Leucotomy in Persistent Anxiety

SIR,—I read with interest Dr. G. D. F. Steele's article (July 14, p. 84) on a case of persistent anxiety and tachycardia successfully treated by prefrontal leucotomy. His report should remind us of the stringent need to select carefully all patients to be submitted to physical methods of treatment, especially those which cause irreversible damage to normal tissues. Furthermore, as Dr. Steele is at pains to underline, the improvement in this type of case is obtained at no small price. Leucotomy should still be regarded as last on the list of therapeutic manœuvres in the psychiatrist's armamentarium when handling psychotic or non-psychotic patients. Like other therapies, leucotomy may yield good, bad, or indifferent results. Rose and Solomon in *Failures in Psychiatric Treatment* (Grune and Stratton, New York, 1948) indicate that we shall not achieve an understanding of the failures until we have more certain knowledge of why or how the operation is successful.

One danger stemming from the publication of such a case as Dr. Steele's is the arousal of a morbid therapeutic zeal in those training to be psychiatrists. Dr. W. Lindesay Neustatter's sober reflections (*Lancet*, 1951, **1**, 1331) on the use and abuse of electroshock therapy are equally applicable to leucotomy. Indiscriminate prescription of leucotomy will not only bring the treatment into disrepute, but may also turn back the clock to an era of empirical therapy. Leucotomy is too close a derivative of mediaeval trephining in mental disorder to allow us to feel comfortable.—I am, etc.,

Cincinnati, Ohio. A. B. SCLARE.

Prickly Heat and Heat Exhaustion

SIR,—The additional information provided in Dr. W. S. S. Ladell's letter (July 21, p. 177) indicates that his subject had symptoms of exhaustion over a period of months and therefore is unlikely to have suffered merely from simple prickly heat. Since at no time did the subject seem to have any marked reduction in the ability to sweat he did not show the clinical picture of anhidrotic heat exhaustion as we saw it in Karachi. On the evidence provided by Dr. Ladell's case we must therefore conclude, with great reluctance, that this syndrome is not the same as type II heat exhaustion.

The mean daily temperature at Karachi in 1946 was of the order of 90° F. E.T. (32.2° C.) for several weeks, with a relatively small diurnal swing. Under these conditions subjects could have marked impairment of sweating without symptoms of exhaustion. In contrast, Dr. Ladell's subject, exposed to environmental stress of the same sort of severity, had symptoms without any marked sweating deficiency, so the symptoms were not obviously anhidrotic in origin. Further, the clinical distinction between active prickly heat and anhidrotic heat exhaustion is not meaningless. They never coexisted, and the skin was quite different in the two conditions.

The mildness of the heat exhaustion in Dr. Ladell's subject unfortunately does not resolve our differences (see July 14, p. 119), since we feel that sweating deficiency is the proximate cause of the lowered heat tolerance (at least in anhidrotic heat exhaustion), not something which develops at a later stage (as in the train of events suggested by Dr. Ladell). We did make the observation, however, that while the intensity of exhaustion symptoms depended principally on the heat stress to which our subjects were exposed, there was an individual threshold for such symptoms.

The need for making a distinction between a failure of adaptation and a disease of adaptation is especially evident when considering heat stress. It is obviously always possible to find environmental conditions sufficiently severe to overtax any particular individual's ability to adapt, but such a failure would not normally be considered a disease. Only if the environmental conditions were of not more than normal or average severity might the individual be considered to have a disease of adaptation, and the difficulty in deciding what is normal or average increases the need for being clear about the distinction. In addition, any disease (in the usual sense of the word) which reduces heat tolerance will cause, under stress, symptoms of a failure of adaptation to heat. But this would not be a reason for labelling congenital absence of the sweat glands, for example, a disease of adaptation. A breakdown in any one of the many processes (circulatory, sudoriferous, nervous, mental, etc.) concerned in adaptation to environmental heat will mean a failure of adaptation. Yet the clinical picture will depend on the site of the breakdown, and we doubt the wisdom of selecting one particular syndrome as a disease of heat adaptation.—We are, etc.,

G. O. HORNE.
Leeds. R. H. MOLE.

Use of the Self

SIR,—Dr. R. Halstead Dixon (July 21, p. 179) deals with the problem of coronary thrombosis on the principle of employing "deep breathing" as a means of combating the growing menace which coronary thrombosis has been acknowledged to be.

Could you not go further in this direction and bring to the notice of your readers the work of Mr. F. Matthias Alexander, who is well known as having been the inventor of a technique which a person may employ for the conscious guidance and control of reaction on the principle of the employment of Nature's integrative mechanism which Mr. Alexander discovered and called primary control? A person who employs the F. Matthias Alexander technique is enabled to adjust the self as a whole in a way which permits the head to go forward and up, the neck to relax or to be freed from harmful tension, the back to lengthen and widen, and the arms, hands, and fingers, the legs, feet, and toes, to be adjusted in a manner which enables them when called upon for performance to operate in association with an overall outward thrusting of the self as a whole upon its environment. Such an adjustment of the self as a whole provides circumstances in which all the internal mechanisms may operate with the greatest possible freedom within the greatest possible space which a person may make available for their accommodation.

These circumstances allow the floating ribs to have their greatest possible range of movement, and not only open out the lungs and the channels of the circulatory mechanisms as well as the internal viscera in the way allowing the greatest freedom, but release the mechanisms of the central and peripheral nervous mechanisms from the constrictions and restraints which may be shown to be associated with a habitual or instinctive and frequently unthinking use of the self as a whole.

If it is true that surgeons believe that it is worth while employing the principle of deep breathing as a means on which they may be able to rely to prevent coronary thrombosis after operations, is it not reasonable to argue that a person who employs the self in accordance with a principle that allows the lungs their greatest possible freedom and the floating ribs their greatest range of movement thereby reacts in his living in a manner which may be judged to offer means of preventing many catastrophes besides those having the magnitude of coronary thrombosis?—I am, etc.,

Bolton. MUNGO DOUGLAS.

"War" and "Peace"

SIR,—Dr. H. E. Vickers (August 4, p. 300) criticizes the action of the Central Medical War Committee in asking doctors to register for service in a possible emergency. I remember that in 1938, when the response to a similar appeal was almost unanimous, there were a few doctors whose attitude was that of Dr. Vickers. Whilst never doubting the sincerity of their intentions, one trembles to think what might have happened if they had had their way. There would have been no A.R.P. centres ready and staffed, whilst the allocation of doctors to suitable work would have been very difficult, if not chaotic.

More than once Dr. Vickers begs the question. Is he just in charging us with spending time and money on atomic warfare? And is it fair to quote Hippocrates in this connexion? I am ignorant of Hippocrates' views on war, but