

danger of development of carcinoma of the breast. Clinical examination reveals merely the usual wide variations in consistency and nodularity of normal breasts, and the condition has no organic significance.

DAVID PATEY

Hythe, Kent

Self-assessment tests

SIR,—Your leading article on "Antibiotics again" (8 May, p 1107) drew attention to the use in America of self assessment programmes in continuing education based on simulated patient problems. It concluded by commenting that "a British programme of this type might be difficult to finance." In the same issue another leading article, "Politics and pharmaceuticals" (p 1105) reported criticisms of expenditure in the pharmaceutical industry.

Over the past year a similar self-assessment exercise has been carried out in the United Kingdom¹ and this has been supported financially by a British drug company. A programme in six parts was mailed over a period of six months to 29 000 doctors. This presented the history of a patient with both physical and psychological disease. Readers were invited to make decisions about the management of the patient, including history-taking, examination, further investigations, treatment, and follow-up or referral for a specialist opinion.

The programme was so designed that the reader was able to compare his own decisions with those of his colleagues and of a panel which included general practitioners, general physicians, and specialists. It is estimated that 15 000 doctors took part in the programme, although some did not complete all stages of the series. As in the American study some surprising results emerged. For example, only half of the respondents wished to take a drug history in the patient with erythema nodosum and 20% did not arrange to see her for two weeks when she became depressed and potentially suicidal. A full report of the experience gained in the exercise will be published and a further programme is at present under way.

RONALD M HARDEN
ANN P DUNBAR

Centre for Medical Education,
The University,
Dundee

¹ *Medical Education*, 1976, 10, 138.

Fitness to drive

SIR,—There is a disquieting example of double standards in the assessment of applications for disabled persons' car badges as opposed to the assessment of medical fitness to drive. For the former a person declares his disability, be it an amputated limb, defect of spine or central nervous system, motor defect, or permanent and substantial disability causing difficulty in walking, and the disability is certified by his or her general practitioner or an authorised member of the social services department, without any reference to the person's fitness to drive.

It is evident from those applications referred to me for a further medical opinion by the social services department that many "relevant" or "prospective" disabilities are unlikely to have been notified to the licensing centre by

the applicant as the law requires. Furthermore, with the possible exception of the Greater London Council, authorities which issue badges are not prepared to pass on any information to the licensing centre. Much of the detailed and valuable advice which has gone into the booklet *Medical Aspects of Fitness to Drive*,¹ and the legislation to which it refers, is therefore inapplicable.

Until the situation has been clarified between the DHSS and the Department of the Environment the least that local authorities could do would be to require applicants to state whether or not they have declared their disability to the licensing authority. GPs and local authorities could also inform applicants of their obligations by means of a suitable leaflet.²

M J BALL

Hertfordshire Area Health Authority,
Hemel Hempstead

¹ Medical Commission on Accident Prevention, *Medical Aspects of Fitness to Drive*, ed P A B Raffle, 3rd edn. London, MCAP, 1976.

² Central Office of Information, *Driver Licensing System, Changes in Medical Assessment of Drivers*. London, HMSO, 1975.

Depot neuroleptics

SIR,—Dr J P R Young and his colleagues (8 May, p 1116) conclude that flupenthixol is a useful treatment for depressed outpatients and they raise the question of using depot flupenthixol in the management of depression.

Depot neuroleptics are marketed primarily for the management of chronic schizophrenia, but there have been reports on the use of these drugs for other conditions.^{1,2} Clinical experience at this hospital would indicate that depot neuroleptics can usefully be given to a variety of non-psychotic patients. By and large the patients so treated have been suffering from either severe behavioural disorders, aggressive psychopathy, or alcoholism.

A heterogeneous group of eight resistant neurotic patients have been given fluspirilene in a dose ranging from 2 to 4 mg each week. This type of intramuscular therapy has been successful in resolving symptoms where previous oral therapy with antidepressant drugs and benzodiazepines had not been successful. The responsive patients presented with paranoid, depressive, or phobic symptoms associated with behavioural irritability. Patients whose symptoms were entirely subjective did not respond to fluspirilene.

It does appear that the long-acting tranquillisers can be usefully prescribed in a variety of psychiatric conditions. We feel that this finding should be further explored because the intramuscular route of administration of tranquillisers has certain advantages over the oral route.

ERNEST H BENNIE

Leverndale Hospital,
Glasgow

¹ Bennie, E H, and Kinnell, H G, *Lancet*, 1975, 2, 1303.
² O'Flanagan, P M, *British Medical Journal*, 1974, 3, 258.

Daily antihypertensive therapy

SIR,—Drs A P Douglas-Jones and J M Cruickshank (24 April, p 990) suggest that mild hypertension could be adequately controlled by a single daily dose of the beta-adrenergic blocking drug atenolol.

We have recently completed a study of the pharmacokinetics of another beta-blocker, metoprolol, in a small group of young healthy volunteers. The beta-blocking effect of the drug was assessed by measuring the reduction in tachycardia induced by standardised exercise on a bicycle ergometer. After a single 200-mg dose of metoprolol there was a significant effect in 30 min ($P < 0.05$) which persisted throughout the day and was still significant at 12 hours ($P < 0.01$). Furthermore, the pre- and post-exercise pulse rates had not returned to those obtained 24 hours after placebo administration. These results suggest that when 200 mg or more of metoprolol is prescribed a single daily dose, particularly if taken first thing in the morning, would be rapidly effective and would maintain significant beta-blockade while the patient is awake and active and should provide adequate control of milk to moderate hypertension.

This suggestion will have to be evaluated by further clinical trials when the control of blood pressure over 24 hours and the incidence of adverse effects on once-and twice-daily regimens can be compared. Once-daily treatment with metoprolol and perhaps other beta-blockers is likely to improve patient compliance and make long-term therapy for hypertension and angina more acceptable.

M J KENDALL
R A YATES

Department of Therapeutics and
Clinical Pharmacology,
Queen Elizabeth Hospital,
Birmingham

Multiple sclerosis and poliomyelitis

SIR,—Your leading article (1 May, p 1030) does not mention the name of the person who first drew attention to the analogy between the epidemiology of acute anterior poliomyelitis and multiple sclerosis. This was Dr David Poskanzer,¹ who, with his colleagues Drs Schapira and Miller, published his ingenious hypothesis in 1963. It is important that this point should be made, as confirmatory evidence of an epidemiological pattern along the lines they suggested is now beginning to appear.

E D ACHESON

Faculty of Medicine,
University of Southampton

¹ Poskanzer, D C, Schapira, K, and Miller, H, *Lancet*, 1963, 2, 917.

Unexplained bitemporal swelling

SIR,—A minor but puzzling syndrome was recently encountered on our teaching medical service and we wonder if your readers have previously observed it or can give us any suggestions.

The patient was a 27-year-old white woman who presented with bilateral temporal swelling accompanied by blurred vision, sweats, nasal congestion, and an oral temperature of 38.6°C. There was no history of trauma, diplopia, tenderness, rashes, or joint complaints. She had a long medical and psychiatric history, including a seizure disorder for which she was maintained on diphenylhydantoin. The other medications included desipramine, chlorpromazine, loxapine succinate, and benzhexol hydrochloride.

She was a healthy, alert young woman, somewhat apprehensive but in no distress. Symmetrical areas of soft-tissue swelling about 4 cm in diameter were noted in the temporal regions protruding