or any other drugs. A further liver biopsy (percutaneous) was performed in April 1967 and showed marked sinusoidal congestion with disappearance of parenchymal cells around the central veins. Fibrosis was less marked than in the previous biopsy, and the lobular architecture was maintained. A small hepatic vein showed eccentric fibrous thickening of its intimal coat diminishing the lumen of the vessel by about one-third. A central vein was similarly partly occluded.

At this time liver function tests were normal apart from alkaline phosphatase 27 King-Armstrong units and bromsulphalein retention 19% at 30 minutes.

Her health is now excellent, she has gained 1 stone (6.4 kg.) in weight, there has been no recurrence of abdominal pain or swelling, and her liver is only just palpable.—We are, etc.,

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Dysphagia

SIR,—Dr. C. F. Hawkins in his article "Dysphagia" (16 December, p. 663) suggests that the high incidence of carcinoma of the oesophagus among the Bantu might be linked with the native beer-brewing methods.

The high incidence of oesophageal carcinoma among the Bantu is not evenly distributed, but occurs in rather restricted geographical areas. In one such focus, in central Malawi, it appeared to me that the disease was strongly related to "sideropenic dysphagia" (Patterson-Kelly or Plummer-Vinson syndrome) rather than with the beer-brewing methods, which are similar over the country. In that particular place hookworm infection and schistosomiasis were hyper-endemic, while dietary iron supplies seemed extremely poor. Very often the patients gave a history of prolonged dysphagia which was unlikely to have been caused by the malignant lesion only. The tendency of the lesion to occur in the upper part of the oesophagus further supports this aetiological possibility.

It would be interesting to compare the present incidence rate of oesophageal carcinoma in such foci to the rates a few years after effective control of the parasitic diseases.—I am, etc.,

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A. UR.

Acute Necrotizing Encephalitis

SIR,—In view of recent interest in this subject¹⁻³ we would like to report another case.

A youth aged 19 was admitted to Hammett Hospital in March 1967 with a seven-day history of frontal headache, pyrexia, cough, and chest pain. A chest x-ray showed collapse of the right middle lobe and patchy opacities in both lower lobes. He rapidly became confused and developed marked neck and back stiffness. This was followed by generalized and focal convulsions and coma and a left hemiparesis. The cerebrospinal fluid showed a raised leucocyte count with some red cells and a high protein and normal sugar content. The electroencephalogram showed diffuse slow wave abnormalities. An angiogram was probably normal, but raised

the possibility of a space-occupying lesion in the right temporal lobe. Exploratory burr holes showed xanthochromic fluid and oedema of the brain.

At necropsy there was widespread oedema of the cerebrum affecting mainly the right temporal lobe. Haemorrhagic foci were scattered through the brain. The cerebellum was normal. Histologically there was necrosis of the grey matter of the cerebrum, most marked in the right temporal lobe, with perivascular lymphocyte cuffing and type A intranuclear inclusions. The pneumonic lesions, probably due to aspiration, were typical of bacterial infection, and no intranuclear inclusions were found in the lung. Herpes simplex virus was later isolated from the brain.—We are, etc.,

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Psychotropic Drugs

SIR,—The national suicide rate, suggested by Dr. J. T. Hutchinson (2 December, p. 555) as an index of efficiency of psychiatric treatment, is still affected far too much by other complex sociological influences. The fact that the suicide rate reached a new peak during the years of greatest popularity of the monoamine-oxidase inhibitor drugs is probably irrelevant, though it does make one wonder about the "prevented suicides" against which we are asked to balance the known dangers of these drugs.

Statistics likely to reflect more closely any change in efficacy of outpatient therapy are those relating to admissions to psychiatric beds. A new outpatient or preventive treatment which was fully effective would reduce the admission rate for the condition concerned towards zero. It is therefore interesting to study the effect of the introduction of the new antidepressant drugs on the admission rate for depression. I am grateful to the Ministry of Health for supplying me with recent figures (for 1964-5-6) which make it possible to compare admissions (England and Wales) in 1966 with those in 1958. Tofranil (imipramine) was marketed here in 1959, and in 1966 there were 1,500,000 prescriptions written outside hospital for one brand of tricyclic antidepressant alone (*MIMS* now lists 29 proprietary antidepressants). The figures quoted below show total psychiatric admissions, with the admissions in each of the major subgroups of depression. These will cover virtually all patients thought by the psychiatrists concerned to be suffering primarily from a depressive disorder. The raw figures for the two years are not immediately comparable, because of differences in presentation, but it is fair to compare the

proportion of the total which is occupied by any diagnostic group.

During the years 1959-66 no new outpatient therapy of comparable importance was introduced for any other psychiatric disorder, and yet we find an increase in the admission rate for depression which is greater than that for any other major diagnostic category. The diagnoses are being made by psychiatrists whose criteria are not likely to have changed greatly during the period. However, as will doubtless be pointed out, it remains theoretically possible that the great expenditure on antidepressants is effectively keeping patients out of hospital. If we assume that a recent assessment of the value of the drugs (80% effective in endogenous depression) is correct, then the 61,000 admissions in 1966 represent 305,000 potential admissions, 80% of whom responded to treatment and 20% of whom got through the successive nets of general-practitioner and psychiatric outpatient medication. Thus we must postulate an increase, in eight years, of potential admissions for depressive psychosis from 33,522 (1958) to 305,000 (1966). I feel that this is unlikely. It must be understood that this argument does not involve the vast numbers of patients who visit surgeries complaining of feeling a little run down and who in the past may have been called neurasthenic, were given a cheap tonic or word of encouragement, and usually got better. Now they may be called "depressives," be given antidepressants, and usually get better. This increase in diagnosis of depression in general practice is probably very great, but it is largely a new label for old conditions, and does not affect the number of patients who are depressed enough to agree to stay in hospital, usually for E.C.T.

There are various other possibilities, each of which may find support, but most of them lead to the somewhat odd conclusion that the introduction of an effective form of treatment, used to keep patients out of hospital, has been followed by an increased admission rate (relatively as well as absolutely). It should be noted that we can accept an increase in potential admissions for depression over this eight-year period of nearly 100% without needing to assume any effectiveness at all for the drugs. This is the straightforward interpretation of these statistics and one which is supported by a review¹ of several of the better clinical trials. For example, the M.R.C. demonstrated that in endogenous depression the patient was just as likely to leave hospital after a stay of average length if he received inert placebo as if he received Tofranil, while Nardil (phenelzine) was likely to retard progress.² Again, a recent trial in general practice³ of treatment for neurotic depression appeared to show that neither Tofranil, Trypizol (amitriptyline), nor Trypizol plus Librium (chlordiazepoxide) was more effective than phenobarbitone (which was marginally the best treatment of the four).

Destructive criticism is always easier and less valuable than constructive, but at times it may be a necessary prelude to further progress. Apart from the unfortunate effect which misguided enthusiasm may have on research, one must remember that £1m. wasted on unnecessarily expensive N.H.S. prescriptions means £1m. taken away from some other valuable part of the service. It has been rightly said⁴ that these drugs have greatly added to the satisfaction that the doctor can get from the management of his depressed patients. It seems that we may be moving from an era of simple placebos for patients into one of complex placebos for doctors.—I am, etc.,

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Year	Total Psychiatric Admissions	Depressive Psychosis	Neurotic Depression
1958	94,083	33,522 (35.6%)	5,468 (5.8%)
1966	163,980	61,023 (37.6%)	10,879 (6.6%)