localisation, and associated symptoms of the headache rapidly outline and give a lead to the diagnosis. Having taken an adequate history and examined the patient, commit yourself by writing down the diagnosis in your notes or in a letter to the consultant—and keep a copy. Learn from the reply and thus benefit from your own and others' experience. Remember also that in consultant practice we are by no means always confident in our initial diagnosis: the picture clears with time and response to reassurance and treatment, as well as with failure or progression.

Is the effort worth while? If headache is common in your practice and you wish to decide with which patients you can cope and those who need hospital referral—and to the right specialist—then the answer is obvious.

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⁴ Blau JN, Wilkinson M. A separation of tension and muscle contraction headache in the differential diagnosis of migraine (Abstract). *Headache* 1982;22:152.

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Caring for the young disabled

Are we complacent in supposing that the most severely disabled people living in the community are in touch with all the right agencies? At a conference of the Society for Tissue Viability held last month Dr T Price described a survey he had carried out in the borough of Harrow in which he had tried to identify very severely disabled young people. He had used the Harrow Social Services very severely handicapped register, the community nursing disabled service, and the Northwick Park Hospital physiotherapy department's "at risk" register of patients who might benefit from intermittent physiotherapy. Eight of the 28 most disabled patients on the nurses' list were not among the 89 cases on the social services register. Moreover, the total of about 100 identified in the age range 16-59 was probably not the true total: on the basis of the survey by Harris,¹ Dr Price estimated a total of 130. That figure rested on extrapolation, but it did seem likely that some had slipped through the net. Five years after the Chronically Sick and Disabled Persons Act 1970 Knight and Warren had found that even in the areas with the most active social services some handicapped people were not in touch with any of the professional services, while many more were not getting all the forms of help they needed and wanted.²

May not some people, however, choose not to be registered? Some may be getting help anyway and others may not need it. But in such cases some desirable aids or services may possibly be overlooked. Even where no help is wanted—as perhaps with some young people living with their parents—short or long term care may be needed in the future, perhaps suddenly, and this must be catered for in planning. The Harrow survey

was in fact prompted by the need for up to date information for the new young disabled unit serving Harrow and Brent. If planners are to provide intermittent residential care and sometimes day places to give families a break and to help in emergencies—just as important as providing a long term home—they must know the community's needs. These are the arguments for effective case finding with continuing surveillance² and for more communication between social and health services and other agencies.

Sadly, however, many units for the young disabled offer little by way of intermittent or day care. By 1979 there were 2050 places in the 86 units in Britain—everywhere far short of the 15-25 beds per 100 000 population that have been recommended. Three functions for these units have been proposed by the Health Departments: family support by holiday admission, day care, and shared care; rehabilitation; and long stay care. But of 46 units surveyed recently, 29 were almost entirely for long term patients (C J Scott, paper presented to a seminar organised by Leeds University's department of rehabilitation medicine, October 1982).

Speaking about young disabled units at the conference, Dr Anne Chamberlain discussed their frequent failings on the basis of her own experience and of the Leeds seminar. The main problems are due to the units having too few staff (especially remedial staff) with too little time to create a dynamic unit and to their lacking appropriate day facilities and activities. With over 10 years' experience and much skill and interest the NHS should be looking, said Dr Chamberlain, to expand creativity in these units and to make them cater for many more people living in the community.

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Staff editor, *BMJ*

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² Knight R, Warren MD. *Physically disabled people living at home: a study of numbers and needs*. London: HMSO, 1978. (DHSS Report on Health and Social Subjects, No 13.)

Panic disorder

Two major systems of classifying diseases take different approaches to coding anxiety disorders. The American *Diagnostic and Statistical Manual of Mental Disorders*¹ recognises, whereas the *International Classification of Diseases*² does not, a separate form of anxiety disorder; this generally occurs in late adolescence or early adulthood, is characterised by the sudden, dramatic onset of an overwhelming sensation of terror and imminent collapse, and occurs without understandable cause. The ninth revision of the *International Classification of Diseases*² recognises that anxiety may be a prominent feature of the emotional turmoil that results from acute or prolonged stress and advises that mixed states of anxiety and depression should be categorised as neurotic depression. It omits the concept of an anxiety prone personality disorder but, neurosis apart, the main category reserved for anxiety disorder is a single one which is allotted a plural form: anxiety states (300.0). Its two components are anxiety neurosis (or reaction) and panic attack (or disorder), but neither receives further definition in the glossary.

The classification used in the United States (*Diagnostic and Statistical Manual of Mental Disorders*, third edition)²

allots separate categories to these forms of anxiety disorder—that is generalised anxiety disorder (300.02) and panic disorder (300.01). Furthermore, it recognises two distinct forms of agoraphobia—agoraphobia with panic attacks (300.21) and agoraphobia without panic attacks (300.22). Extensive definitions of all these categories are given. Panic attacks are defined as discrete episodes of apprehension or fear accompanied by at least four (from a list of 11) symptoms of somatised anxiety such as dyspnoea, palpitations, chest pain, and faintness. Panic disorder is defined by the occurrence of at least three panic attacks in three weeks in the absence of a life threatening situation or the coexistence of other psychiatric disorder.

Does this delineation of a separate form of anxiety disorder matter? The answer must be yes, for the existence of panic disorder is confirmed by clinical observation and it is becoming clearer that the correct choice of treatment depends on the form of anxiety. Though most psychiatrists accept that both biogenic and psychogenic factors contribute to the development of depressive disorders, there is a general unwillingness to acknowledge a biogenic origin for anxiety. The term “endogenous anxiety” has not yet crossed to the British side of the Atlantic, yet evidence accumulates for considering panic disorder to be biogenic or endogenous. In 1959 West and Dally³ observed that a form of neurotic disorder characterised by panic attacks and phobic symptoms responded to treatment with monoamine oxidase inhibitors and, since these drugs were conventionally regarded as antidepressants, they called the disorder “atypical depression.” Shortly afterwards an American worker made a similar observation and showed that an anxiety syndrome characterised by sudden onset, panic attacks, palpitations, and foreboding of death responded to a tricyclic antidepressant drug.⁴ A recent paper has summarised the evidence for response of panic disorder to either monoamine oxidase inhibitors or tricyclic antidepressants.⁵

Sheehan *et al* introduced the term endogenous anxiety for a disorder which is marked by spontaneous panic attacks, multiple autonomic symptoms, and overwhelming fear⁶; they pointed out that this disorder has sailed through medical history under many aliases, including effort syndrome, cardiac neurosis, separation anxiety, and the hyperdynamic beta-adrenergic circulatory state. They drew attention to the chronic course of this disorder before its effective treatment with antidepressant drugs was recognised. It is now time for this fact to be underlined. Patients suffering from this condition often present at accident and emergency departments, whence they may be referred to cardiac clinics and other medical departments: time and expense may be wasted on diagnostic procedures, and the patient, becoming increasingly demoralised by the unexplained attacks, develops ever more firmly entrenched hypochondriacal beliefs. If the patient is referred for psychiatric treatment psychotherapeutic methods, including behaviour therapy and cognitive techniques, will be ineffective until the panic attacks stop. Panic anxiety rapidly leads to secondary avoidance responses and the familiar neurotic disorder of agoraphobia develops.⁷ If antidepressant drug therapy is to be effective it must be prescribed early in the course of the disorder; entrenched phobias cannot be expected to respond to drugs and will require psychotherapy.

There are no firm grounds for preferring one type of antidepressant drug to another in the treatment of panic disorders, though two recent studies have shown that a monoamine oxidase inhibitor is more effective than a tricyclic drug in relieving anxiety accompanying neurotic depression.^{8,9} Patients suffering from panic disorder are very sensitive to the

side effects of these drugs and often stop treatment unless the dose is initially low and increased gradually over two or three weeks.

The increasing evidence that there is a biogenic form of anxiety disorder characterised by spontaneous panic attacks raises interesting questions and new directions for future research. The biological substrate of the disorder is likely to be similar to that of the biogenic form of depression since both respond to the same treatment. In turn this raises the question of whether panic disorder is atypical depression; certainly symptoms of both disorders may occur together but either may exist alone, and this points to a dimensional rather than a categorical classification and returns us to a view, recently abandoned, that at least some forms of anxiety state should be classified as affective disorder.¹⁰ A recent review has also suggested the need for new thoughts on classification.¹¹

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Infection and defences in neonates

Sepsis neonatorum—bacterial infection in the first month of life—affects up to 10 babies per 1000 births. Septicaemia accounts for up to half these cases, and about one in five babies with this develop meningitis; infection may also involve bones, joints, kidneys, or lungs. Preterm babies are especially vulnerable, but those born at term are not spared.

The clinical features of neonatal septicaemia range from a fulminating, early onset type presenting in the first 24 hours of life with peripheral circulatory failure and respiratory distress to a more indolent form manifesting later with non-specific signs such as an unstable body temperature, lethargy, jaundice, apnoeic attacks, and abdominal distension. Sclerema—a diffuse, non-oedematous, tallow like hardening of the sub-