

initially treated in an identical fashion. It makes me wonder whether in fact Chinese treatment is really St. Peter's treatment and whether, perhaps, Chairman Mao paid us a surreptitious visit before the cultural revolution (or vice versa?).—I am, etc.,

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### Medical Prisoners in Chile

SIR,—There has been some expression of concern recently in the press for the political prisoners held by the new military régime in Chile. However, little has been heard of the fate of the many members of the medical profession arrested by the military junta after they came to power in September 1973.

According to the testimony of escaped colleagues, these doctors, nurses, and others were rounded up shortly after the new régime came to power simply for being supporters of the medical policies of the Allende government. In this way they are being held without trial for their medical beliefs and in no way can they be considered political prisoners. President Allende was trying to pursue medical policies designed to take the emphasis away from the urban élite and redistribute health facilities to the bulk of the Chilean population in the rural areas.

I believe that it should be a matter of concern to all members of the medical profession, all over the world, that these doctors should be persecuted for the practice of medicine to the best of their ability. I feel sure that if the new junta believed that the eyes of the medical profession were watching their treatment of these doctors, then they would moderate their actions. I would therefore like to ask all those doctors who are indeed concerned at the treatment of their colleagues in Chile to write to those in power expressing this concern. I have a list of addresses to which they should write and can also arrange translation facilities where necessary.—I am, etc.,

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### Response to Propranolol and Diazepam in Somatic and Psychic Anxiety

SIR,—The recent paper by Drs P. J. Tyrer and M. H. Lader (6 April, p. 14) clearly differentiates two entirely different kinds of anxiety. Both kinds of anxiety are met with in student health practice, particularly in the period approaching a major examination. Drs. Tyrer and Lader called their anxieties "somatic" and "psychic" and this goes some way to clarifying a situation in which nomenclature has fogged our thinking since the nineteenth century. Writing about the connexion between lactate metabolism and anxiety, Pitts and McClure<sup>1</sup> wrote: "Anxiety reaction is not symptomatically distinguishable from anxiety neurosis or from the disorders represented by the terms neurocirculatory asthenia, vasoregulatory asthenia, nervous tachycardia, effort syndrome, neurasthenia, Da Costa's syndrome, vasomotor neurosis, nervous exhaustion, irritable heart,<sup>2</sup> soldier's heart and others. . . .

This semantic confusion has probably impeded and almost certainly not facilitated the study of lactate metabolism in anxiety neurosis." They went on to define an anxiety attack and were able to reproduce it in susceptible cases (which closely resemble Drs. Tyrer and Lader's "somatic" group) by lactate infusion.

In the student age group it is clear that the adrenaline-lactic-acid autonomically mediated anxiety in the examination period is much more a fear reaction, and the observation of a tense, white-faced patient with sweating hands and feet complaining of a multiplicity of anxiety-oriented symptoms should not automatically lead to "tranquillization." If we accept the differentiation of Drs. Tyrer and Lader, then it becomes apparent that the somatic group (with a rapid pulse) is likely to be helped by propranolol and the psychic group is not. Psychic anxiety as they define it seems to come much more into the "depressive" range of illness. The use of propranolol is contraindicated in this group of patients, firstly because of its ineffectiveness in symptom relief and secondly because it produces side effects of its own which it does not seem to produce in autonomically mediated anxiety attacks. The clinical touchstone to differentiate these two groups of patients is a labile pulse rate which under the "stress" of a surgery consultation may rise to 110-140 per minute.

Students in the somatic group are very rewarding to treat as their behaviour is exclusively examination-oriented and has been conditioned in the Pavlovian sense. The interruption of the autonomic pathway removes the effect of conditioning and a couple of successful examinations may serve to recondition the patient without the need for any complex medical or psychotherapeutic regimen. The first 20 patients in whom propranolol was used specifically in a somatic group collected in 1970-72<sup>3</sup> were each matched by age, sex, year, and faculty with the next student alphabetically (whether they had been seen in the health centre or not). The examination results were compared and in each of the two groups three got distinguished degrees, 15 got moderate results, and two failed or had to resit an examination. Looked at from the outside this is not impressive. However, my own assessment of the patients was that in many cases the examination would have been missed or, if attendance had been achieved, the backlash would have ensured failure. It is difficult if not impossible to perform controlled experiments on this group before examinations because, where the diagnosis is established, in my opinion no other treatment is effective so that we are in the position of doing experiments for academic curiosity in a situation where a patient's whole life will be altered by our inactivity. The ineffectiveness of adequate daytime tranquillization has been mentioned previously<sup>3</sup> and the clinical picture of "slow motion panic" is a familiar one to student health doctors.—I am, etc.,

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<sup>1</sup> Pitts, F. N., and McClure, J. M. jun., *New England Journal of Medicine*, 1967, 277, 1329.

<sup>2</sup> Da Costa, J. M., *American Journal of Medical Services*, 1871, 61, 17.

<sup>3</sup> Conway, M., *Practitioner*, 1971, 206, 795.

### Reversing the Brain Drain

SIR,—In recent times much attention has been given to the exodus of young doctors for the financially more rewarding positions open to them in the U.S. and Canada. It has occurred to me that it would be possible to reverse the brain drain or at least to compensate for it. To my knowledge there are not a few qualified U.S. physicians who would be glad to serve abroad if the opportunity were offered to them. Because of the large income many of them command they are in a financial position to retire at the age of 50 if they so desire. In ordinary circumstances they would not dream of doing so because medicine is their life and they would be bored and frustrated without practising their skills. Therefore many of them give an increasingly large proportion of their time to voluntary services, research, and teaching.

It is these doctors that I believe it would be possible to attract to these shores if an organized framework were set up within which they could be received. They would not be in competition with local doctors since they would not be in private practice but would be directed to institutions where their services are needed. This would make available, with no cost to the Health Service, a sizeable reservoir of well-trained physicians. Some easily organized amenities, such as housing and facilities to widen their social horizons, would probably be sufficient, especially if the official nature of the enterprise enabled them to claim U.S. tax deductions for their out-of-pocket expenses. These doctors, unlike their British colleagues in the large cities, would probably welcome being posted to the provinces since the opportunity to mix with the local communities is usually easier in the smaller towns.

I myself am a U.S. physician who retired from a busy private practice in order to take up a new career in teaching and writing. Currently I am lecturing in an honorary capacity at one of the teaching hospitals of London University.—I am, etc.,

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### Skull Transillumination

SIR,—Transillumination of the skull of infants and young children is a simple procedure which takes about two minutes to perform, requires inexpensive equipment, and may yield valuable information. Intracranial collections of fluid such as subdural effusions, hydrancephaly, or porencephalic cysts may be readily identified. The technique involves taking the child into a completely dark room or cupboard and applying a light to different parts of the skull. The light should be shielded from the observer's eye, and this demands a flexible lamp shade which will mould to any irregularities on the infant's skull.

There is no torch designed for this purpose on the market in this country. After several attempts with sticking plaster and rubber pessaries a simple solution was evolved using an infant oxygen funnel (McKilroy's Inhaler, Medical and Industrial Equipment, Manchester). The bell is trimmed to a diameter of 2-3 cm and the