doubt to all believers, and Mr. A. W. Fowler's plea (28 September, p. 806) for the withholding of surgical treatment from the refractory and still-smoking patient, and even the denial of anaesthetics, no doubt represents the next stage of modern militant medicine. As a follower of the old-fashioned view that the doctor should advise rather than try to bully, and that scientific medicine should be concerned with the investigation of all possible environmental causes of disease regardless of political, economic, or commercial consequences, I should like to point out that the long-awaited second report of the Royal College of Physicians concerning the relationship between atmospheric pollution and carcinoma of the lung and other diseases, which was promised on page 2 of the first report, *Smoking and Health* in 1962,[1] may perhaps shed some more light on the causes of the tremendous increase in lung cancer.

Should the authors of this report, which will have been 10 years in preparation next April, still have any hesitation in knowing where to look for a possible culprit, there is always the investigation of the carcinogens in diesel exhaust fumes. The theory that these fumes could play a part in the causation of lung cancer has been rejected many times in Parliament by official spokesmen, is totally ignored by the motor and oil industries, and it not even favoured by the tobacco manufacturers. On one occasion, when I suggested it to a representative of the tobacco industry, I was told that it was not considered ethical to "knock somebody else's product."—I am, etc.,

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REFERENCE
1 *Smoking and Health*, 1962. Royal College of Physicians of London. London

Fluphenazine Enanthate and Schizophrenia

SIR,—Since the introduction of antipsychotic medications, one of the problems has been to ensure that patients who need them continue to take them. Several papers[1-4] comment on this difficulty; it is accentuated by the fact that the therapeutic action of such preparations may persist for some little time after they have been discontinued, so reinforcing the patient's idea that he no longer needs to take them. Relapse and readmission due to defaulting on medication is a recurrent and well-recognized syndrome in all too many chronic patients, and when a long-acting injectable phenothiazine in the form of fluphenazine enanthate was introduced two years ago we decided to evaluate its usefulness in this type of problem.

An initial trial in 20 hospitalized patients of poor prognosis (all cases of chronic schizophrenia, mostly undifferentiated in type) showed slight advantages only over the previous oral medication, but three of the patients were able to spend more extended periods of leave out of hospital; there was also some nursing advantage in so far as medication was simplified. In this type of disorder the advantages of fluphenazine enanthate appear to be only marginal; but in cases of the recurrent, relapsing type who improve on medication, but who tend not to take it regularly, the fortnightly injection technique does seem to be worth serious consideration. Sometimes the patient's stability and his capacity for social adaptation are remarkably improved. In our experience paranoid schizophrenia responds better than other varieties, and any such patient who has relapsed more than once due to failure to co-operate in maintaining medication is a potential candidate for this form of treatment.

More than 30 cases of paranoid schizophrenia have been satisfactorily maintained out of hospital on fortnightly injections, varying from 8 to 37.5 mg., for periods of up to 18 months. One patient only has required a short period of readmission; one (an unstable wanderer) drifted away and vanished; two patients were relatively sensitive to the drug and complained of dyskinetic symptoms (mainly feelings of fatigue in the legs) even on 5-mg. doses, so treatment was abandoned. Routinely, a full blood count, sedimentation rate, and battery of liver function tests were carried out prior to starting treatment. Thereafter, random checks did not disclose any evidence of blood dyscrasia, liver damage, or raised blood urea. All patients were offered benzhexol (Artane) 5 mg. b.d. in case of side-effects. General anaesthesia for surgical operations was carried out on four occasions in three patients without complications attributable to the fluphenazine. Treatment has always been commenced on an inpatient basis, on a dosage of 12.5 mg. intramuscularly, and the initial period of observation and stabilization lasts approximately five to nine weeks. This is followed by discharge and maintenance. A fixed interval of two weeks between injections is used in all cases, the dosage being adjusted (usually upwards) from the initial dose in order to give symptomatic control within this period.

The injection should always be given by someone who can at the same time review the patient for any developing side-effects. The best methods of ensuring this seem to be to have the patient return to the hospital or to a clinic staffed by the hospital; or to have the patient visit his general practitioner; or for him to be visited by a member of the hospital nursing staff. Whatever method is chosen, it is important to avoid the hazards that could occur owing to overlapping—for example, side-effects going unrecognized, or additional phenothiazine medications being prescribed.

A review of 15 British references to fluphenazine enanthate[5-19] indicated that 13 of them found some advantage in this injectable long-acting antipsychotic. In the present state of the art it seems to us likely to be the treatment of choice in many cases of paranoid schizophrenia.—We are, etc.,

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2 Pasamanick, B., Scarpitti, F. R., Lefton, M., Dinitz, S., Wernert, J. J., and McPheeters, H., *J. Amer. med. Ass.*, 1964, **187**, 177.
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5-19 Available on application to writers.

Urinary Tract Infection

SIR,—I regret that I misled Dr. S. H. Purser (12 October, p. 122) into thinking that my patients' urine specimens were cultured only if five or more pus cells were seen per high power field. The patients attended a local pathology laboratory and the urines were centrifuged before microscopy, as my letter stated (21 September, p. 745). Transport media, therefore, were not required.

Dr. Purser questions the value of sensitivity tests, particularly in the initial management of the patient with urinary tract infection. His reasons seem to be that first, the antibiogram does not always correlate with clinical results—sulphonamides seem to work; and that, second, the results of sulphonamide disc tests are difficult to interpret.

In answering the first point I would agree that patients with proved infections may