Correspondence

Letters to the Editor should not exceed 500 words.

Freedom to Prescribe

SIR,—It is not surprising that the referees in cases of the kind you describe under the heading "Was it a Drug?" are in some difficulty.

Their function was, I believe, to distinguish drugs from foods, beverages, and toilet preparations. However, the Macgregor Committee (Standing Joint Committee on the Classification of Proprietary Preparations) in its 1967 report says that "there is no definition in general terms of what constitutes a drug." They then express the view that "a drug is a substance that has a pharmacological effect on the body *and* is used to prevent or treat disease" (my italics). This definition would have the effect of excluding many dermatological treatments which are specifically intended to avoid pharmacological effects in the body.

A treatment of scabies, for example, should avoid any pharmacological effect in the body. In the case you have quoted (*Supplement*, 11 January, p. 13) Tetmosol soap was disallowed because it could not have been effective, although the patient was in fact cured of scabies for which it had been prescribed. It is not mentioned that any other treatment was given, and one wonders whether the referees attribute the cure to "supportive measures."

Supportive measures are given the credit for the patient whose ulcer healed while Glucodin was being used, but unless the referees saw this patient and followed her progress one may doubt whether this is the way to assess the effects of treatment. In fact, Glucodin seems to have been condemned chiefly because it is not in accordance with accepted medical practice.

Disfex Skin Cleanser was disallowed because the referees thought that 3% hexachlorophane was not enough to influence acne. Having regard to the difficulty of treating this stubborn disorder, one wonders how the referees were able to reach this clear, if arbitrary, decision.

The effect of this system is that National Health Service prescribing is being kept to the "O.K." treatments, and the freedom of the prescriber to adopt untried methods, or even methods which the referees do not know enough about, is to be bought out of his own pocket.—I am, etc.,

London W.1. F. RAY BETTLEY.

SIR,—Under "Was it a Drug?" (*Supplement*, 11 January, p. 13) you report the findings of referees who thought that Tetmosol soap "had no appreciable chemical value for the treatment of scabies."

During the war on the instructions of the War Office I carried out extensive investigations in three medical centres in the Western Command in which soldiers suffering from scabies were issued with Tetmosol soap to use in their own units. The results were satisfactory and accepted as such by a committee of the War Office and Medical Research Council to which I reported. However, it was pointed out that it would be far more expensive to issue Tetmosol soap on a wide scale as a prophylactic than to allow the soldiers to contract scabies and then cure them with benzyl benzoate. These results were never published, but Tetmosol soap has been successfully used in a mental hospital where scabies was more or less endemic.—I am, etc.,

Leeds 2. F. F. HELLIER.

Status Epilepticus and Diazepam

SIR,—The title of Dr. D. S. Bell's paper the "Dangers of Treatment of Status Epilepticus with Diazepam" (18 January, p. 159) is unfortunate. He shows hypotension has occurred in severely ill patients with status epilepticus who have received a variety of drugs, especially barbiturates. Surely the common factor was the severity of the illness in his patients. He records that "hypotension does not seem to have occurred in the course of the extensive use of diazepam in the treatment of tetanus, even though barbiturates were also given in many cases."

The most important factor in the management of status epilepticus is the early and energetic treatment of frequently recurring major fits, and here diazepam is the drug of choice. We have here some 320 children with epilepsy, and the prevalence of fits varies enormously from those who are well controlled, with infrequent fits, to those with frequent major fits and often with daily minor fits. A small proportion can, for no obvious reason, develop serial fits, and early treatment of these is essential. Oral chloral hydrate is our first choice, but if the fits are severe, the child unable to swallow, or known as a severe "fitter" then diazepam is given intramuscularly in 5–10 mg. doses. Since 1965 the drug has been given to 125 children. Grand mal fits have been controlled, but it was of little help in the treatment of "minor status epilepticus." Status epilepticus used to be a fairly frequent emergency here but has not been recorded for over three years.

My real plea is that diazepam should be given early for severe fits recurring in quick succession. It should become a most useful drug for the general practitioner with the

advantages that it is effective, can be given in a disposable syringe, is painless, odourless, and virtually non-toxic. It seems illogical to administer phenobarbitone or phenytoin intramuscularly to patients with severe recurrent fits who almost certainly have had maximal doses of these drugs over the years. Occasional hypotensive reactions in seriously ill people should not be allowed to detract from the very real value diazepam has in the control of severe fits and the prevention of status epilepticus.—I am, etc.,

JAMES BOWE.

Lingfield Hospital School,
Lingfield, Surrey.

SIR,—It is incumbent upon all medical practitioners to know how to cope with potentially mortal medical emergencies. Status epilepticus is such a one. As practitioners involved in the prevention of the serious sequelae of status epilepticus in early childhood, in the management of chronic epilepsy, and in the serious appraisal of therapies, we were considerably concerned by the article "Dangers of Treatment of Status Epilepticus with Diazepam," by Dr. D. S. Bell (18 January, p. 159). Its misleading title may serve by itself to alarm practitioners into avoiding this highly efficacious, small-dose, low-toxicity drug as their treatment of first choice, and thus set up that very state of affairs which the author purports to prove to be so unsatisfactory.

Status epilepticus is potentially highly lethal. Apart from "accidentally" complicating some chronic epileptic disorders, it often represents the terminal phase in fatal brain diseases of whose symptoms epilepsy is among the more obvious. Considering, therefore, that the 25 cases mentioned were drawn from psychiatric sources in the first place and were "refractory to conventional methods of treatment" in the second, to have but one death remotely connected with the therapeutic technique may be considered more of a triumph than a disaster. When it is described that the patient who died was given, in the first 34 hours of treatment, 10 ml. paraldehyde, 200 mg. phenobarbitone, 250 mg. phenytoin, 810 mg. of diazepam, plus "her usual oral dose of sulthiame," it may be considered unwise to venture the opinion that death was due to any one thing in particular. But to conclude that these findings should modify the view that diazepam is the drug of first choice is quite unjustified, since the article is more a catalogue of occasions when it was *not* used first.

The adequate investigation of the useful potential and dangers of a therapy is arduous enough, but it should be equally incumbent on those who determine the dangers as on those who extol the benefits to exhibit scientific rigour. Thus there is no indication of the age, sex, or clinical condition of any particular patient, nor any information concerning the likely basis of the epileptic disorder, its age of onset, or its duration. It remains unknown how an adequately representative blood pressure was recorded from a patient in, presumably, grand mal status; nor why in Case 1 the blood pressure had needed to be recorded two-hourly for the previous two months, nor why in Case 2 a blood pressure of 120/100 was considered "hypotension"; nor how "her usual oral dose of sulthiame" was administered to a patient in terminal status; nor how, in general, the hypotensive effect of a drug could be assessed when it might be given by massive, high concentration intravenous injection, or by intramuscular injection (with its variable absorption rate), or by intravenous drip (at whatever dilution and rate).

While believing it wise that the potentially serious unwanted effects of drugs should receive adequate dissemination, we feel that a wide circulation general journal, under a misleading title, is not the place for anecdotal jottings.—We are, etc.,

DAVID C. TAYLOR.
CHRISTOPHER OUNSTED.

Institute of Experimental Psychology,
Human Development Research Unit,
University of Oxford.

SIR,—I read with interest the article written by Dr. D. S. Bell on the dangers of treatment of status epilepticus with diazepam (18 January, p. 159). I am in agreement with Dr. Bell that diazepam is very effective and safe in the treatment of status epilepticus. It is remarkably free from undesirable effects when it is used under proper observation and the parenteral dose does not exceed more than 40 mg. per hour.

In the past six months we have treated five adult patients suffering from status epilepticus with this drug. Initial response to a bolus dose of 10 mg. of diazepam, given intravenously, brought prompt arrest of the seizures in all patients excepting one, to whom 40 mg. of diazepam intravenously had to be given over a period of half an hour, and this was followed by mild, transient hypotension, which was easily combated by raising the foot end of the bed. In these cases the status epilepticus was precipitated by either self-withdrawal or a missed dose of anticonvulsant therapy, and the patients did not have any anticonvulsants for at least four to six hours before their arrival in hospital.

Thus, I consider diazepam a safe and first choice drug in the treatment of status epilepticus if the patient is not given any parenteral anticonvulsant therapy in the previous six hours of treatment, and if the dose of diazepam does not exceed more than 40 mg. in an hour.—I am, etc.,

S. N. SINHA.

Royal Infirmary,
Sunderland, Co. Durham.

Overinvestigation

SIR,—With the costs of the Health Service now approaching £2,000m. in place of the £150m. 1948 estimate of Mr. Aneurin Bevan, I feel there must be many causes at work.

We all know of the overstaffing which provides one registrar for every three beds at one London teaching hospital and three professors of medicine at another, but there is a tremendous drain on our spend-happy exchequer in the overinvestigation and overtreatment of patients.

As witness of this I would like to give a recent personal experience of a man who had been operated on two years previously in his home country for carcinoma of the colon. He came to me with intestinal obstruction. I found that he had multiple intraperitoneal recurrences and made a short circuit to overcome the obstruction. Eight months later he was admitted to a London hospital because his life was drawing to a close. If there had been any doubt about it a telephone call or a letter to me would have permitted me to tell the consultant in charge that this was the case, if he did not appreciate the significance of the enlarged liver and large masses in the abdomen and the great oedema of one leg, not to mention the recent laparotomy scar. Instead of doing this and saying *nunc dimittis* and letting the poor man depart in peace, 24 blood and biochemical tests were done upon him and 20 *x*-rays were made, including an intravenous pyelogram. In addition an isotopic scan was added for good value, and then after 14 days in hospital with full doses of steroid and expensive antibiotics this hopeless case passed away. Curiosity seems to have ceased with his death, as there was no necropsy.

The far too numerous hospital secretariat weighed in with a three-page letter of all the blood tests and *x*-rays which were of no interest to myself or the general practitioner. Finally, it seems this dying man received about £300 worth of expensive treatment to which he was not entitled, as he was a well-to-do inhabitant of an island in the Mediterranean.—I am, etc.,

London W.1. A. DICKSON WRIGHT.

Education in Psychiatry

SIR,—May I take a little of your space to congratulate Sir Denis Hill on his masterly and statesmanlike lecture (25 January, p. 205)? It reads like a new "Charter" for those of us—a small minority among psychiatrists hitherto—who have long pressed for adequate recognition of that vast field of study and treatment subsumed under the terms "neurosis" and "behaviour disorders." These were neglected and played down so long as psychiatric training and policy were in the hands of "mental hospital" men.

But just because Sir Denis's lecture is so splendid in scope, I venture to offer a correction of a historical inaccuracy which has crept into his derivation of the split between mental hospital "psychiatry" for psychotic inpatients, and the "psychological medicine" of the teaching hospital departments started after the first world war. With two exceptions, the teaching psychiatrists of the first generation were "asylum" men: Armstrong-Jones, Porter Phillips, Petrie, Maurice Craig, James, etc. Even Bernard Hart, of University College Hospital, was a "pukka" psychiatrist, though greatly influenced by the "new psychology." What small influence the Freudian discoveries about neurosis had in the psychological medicine departments came mostly a good deal later, from a grudging recognition of outpatient needs for psychotherapists—invariably in subordinate "clinical assistant" status under the chief. These came mainly from the available pool of trained psychotherapists and analysts turned out by the Tavistock Clinic, the Cassel Hospital, and the (then) lively psychological service of the West End Hospital, and rarely from psychoanalysis itself. These three small specialized centres, struggling on the periphery, slowly changed the climate and policy for selecting the *second* generation of psychiatric teachers in some undergraduate schools, from the mid-'thirties onwards.

In the main, psychiatric teaching between the wars was Kraepelinian, or at best Meyerian, and the conservatism and ambivalence of both the teaching faculties and of