

veloped mostly in the past five years, and he is convinced that although an expensive specialty it should be protected from cuts. "There is no doubt that neonatal intensive care saves the lives of many babies and that is of incalculable value, but perhaps more important in an unemotional economic sense is the improved quality of the babies that survive." Institutional care of the physically and mentally handicapped is enormously expensive. Neonatal intensive care reduces the number of brain-damaged babies and therefore, although expensive, can ultimately save large amounts of money. "Cuts here would be self-defeating."

Turning to conventional paediatrics, Dr Horace thinks that there is more room for saving here. "The first thing to do is to use hospital time, which is expensive, more efficiently. Paediatrics has always been a specialty that aimed to keep patients out of hospital as much as possible, but even so there is room for improvement." Day beds are already much used but could be used more. Every time a consultant admits a child he should ask himself whether the admission is really necessary. And then once patients are in the hospital the time should be used as efficiently as possible. Tests should be arranged before the child is admitted, and he should be allowed out as soon as possible and not be kept waiting for results or the arrival of a

tertiary care specialist. And patients should be allowed out at the weekend whenever possible.

Outpatient clinics could be used much more efficiently as well. "Consultants have tended to move too far away from the genuine consultation. They should see a patient referred by a general practitioner, give the GP an opinion, and leave the continuing management to him." Clinics tend to fill up with patients having follow-ups who could usefully be discharged. This is often because the follow-up patients are seen by junior staff, who are understandably rather timid about discharging. "Consultants should intervene in these clinics and discharge more patients."

Although consultants are paid a fee for domiciliary visits, Dr Horace believes that the visits often result in a saving for the Health Service. If a GP is worried about a child acutely ill then he has the choice of sending the child up to the hospital to be seen by a registrar or calling a consultant out. A registrar will often feel obliged to admit the child, but a consultant seeing a child in his own home, if the parents are capable and the home is suitable, may feel able to manage him at home. Recently Dr Horace saw a child with rheumatic fever on a domiciliary visit—he was able to manage that child at home and thus saved at least a month's care in hospital.

For Debate . . .

Multiple sclerosis: what can and cannot be done

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After a recent clinical trial of γ -linolenate (Naudicelle)¹ in the treatment of multiple sclerosis (MS) and the subsequent evaluation of the results,²⁻⁴ inquiries from lay people, general practitioners, and consultants show that much confusion exists about the management of the disease and its early diagnosis. Recent confirmation in America⁵ of the value of one of our major tests for MS,⁶ with the publicity it attracted, has compounded this confusion. We should therefore like to set the record straight with the following points.

(1) There is no cure for clinically established MS.

(2) Early cases may be diagnosed on presentation of the first symptom or sign, and there is no longer need to wait for "dissemination in space and (wasted) time." On the other hand, the tentative diagnosis of MS may be set aside at an early stage or the anxieties of relatives allayed. Actually, the erythrocyte unsaturated fatty acid (E-UFA) test⁶ indicates the presence of the inborn anomaly always present in a sufferer from MS. Even then he may develop another disease, though an MS-like symptom makes the diagnosis virtually certain. The association of glioma with MS, however, is well recognised. A word of

caution should be added. If an MS patient is under full ACTH therapy or at a point within three weeks of finishing such treatment then his blood test will be negative and only later revert to positive. Patients, if they are to be tested, should be examined before any therapy is begun, and this includes the patient who may have dosed himself with sunflower seed oil or naudicelle.¹⁰ In the latter case a prostaglandin test may still be positive.^{6a} Some drugs, for example, furodantin may also interfere, but not valium or baclofen.

(3) In our own (uncontrolled) experience, patients with early disease appear to benefit from γ -linolenate treatment (2 capsules thrice daily half an hour before meals in water, together with 100 mg vitamin (antioxidant) and a diet low in animal fat to aid absorption of the unsaturated medicament) in that the number, severity, and duration of acute attacks is reduced. Many patients no longer resort to steroids with their commonly unpleasant (and, indeed, dangerous) side effects. Patients with late MS in a static phase do not appear to benefit, though an occasional patient is emphatic about feeling better. Needless to say, physiotherapy, good advice on mode of living, non-exposure to heat (especially sunbathing), and so on, all have their parts to play—as well as sympathetic guidance in adopting the diagnosis and an explanation that MS is essentially a benign disease.⁷ Attendance at MS gatherings where miracle seekers congregate may well engender a wrong and depressing opinion. We often give the *BMJ*'s excellent leading article⁷ to our more intelligent patients.

(4) Testing large numbers of the families of patients with MS has uncovered no Mendelian principles that determine the inborn anomaly in the handling of unsaturated fatty acids

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(UFA) of linoleic and arachidonic (LA:AA) type underlying the disease,^{8,9} though clusters in families are more pronounced than generally believed. The anomaly described by Thompson can be rectified by prolonged treatment with γ -linolenate.¹⁰

(5) Every mother of a patient with MS shows a minor (intermediate) deviation from normal¹¹ and most first daughters of patients show it too (slow with LA, fast with AA in the E-UFA test). Such women we have called "red circles": they never develop MS themselves but are capable of bearing children with the defect, which may result in MS when they grow up.

(6) On the other hand, a woman who is not a "red circle" cannot bear a child who will develop MS even should she have the misfortune to marry a husband who develops the disease. Testing such women eliminates much scarcely concealed anxiety. If, however, a woman is a "red circle" then her children should all be tested in early life.

(7) Myelin is laid down with maturity from about midfetal life until 5 years of age and thereafter with diminishing vigour until about 16 years. Later in life turnover is much less, though some is believed to go on until later decades. Hence if we are to prevent the defect that leads to the laying down of MS-susceptible myelin, it should be detected as early as possible and corrected so that normal, non-susceptible myelin is laid down from the rectified surfaces of oligodendroglial cells.¹² In this way the disease may be prevented before a cure (or the cause or causes) are known. Once faulty myelin has been laid down the problem is intractable and is in some ways similar to that of phenylketonuria.

Testing young children (in the first few months of life) who are near relatives of a sufferer from MS is therefore of paramount

importance. Large-scale testing has been made much easier by the development of automatic machines in East and West Germany, France, England, and America—though there are attendant dangers in the unskilled preparation of red blood cells. Children thus found to have the defect may well be prevented from developing MS—a possibility that could antedate a cure for the disease. A moderate sum of money wisely spent on work directed to such a goal is likely to yield results of much greater benefit to the health and economy of the community than are large sums spent on the intellectually exciting elucidation of molecular mechanisms. With the recent American and Italian¹³ confirmations of the validity of the E-UFA test, the onus for exploring methods of preventing MS lies with the DHSS.

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Reading for Pleasure

Confessions of a book-drunk

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I remember a conversation long ago with a then up-and-coming young academic—now replete with honours, a knighthood, and, most important, a good beat on the Tay—in which he called to mind one man's version of reading for pleasure. It was, in that heyday of science, the chance to retire to bed with a heap of journals and get the opportunity to mull over the advance of science both in general and in your own specialty. An odd attitude, maybe, but one which fulfilled him and he regarded as pleasurable. Which leads me on to say "What is reading for pleasure?" How do we allot the pleasure-pain principle, because if one allows the former one must admit that there is a certain amount of the latter—namely reading for pain, or, put another way, for duty? I am uncertain about such a dichotomy because on the whole all my reading is a pleasure because I enjoy virtually anything that is constructively written and, moreover,

if it is not I take a sadistic pleasure in destroying and sometimes rewriting it. The word workaholic is popular these days—I've encountered it this week in *The Motor*, the *Financial Times*, and the *Observer* (where did it originate because I remember being accused by my first assistant of being one at least eight years ago?)—but I suppose I'm really a biblioholic. That is different from a bibliophile and merely means that I cannot resist reading everything that swims across my line of vision—the cereal packets at breakfast, the comics on my patients' lockers, the papers my fellow travellers in the tube dangle tantalisingly near me, the correspondence on the desks of others. As to the last, an ability to read upside down and back to front is useful if one is up for an interview or in any way trying to outsmart the opposition.

My biblioholic status makes me very unsystematic and a poor contributor to this column. I am amazed by and put to shame because of the erudition and determination of my fellow contributors who have read everything of *this*, kept up to date with the important contributions of *that*, and generally make me feel that I am a slow reader struggling unsuccessfully to keep up with the pace set by all these literati who masquerade as doctors. There is system in their reading—the English novel, the Russian heavies, the pursuit of hobbies, or the acquisition of recondite knowledge. By contrast, I plough along

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