which is empty during surgery hours apart from the surgery section. The women with cystitis were instructed to use the male urinal, urinating in an erect position separating the labia, and observing the stream. The use of the male urinal avoided fears of urinating over the edge of the bowl and enabled the patient to observe her stream in seclusion.

Twenty-eight patients who were unable to aim a firm forward stream were referred to the hospital for evaluation after first excluding the presence of a prolapse or obvious abnormality. Twenty-four patients were found to have a tight urethral orifice which was dilated with sounds; four were found to have large atonic bladders. Following dilatation there was an 80% improvement in symptomatology. One patient who had had chronic cystitis for eight years, fully investigated in two hospitals, has been symptom-free for three years. A control group of 20 patients who had never had cystitis or difficulty in micturition were able to aim a firm stream of urine and did not report any marked spraying.

The results suggest that urethral stricture is more common than supposed and erect micturition is a simple way of suspecting this in general practice.

I am very grateful for the encouragement of Professor J. P. Blandy in composing this letter.

—I am, etc.,

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Rosette-forming T-lymphocytes in Malnutrition

SIR,—We were interested in the preliminary communication by Professor R. K. Chandra (7 September, p. 608) dealing with rosette-forming T-lymphocytes and cell-mediated immunity in malnutrition. We have performed similar investigations on children with protein-calorie malnutrition and oedema (kwashiorkor), and though we have previously confirmed depressed lymphocyte transformation to phytohaemagglutinin (PHA) in these children¹ we have found normal percentages of rosette-forming T-lymphocytes in their peripheral blood.

Fifteen patients with kwashiorkor (Wellcome criteria²) were studied at the time of admission to determine percentages of rosette-forming cells in peripheral blood. The age of the patients was from 6 months to 2 years and 10 well-nourished children of a similar age range, admitted to hospital with infections or for elective orthopaedic procedures, served as controls. Spontaneously rosetting T-lymphocytes were detected by the method of Jondal *et al.*³ after lymphocyte purification using gelatin and carbonyl iron. The technique was checked daily with a normal adult control (normal range 50-70%).

As can be seen in the accompanying figure no significant difference exists between the percentages of T-lymphocytes in the peripheral blood of the malnourished and the control groups ($P>0.2$). These discrepancies could reflect differences in case material in that the children in Professor Chandra's series were more marasmic than ours and only two were oedematous. Similarly the ages of the patients in the former series were not indicated.

It is of interest that a recent study of cell-mediated immunity in children with protein-calorie malnutrition⁴ indicated a correlation between depressed ³H-thymidine uptake and folate deficiency. This finding would suggest that impaired lymphocyte response to PHA in these children is due to a qualitative lymphocyte defect rather than due to a quantitative reduction in T-lymphocyte numbers.

This work was supported by a grant from the South African Medical Research Council.

We are, etc.,

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1 Geefhuysen, J., *British Medical Journal*, 1971, 4, 527.

2 *Lancet*, 1970, 2, 302.

3 Jondal, M., Holm, G., and Wigzell, H., *Journal of Experimental Medicine*, 1972, 136, 207.

4 Burgess, B. J., *et al.*, *South African Medical Journal*, 1974, 48, 1870.

Agoraphobia

SIR,—Like Dr. D. E. I. Friedman and Dr. A. G. Zermansky (23 November, pp. 467 and 468) I was disappointed in your leading article (26 October, p. 177). The syndrome of agoraphobia is multi-faceted¹ and represents in some the aftermath of a depressive illness frequently still unresolved when treatment for the phobia is requested. In others it consists of maladaptive conditioned responses maintained by habit, while still other sufferers are prone to a variety of psychological conflicts and primary or secondary gains that play an integral part in the formation and maintenance of phobic symptoms. Snaith² went so far as to suggest dropping the term agoraphobia and substituting "non-specific insecurity fears." Certainly in each case an attempt must be made to understand the illness in the light of past and current life events and to explore the particular meaning and significance of symptoms for the individual. To advocate controlled prospective trials of, for instance, psychosurgery, which at present occupies a very insignificant role in treatment, for patients with such disparate aetiologies and

needs seems crude and inappropriate. Furthermore, I was surprised by your inference that by "psychological measures" solely behavioural techniques were meant, thus taking no account of the uncovering of motivation through insight therapy. As Dr. Friedman points out, the results of behaviour therapy in agoraphobics are significantly improved when practised in conjunction with interpretative psychotherapy.

Preliminary analysis of 68 personal cases of agoraphobia yielded 56% in whom factors of psychological gain prevented success with deconditioning; half of these subsequently responded satisfactorily to the same measures when insight had been gained into psychological difficulties and appropriate emotional readjustments made. While it is not enough to deal with conflicts, relationship problems, and psychological gains alone, however, and it is evident that patients have to face the phobic situation before they can improve, the converse seems equally applicable in a considerable proportion.

As a founder member of the Phobics Society, Manchester, I am of course in agreement that self-help groups of sufferers can be extremely valuable, but to equate, as you do, the support they offer with the highly structured, systematic programme of group flooding, carried out by a trained nurse therapist with the backing of the parent hospital, is hardly justifiable. Recent clinical experience indeed confirms that cohesive group flooding *in vivo*³ is the most realistic (in terms of staff time) and also the most successful behaviour therapy for this at times intractable disorder.—I am, etc.,

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1 Marks, I. M., *British Journal of Psychiatry*, 1970, 116, 377.

2 Snaith, R. P., *British Journal of Psychiatry*, 1968, 114, 673.

3 Hand, I., Lamontagne, Y., and Marks, I. M., *British Journal of Psychiatry*, 1974, 124, 588.

Economies in the N.H.S.

SIR,—With regard to Dr. D. Atkinson's letter (16 November, p. 406) commenting that an apparently mobile patient attended surgery on foot and said that the hospital had told him to contact his G.P., who would order an ambulance for subsequent conveyance to hospital, I would like to point out that the position from the ambulance service point of view is as follows.

The procedure supported by the Department of Health and Social Security for the conveyance by ambulance of outpatients is that the G.P. orders the ambulance for the first visit to hospital (having, of course, satisfied himself that no other means of transportation is feasible). After the first visit subsequent authorization for ambulance transport must be made by the hospital—that is, authorization must originate from the source where treatment is given. In the case in question the G.P. had the right to refuse ambulance transport and his only action to assist the patient would have been to question the case with the appropriate clinic at the hospital.—I am, etc.,

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