should be made of each necessary diagnostic procedure. A full description of our experience with monoarticular arthritis in children has recently been published, which a more specialized audience may perhaps find useful.[1]

Finally, as Professor Illingworth well knows, some large-scale well-controlled studies have shown that cortisone,[2] prednisone either in moderate dosage,[3] or in larger dosage,[4] or in more prolonged dosage,[5] shows no superiority to acetylsalicylic acid in preventing residual rheumatic heart disease. Others have claimed that it does, and there are controlled trials to support this view. Our own view at Taplow on the basis of various controlled trials and with experience of over 1,500 cases of rheumatic fever is as expressed in my article, that prednisone does not prevent the development of rheumatic heart disease but may be better than salicylate in preventing failure in cases of moderate or severe carditis.—I am, etc.,

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REFERENCES

1 Bywaters, E. G. L., and Ansell, B. M., *Ann. rheum. Dis.*, 1965, **24**, 116.
2 Rheumatic Fever Working Party of the M.R.C., *Brit. med. J.*, 1960, **2**, 1033.
3 Combined Rheumatic Fever Study Group, *New Engl. J. Med.*, 1960, **262**, 895.
4 —— ibid., 1965, **272**, 63.
5 Bywaters, E. G. L., and Thomas, G. T., *Brit. med. J.*, 1962, **2**, 221.

Acute Non-specific Pericarditis

SIR,—Readers of your leader (10 July, p. 60) who may not have quick access to pathological journals would be interested to know that, although fatal cases of this condition are very rare in humans, Appleby and Fraser[1] reported six fatal cases in chimpanzees in the collection of the Royal Zoological Society of Scotland at Edinburgh.

These six cases were found in nine chimpanzees which died between August 1957 and November 1958. In all six, pericardial thickening was a principal feature, and in five the sac was distended with fluid. The authors do not mention the sex of the six cases. They comment that this condition in chimpanzees differs from that usually seen in man in being chronic and fatal rather than acute and benign and they add that the disease continues to occur sporadically in the Edinburgh collection.—I am, etc.,

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REFERENCE

1 Appleby, E. C., and Fraser, G., *J. Path. Bact.*, 1962, **84**, 245.

Eclipse of Hysteria

SIR,—We consider the letter from Dr. E. F. Murphy in your issue of 26 June (p. 1674) most timely. During the recent winter there was an outbreak of benign myalgic encephalomyelitis in a circumscribed area in Church End, Finchley. Some 80 cases were observed in the practice of one of us (B. S.). The clinical course was identical with that seen in the Royal Free Hospital outbreak of 1955. Many patients in this present series have exhibited the same apparently functional disturbances which characterized the aftermath of the 1955 cases, and a few have proceeded to true depression. It is of supreme importance that these unfortunate subjects should not be labelled hysterical. If the word hysteria is used at all it should be qualified by the prefix "organically determined." We agree with Dr. Murphy that experience with this disease of still unproved aetiology makes us wonder if there is such an entity as "pure" hysteria. Although it may not always be possible to define the underlying pathology, it is surely wise to regard all hysteria as probably organically determined.—We are, etc.,

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Diagnosis of Hysteria

SIR,—I have read Dr. Eliot Slater's article (29 May, p. 1395) with much interest but with, I fear, very considerable disagreement.

Hysteria, in my opinion, has a definite and very precise psycho-pathology, and I do not think we have yet improved on Babinski's dictum that "hysteria is caused by suggestion and can be cured by suggestion." I would go even further and state that the psychiatrist or general practitioner who has not mastered the technique of suggestion will find the treatment of these patients a nightmare. I have given a full account of the technique of *waking suggestion*[1] elsewhere.[2]

The confusion in the diagnosis and treatment of hysteria lies entirely, in my opinion, in a failure to differentiate two types of anxiety—the anxiety which is based on depression and the anxiety which is based purely on suggestion. In cases where depression is the real factor suggestion will be valueless and dangerous, and in cases where suggestion is the real factor E.C.T. and other measures will be valueless. (Very strangely, overlapping cases are quite rare.) But all cases based on suggestion should respond immediately to correctly given counter-suggestion, and in my experience of many hundreds of such cases treated in out-patient departments such cures are complete and lasting. To avoid confusion, I think one should call the latter by the old name "anxiety hysteria" and restrict the term "anxiety neurosis" to cases based on depression. In practice, I found the incidence of these conditions approximately equal. But might I again emphasize that although these conditions may at first sight seem indistinguishable they are poles apart in psychopathology and are completely separate clinical entities. I do not think the term "conversion hysteria" is particularly useful. In anxiety hysteria physical symptoms (fainting, vomiting, giddiness, paralysis, etc.) may be marked but are more likely to be completely absent, and their presence in no way affects the treatment, except that, of course, somewhat different techniques of suggestion will be required.

As a slight reminder of the power of suggestion, I am sure that Dr. Slater is familiar with the hysterical symptoms frequently exhibited by medical students on beginning clinical work. Fainting in the operating theatre is the commonest, but usually also a number of the prevailing "diseases" are acquired. In my time the "favourites" were appendicitis, tuberculosis, and heart disease, but no doubt some of these are now supplanted by such things as leukaemia, lung cancer, etc.—I am, etc.,

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REFERENCES

1 Brown, William, *Post-graduate Lectures*, 1924. London University.
2 Thompson, R., *Practitioner*, 1951, **166**, 269.

"Early Curable Stage" of Rheumatoid Arthritis

SIR,—Dr. Francis Bach (26 June, p. 1671) does not share my doubts about the value of treatment in "early" rheumatoid arthritis, but unfortunately he fails to tell us what treatment we should give. He says: "... of the remaining seven [patients out of every ten] the 'activity' of their disease, their ability to cope with it, and the sort of life that they will be able to live, does depend on our recognition of the disease, preferably in its early phase, and on our giving proper advice which is accepted and carried out, sometimes over many years, by the patient and his doctor." What is this "proper advice"? He says that physiotherapy has a "limited but well-defined role in the management of these patients." What is this role?

Dr. Bach tells us that: "Every day the Secretary of the B.R.A.A. receives letters from our members or from the general public ... saying that their doctors have told them that they have arthritis, that nothing can be done for them." I suspect that these doctors said no such thing, and it is astonishing that conclusions should be drawn from patients' descriptions of alleged statements by their doctors. I have had discussions along the following lines with the subjects of rheumatoid arthritis who have been referred to me. *Q.* What treatment are you having? *A.* (truculently) I'm having no treatment of any kind. *Q.* Do you mean you are having no tablets? *A.* Oh yes, I am having *tablets*. *Q.* Are they doing you any good? *A.* No, they are absolutely useless. *Q.* Do you mean they don't relieve the pain? *A.* Oh well, they do dull the pain for a time. To many patients, therefore, analgesic tablets are not treatment. Yet it often seems to me that the patient's doctor has been right in merely prescribing aspirin.

In dealing with the early case—and I emphasize that my letter was only concerned with the early case—it seems to me that as a profession our fault is not (as Dr. Bach tells us) the failure to give treatment but the giving of too much treatment. Steroids, chloroquine, gold, and phenylbutazone are all dangerous drugs which should be reserved for the severely afflicted but which are too often given to patients with minor diseases who "demand" that something be done.—I am, etc.,

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Emigration of British Doctors

SIR,—Abel Smith and Gales[1] showed that of British born and trained doctors qualifying between 1955 and 1959 only 11.1% were