Biofeedback Therapy for Disturbed Patients

SIR,—For the past seven or eight weeks we (Team No. 3, Rampton Hospital) have been using biofeedback therapy on five of our disturbed female patients. The instruments used are (a) the Myophone (muscle tension), (b) galvanic skin response (G.S.R.) indicator and (c) the E.E.G. 90 (alpha and theta wave recorder).

We have at least four sessions per week with each patient lasting about 15 minutes. The first four or five weeks were devoted to relaxation with the help of the Myophone and G.S.R. indicator and for the past three weeks we have been pleasantly surprised with the apparent ease with which each of these patients voluntarily produces alpha waves. They are also adept at blocking alpha production. The voluntary production of alpha waves has a beneficial effect on the patient's mood. I know it is too early accurately to forecast the possible usefulness of the procedure but it appears to me that the combined use of the three instruments has immense potential in dealing with selected (female) patients who are subject to episodes of disturbed behaviour (self-mutilation etc.).

I am not unmindful of the beneficial effects of the patients' relaxation between sessions and, of course, the instruction, guidance, and counselling of the nursing staff during and between sessions. However, all patients voluntarily produce alpha waves and have spontaneously stated that this improves their mood. Certainly the general standard of their behaviour is improving. —I am, etc.,

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Volume of Feeds for Infants of Low Birth Weight

SIR,—The balance studies performed by Dr. H. B. Valman and others (3 August, p. 319) on five infants of low birth weight certainly suggest that larger weight gains with high-volume feeds as opposed to low-volume feeds were due to growth rather than to water retention. These studies, however, were performed when all except one of the infants were at least three weeks old.

The accompanying table shows the gains in weight over the first three weeks of life of two groups of either premature or light-for-dates infants who weighed less than 2,100 g at birth. All were born between July 1973 and September 1974. Babies with post-natal problems such as infection or respiratory distress and those who had regurgitated high-volume feeds when offered were not included in the study. The 16 infants in group 1 were nursed in the special care baby unit of the Royal Free Hospital, London,

and were fed high-volume S.M.A. feeds by continuous intragastric milk drip after the manner of Valman.¹ The 17 infants in group 2 were fed low-volume S.M.A. feeds intermittently by nasogastric tube.

The results suggest that premature babies on high-volume feeds gain weight more slowly than those on low-volume feeds but that light-for-dates babies gain weight at a similar rate whether on high- or low-volume feeds. Therefore there would seem to be no advantage in exceeding a milk intake of 200 ml/Kg/day during the first three weeks of life.—I am, etc.,

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¹ Valman, H. B., Heath, C. D., and Brown, R. J. K., *British Medical Journal*, 1972, 3, 547.

Psychiatric Manifestations of Giardiasis

SIR,—The observation of psychiatric disturbances during *Giardia lamblia* infestation by Dr. A. A. Khan (16 November, p. 407) is interesting but does not justify the suggestion that the organism is causing meningoencephalitis. He is not correct in implying that *Entamoeba histolytica* may cause meningoencephalitis by direct invasion via the olfactory nerves. Cases of cerebral infection with *E. histolytica* are secondary and occur as a result of amoebae spreading from a primary infection of the gastrointestinal tract.¹ Primary amoebic meningoencephalitis is almost certainly a transnasal infection; the organisms responsible in man are *Naegleria spp.*² These differ from *G. lamblia* and *E. histolytica* in being facultative parasites. Their trophozoites can exist independently of the host in damp soil and water.³

While the infective stage of *Naegleria* is the actively-moving trophozoite it is the cyst of *G. lamblia* or *E. histolytica* which, on ingestion by the host, passes through the acid gastric contents and later releases the trophozoites which in the case of *G. lamblia*, infest the small, and in the case of *E. histolytica* the large, intestines.⁴ If meningoencephalitis is suspected the C.S.F. should be examined rather than the E.E.G. Primary amoebic meningoencephalitis is diagnosed by the examination of fresh cerebrospinal fluid on a warm slide,¹ and if *G. lamblia* were causing a similar disease the characteristic trophozoites would be easily spotted.

The behaviour disturbances seen during giardiasis may be related to gastrointestinal disturbances. *G. lamblia* can apparently cause quite severe steatorrhoea, particularly in patients with immunodeficiency syndromes.⁵ Withdrawal or aggressive behaviour can be features in the presentation of coeliac disease in children,⁶ and there may be a link between the diarrhoea of giardiasis and

the behaviour disturbances. It is also worth remembering that metronidazole is not without side effects on the nervous system, particularly at high dosage,⁷ and the improvement in E.E.G. observed in one of Dr. Khan's patients might have been due to withdrawal of the drug rather than cure of giardiasis. —We are, etc.,

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- 1 Symmers, W. St. C., *British Medical Journal*, 1969, 4, 449.
- 2 Carter, R. C., *Transactions of the Royal Society of Tropical Medicine Hygiene*, 1972, 66, 193.
- 3 Willaert, E., et al., *Annales de la Société Belge de Médecine Tropicale*, 1974, 54, 333.
- 4 Faust, E. C., Russell, P. F., and Jung, R. C., *Craig and Faust's Clinical Parasitology*, 8th edn., p. 64. Philadelphia, Lea and Febiger, 1970.
- 5 Ament, M. E., and Rubin, C. E., *Gastroenterology*, 1972, 62, 216.
- 6 McNeish, A. S., and Anderson, C. M., *Clinics in Gastroenterology*, 1974, 3, 127.
- 7 Goodman, L. F., and Gilman, A., *The Pharmacological Basis of Therapeutics*, 4th edn., p. 1152. London, Macmillan, 1970.

Ethics and Halothane

SIR,—Professor J. P. Payne (30 November, p. 529) states that "no cause-and-effect relationship has yet been established between halothane and hepatic damage," and other correspondents rightly make the same point. Japanese suppliers of thalidomide also argued with truth (at that time) that no cause-and-effect relationship had yet been established between thalidomide and congenital abnormalities, and they continued to sell it. They are now regarded as having been reckless and are liable to heavy damages. Public opinion rightly expects doctors to take consideration of reasonable suspicion, and such suspicion has been raised against repeated halothane anaesthetics. A prospective trial in which patients receive repeated halothane when otherwise they would not might show that the chance of serious liver damage was higher in those patients. If it did, they would have been damaged by the trial. This would not be ethical. Professor Payne asks me to declare my interest. It is to prevent patients being damaged by a clinical trial.—I am, etc.,

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Oral Cholecystography: A Sign of Gall-bladder Disease

SIR,—Oral cholecystography remains the method of choice for the radiological study of the gall bladder. The many causes of

Gains in Weight during First 3 Weeks of Life of Infants of Low Birth Weight

Gains in Weight during 1 Week at End of 1st, 2nd, or 3rd Week of Lactation									
Infants	No.	Mean Gestation (weeks)	Mean Birth Weight (g)	Mean Milk Intake (ml/Kg/day) at end of:			Weight Gain (g) during:		
				Week 1	Week 2	Week 3	Week 1	Week 2	Week 3
					Group 1				
Premature	7	33	1,890	240	300	270	-115	+95	+260
Light-for-dates	9	35	1,880	235	300	280	-95	+195	+285
					Group 2				
Premature	8	32	1,700	180	200	195	-40	+120	+245
Light-for-dates	9	35	1,775	165	190	190	+5	+145	+245

non-visualization of the gall bladder at oral cholecystography are well known. In such cases examination of the patient's film may reveal a faintly outlined common bile duct or intrahepatic ducts. This provides useful information per se. It indicates (1) that the contrast medium has been taken by the patient; (2) that the medium has been absorbed and excreted by the liver; and (3) the presence of gall-bladder disease.

In 47 consecutive patients with non-visualization of the gall bladder and visualization of the bile ducts after a single dose of 3.0 g of iopanoic acid operation revealed disease of the gall bladder with calculi in every case, and in addition almost 50% of the patients had calculi in the bile ducts. This is similar to the experience reported by Melnick and Lo Curcio.¹ Since the use of operative cholangiography is now routine (or should be routine) at cholecystectomy I believe that intravenous cholangiography in such patients is no longer necessary, and in view of the potential hazards of both oral and intravenous studies of the biliary tract the numbers of these investigations should be kept to a minimum. So-called double-dose cholecystography in my experience and in the experience of others seldom provides additional information to that available from the single-dose cholecystogram provided the bile ducts are shown. Tomography may provide visualization of the bile ducts in such cases when conventional radiography fails to reveal the biliary tract.² If the bile ducts are not seen after a single-dose cholecystogram, then more valuable information is obtained from intravenous cholangiography.—I am, etc.,

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¹ Melnick, G. S., and Lo Curcio, S. B., *Radiology*, 1973, 108, 513.

² Mujahed, Z., Evans, J. A., and Whalen, J. P., *Radiology*, 1974, 112, 1.

Who Says Was it a Drug?

SIR,—I am not usually inclined to challenge a decision made in favour of a prescribing practitioner but the circumstances reported by your legal correspondent (23 November, p. 477) under the above heading are so astonishing as to overcome my normal reluctance.

In this case (Optimax) the referees decided that the Cadbury's drinking chocolate moiety of nearly 50% was not a drug. The Divisional Court decided to quash their decision. Unlike your legal correspondent, I do not find the relevant regulations either obscure or complex. Regulation 16(7) states that "if any substance which was not a drug was an ingredient in a preparation of which the other ingredients were drugs, the amount to be recovered shall be the price of that substance [calculated in the manner set forth in the drug tariff] together with half the amount of the dispensing fee." This not merely "contemplates" that there "may" be occasions when it is proper for the referees to look at the substance not only as a whole but also at the constituent parts—it indicates that they are at liberty to do so. Nowhere in the regulations is this liberty limited, certainly not because the preparation is marketed as a trade entity. On the contrary, regulation 16(5) states "their procedure shall be such as they may determine." One might possibly go even further and say that the referees are obliged to consider the constituent parts, since by failing to do so they would also be failing to afford the Secretary of State the opportunity to recover money to which he is entitled, which is the purpose of this regulation.

For three of Her Majesty's judges to pronounce in effect that the regulation does not mean what it

says, that when a preparation is referred to the referees as a whole they may not consider its constituent parts, that they do not understand what the regulation is aimed at or that it is merely a legacy of the 1930s is nothing short of astounding. If this decision stands the way is now open for any enterprising firm to find itself an alcohol soluble form of digoxin, put it up in whisky, and call it "Cordimax," of which 20 ml will give the exact therapeutic equivalent of 0.25 mg of digoxin. Any practitioner prescribing Cordimax for a patient requiring digoxin could be confident that whatever a local medical committee decided the referees would be obliged to decide that it was a drug. This is precisely the sort of thing regulation 16(7) is designed to prevent.

Will the Secretary of State now be obliged to take this case to the House of Lords before we all find ourselves offered the opportunity of providing our N.H.S. patients with their drugs in chocolate bars, brandy, or any acceptable food or drink form that does not alter their therapeutic value? Your legal correspondent thinks there may still be trouble when the non-drug element is a non-essential ingredient of the preparation as a whole. Not if this decision stands—for that is the precise position of 50% Cadbury's drinking chocolate in Optimax.—I am, etc.,

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Confidentiality of Medical Records

SIR,—Referring to the B.M.A.'s view on the inadvisability of forwarding hospital letters and reports to insurance companies (23 November, p. 481), it is stated: "It should be remembered that hospital and consultants' reports are confidential in nature." In the matter of hospitals forwarding medical records to the Department of Health and Social Security I feel it should also be the case that general practitioners' letters to consultants are also confidential in nature.

When I was telephoned by the solicitor of a regional hospital board to ask if I would discuss a patient's condition, the patient evidently having claimed against a hospital for an injury, I naturally said that I was unable to discuss any patient with a third party unless the patient asked me to do so. You may imagine my dismay when a letter I had written to a consultant to ask his advice about this patient was quoted back to me by the regional board's solicitor.

I tried to think of ways of stopping this leak in confidentiality. I realized that not only are the hospital records the property of the D.H.S.S. but so also are all our records. In fact, it is written into our impossible contract that records shall be kept on D.H.S.S. forms, which of course remain the property of that department and are not, as I used to think, confidential to the doctor. If not a probability it is a future possibility that other Government departments can have access to patients' "confidential" records by an agreement with the D.H.S.S.—even possibly nationalized industries. I have visions of a new class of unemployable young people growing up in the future because severe stress at some stage has labelled them "unstable personality" or febrile convulsions in childhood have resulted in a "possible epileptic" label. I only hope this is extremist thinking on my part.—I am, etc.,

DAVID R. H. ADDENBROOKE

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SIR,—In a debate in the House of Lords on 20 November Lord Wells-Pestell, Government spokesman, stated that hospital social work records are the property of the local authority.¹ The records in question are kept in relation to the social workers' functions under the N.H.S. Acts and not local government. They hold medical information and may not involve the local authority in any way or they may concern patients living in another local authority area altogether. Surely, then, they should be the property of the area health authority?

Health service social workers have never been written into N.H.S. statutes but their duties have always been a part of Health Service functions. There is nothing in the 1973 Act to suggest that these have changed, but in order to effect their transfer to local authorities they were described (clause 18(4) (a)) as being wholly or mainly employed in local authority functions. Mrs. Barbara Castle has since written that this description was made only to effect the transfer. In counsel's opinion the clause is invalid, but the Secretary of State has not chosen to take legal guidance on this point.

Clause 12(2) is also of questionable legal validity. It requires health authorities to obtain from local authorities the support of social workers employed on local government functions to help them carry out their functions under the Health Service Acts. There will be occasions when such support will be required, but these need not involve N.H.S. social workers appointed before April 1974 to help carry out health functions; nor staff appointed after 1 April who are mainly employed in clinical social work not connected with the 1970 Local Government Act.

The operation of clauses 18(4)(a) and 12(2) has caused widespread disruption of existing services and it is essential that their validity should be determined as a matter of urgency. Social workers in charge of health authority units must know who has the legal right to decide access to the records under their custody and control. More than that, the N.H.S. must decide whether it needs social work support outside matters which stand referred to local authority social service committees. If existing legislation does not provide for what is needed the Act should be amended to ensure that it does.—I am, etc.,

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¹ *Hansard*, House of Lords, 20 November 1974, col. 1061.

Urethral Strictures in Women with Cystitis

SIR,—During the past five years we have developed a method for assessing the presence of possible urethral abnormalities in women with recurrent cystitis. The urethra is normally at an angle of 18° to the vertical plane and in micturition there is a steady stream. We found that a proportion of women complained also of dribbling, spraying micturition, and this group, which contained the patients with recurrent cystitis, was assessed.

The practice is situated in a village hall