

sutured over it. Closed drainage may be made for 24 hours. This leaves no deformity or respiratory disability and the less obtrusive scar is appreciated by some patients.

The transthoracic approach is an advantage in the unusual presence of an infected tracheotomy stoma. The incision can, of course, be extended across the sternum if an unexpected invasive tumour is found.

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Sexual aspects of medicine

SIR,—As a very experienced ward sister who has worked in the direct care of surgical and medical patients throughout my life, I should like to suggest that your recent series of articles on "Sexual aspects of medicine" should be reprinted and made available to all health service workers, whether doctors or nurses, social workers, or other paramedical personnel. It would be a useful work to have as statutory reading for medical and nursing students and could be used in postgraduate courses and seminars. A satisfactory sex life within a committed partnership is an essential part of human life. When such an expression of love is made more difficult by physical disease patients are so often left with little advice as to how to re-establish their former relationship. This applies to every sphere of medicine and much surgery.

Mr A G Amias (14 June, p 608, and 21 June, p 680) dealt fully with the problems of the patient after gynaecological surgery. But what about so many others who have operations which subsequently alter their physical and emotional capacity to re-establish a satisfactory sex life? Patients who have had major operations on the back or limbs rarely get any sexual advice from the surgeon. It is often left to others, and that includes, primarily, the experienced ward sister if she is motivated to help. Patients with a colostomy or ileostomy often experience severe physical and emotional problems in re-establishing a happy sex life and are glad of advice and help. Loss of lower limbs in young adults again affects their sexual life and happiness and much more sympathy and empathy should be shown to these patients. The burned patient is another example of one who may experience sexual anxiety and difficulty because of disfigurement of his or her body or of some deformity of the sexual organs themselves.

Cardiac patients are often given a battery of drugs to take, some of which affect their libido. They may have accompanying depression due to loss of job through ill health or family responsibilities with which they find themselves unable to cope. Psychotropic drugs may be prescribed for this and some of these also affect the patient's libido, apart from the depressed state. A mixture of such drugs can cause impotence in a man, and his worries over this may be greater than those caused by his heart disease and are often shared by his wife. Postoperative cardiac patients also need help. Some seek advice as to whether their "new hearts" will take the strain. One patient had been told by his general practitioner that at his age (44) the time had probably come to "call it a day." To my mind there was no medical need for this as the patient was not acutely ill and abstinence can cause just as much hypertension and aggravation to the man and his mind as does his physical condition. This man subsequently had an operation and afterwards asked me if "sex was still forbidden." I advised him to have gentle sex with nothing too robust and to resume his normal sexual life gradually according to the needs of himself and his wife. Two years later he told me that since he had spoken to me he and his wife had never known such a wonderful sex life.

There are few fields of medicine and surgery which do not affect, physically, emotionally, or both, the patient's ability to establish or re-establish the happy sexual life which is the essential and primal joy of true manhood and womanhood. I therefore feel it the duty of all those concerned for their patients' welfare to give "total patient care" and include in it this aspect of their life by sympathy, empathy, special care and understanding, advice, counselling, or referral for special help. There are many patients who do not receive this care to the extent that they should.

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** This series of articles is to be republished in book form.—ED, *BMJ*.

Adverse reactions to prazosin

SIR,—We were interested to read the experiences of Drs J Rees and H J H Williams with prazosin-induced hypotension (6 September, p 593). Since we published our first observations¹ we have treated 30 hospital inpatients with this drug. Three have become hypotensive within an hour of taking 2 mg of prazosin. One patient became unconscious for 1½ hours and developed mild fever lasting 12 hours. In all three symptoms of hypotension and malaise persisted for about eight hours.

We originally suggested¹ that the manufacturers of prazosin should produce a low-dose tablet which might produce a less drastic effect in patients at risk of hypotension and unconsciousness. Two of our three patients who collapsed after 2 mg of prazosin were given 0.5 mg of the drug, having taken no prazosin for one or two weeks. In neither was any adverse reaction observed. The 0.5-mg tablets were donated by Pfizer Ltd.

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¹ Gabriel, R., Meek, D., and Ghosh, B. C., *Lancet*, 1975, 1, 1095.

Behavioural medicine

SIR,—At times a title is important as a semantic uniform to support a right sense of identity. I believe it is now necessary to have such a title to describe that part of medicine which concerns itself with human behaviour.

The need to strengthen the behavioural aspects of medical education and practice has been widely recognised in recent years, but it has proved very difficult to translate good intentions into practical effect. The chief reason for this seems to be that behavioural science subjects such as sociology, anthropology, or social psychology cannot be applied "undigested" to the problems of clinical medicine. The results of trying to do so have often been frustrating for the behavioural scientists concerned, and have tended to reinforce negative attitudes to the whole subject in both clinical teachers and their students.

It is now clear that the task of applying the behavioural sciences to medicine must involve doctors themselves. The time has

come to recognise a new academic discipline within medicine, which I suggest should be called "behavioural medicine." Pathological medicine seeks to apply the basic natural and biological sciences to the diagnosis and treatment of the pathological changes that occur in the structure and function of the body as the result of disease. Behavioural medicine would seek to apply a range of behavioural sciences to the understanding and management of the disturbances in human feeling and behaviour that cause, or are caused by, the experience of being sick. Pathological medicine and behavioural medicine are necessary parts of clinical practice.

We have made huge advances in pathological medicine in the last 100 years. We have now to attend to behavioural medicine. Such an effort will require an academic base. The title "behavioural medicine" should remind us that what we need is not someone else's behavioural science but our own. We need a department of behavioural medicine in every medical school.

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Genetics of duodenal ulcer

SIR,—The evidence for a genetic predisposition to duodenal ulcer is not "modest" as stated in your leading article (6 September, p 557) nor merely based on the original family studies.^{1,2} The Danish twin data suggest that genetic and environmental factors are about equal in importance in this disease.³

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¹ Doll, R. and Buch, J, *Annals of Eugenics*, 1950, 15, 135.

² Doll, R. and Kellock, T D, *Annals of Eugenics*, 1951, 16, 231.

³ Jensen, K G, *Peptic Ulcer—Genetic and Epidemiological Aspects Based on Twin Studies*. Copenhagen, Munksgaard, 1972.

SIR,—I was a little surprised that your leading article on this subject (6 September, p 557) omitted to mention the known differences in the chemical structure of gastric and duodenal mucus between persons of different ABO(H) blood group and secretor status.

The molecules of mucus are glycoproteins, consisting of a peptide chain with carbohydrate side-chains attached to it. In ABO blood group secretors there is an additional fucose sugar at the end of the side-chains which is not found in non-secretors. In A, B, and AB secretors there is a further additional sugar at the end of the side-chains, which is *N*-acetylgalactosamine in group A secretors and galactose in group B secretors.¹

The lower incidence of duodenal ulcer in the secretors of blood group substances is possibly explained by the extra fucose radicle, which may improve the capacity of the mucus to protect the mucosa against damage by gastric acid and pepsin. Likewise, the lower incidence of duodenal ulcer in A, B, and AB subjects than in group O subjects may be related to the additional *N*-acetylgalactosamine or galactose in the gastric and duodenal mucus of A, B, and AB secretors.

This cannot be the whole story, because non-secretors have the same structure of mucus whatever their blood group and yet