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Self injury and mental handicap

SIR,—Like suicide, self injury is a form of self mutilation and is not always a form of attention seeking due to boredom, as Dr Brian Kirman assumes (31 October, p 1086).

Suicide and self mutilation are often forms of aggression turned inwards and associated with aggression to others. This is particularly true of the mentally retarded. Control of aggression is difficult but notoriously so in those severely retarded.¹ From 1969 onwards there have been several reports on the usefulness of lithium in patients exhibiting aggression. The patients included groups of delinquents, psychotics, and the mentally handicapped. The larger studies indicate a positive response in some 70-75% of cases.²

These figures were confirmed in the first published multicentre double blind trial of lithium in mentally handicapped patients, published last May.³ Until the survey quoted by Dr Kirman⁴ is published it is not possible to say whether the authors were aware of this but it seems unlikely.

Lithium is not necessarily a cure and is usually given only when all other methods have failed, although a plea for its earlier use in these patients was made recently.⁵ It seems helpful in relieving aggression, including self mutilation, in these patients, which distresses them, their relatives, and staff. The grave shortages of staff trained in behavioural techniques may to some extent be relieved if this element is used with effect. The patient may become more receptive to this type of treatment.

P G DALE

Mental Handicap Services,
Goldcrest Hospital,
Sarisbury Green,
Southampton SO3 6ZD

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Potassium citrate mixture: Soothing but not harmless?

SIR,—Drs J E Elizabeth and N J Carter (17 October, p 993) have presented data suggesting that therapeutic or supranormal doses of potassium citrate mixture can cause life threatening hyperkalaemia. Unfortunately their data are incomplete and therefore they may have drawn untenable conclusions.

No reliable estimate of glomerular filtration rate is given, but, more importantly, the authors failed to measure any urinary variables. In health urinary potassium ranges from 30 to 100 $\mu\text{mol/day}$ depending on potassium intake¹ and may rise to twice this figure if progressive potassium loading

is undertaken in people with normal kidneys. Assuming tubular patency, urinary potassium is determined by the quantities of potassium secreted by distal converted tubules and collecting ducts.² Drs Elizabeth and Carter have assumed that in their two patients the rate of ingestion of potassium was greater than the rate of potassium excretion. Both patients had urinary tract infections, the localisation of which was not stated, and the authors assume that "renal function was normal." They do not provide evidence for this supposition. One well recognised feature of acute pyelonephritis is suppression of urine formation due to intrarenal oedema causing an obstructive uropathy which is accompanied by an inability to excrete potassium. This, I suggest, is the most likely cause of the reported hyperkalaemia. The same error was made by the two authors of the two apparently comparable cases cited by Drs Elizabeth and Carter.^{3,4}

Finally, I am surprised that potassium citrate BP is still used. It is a foul tasting solution indicated only if a renal tract infection is to be treated with aminoglycoside.⁵ Sodium bicarbonate is better and more acceptable in this respect.

ROGER GABRIEL

Renal Unit,
St Mary's Hospital, W2 1NY

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Micrometastases in bone marrow in patients with breast cancer

SIR,—The paper by Dr Janine Mansi and others (31 October, p 1093) is essentially on the prediction of the development of symptomatic metastases in breast cancer. Their conclusion that their test epithelial membrane antibody staining of bone marrow is "a useful predictor of early relapse" is not even justified by their own figures. This factor did not emerge as a strong variable and when other prognostic variables were taken into consideration was completely eliminated.

The conclusion from their study must be that the prognostic variables of grade and stage are better at predicting the subsequent development of symptomatic metastases than is their test. Furthermore, their test is difficult to undertake, requiring marrow biopsy at eight different sites in each patient. Measurement of grade and stage are easily undertaken and are in fact routine in many centres. Several years ago we showed that combining these factors gives an excellent index of prognosis¹ and we have recently confirmed the value of this index prospectively.²

As to the accuracy of the bone marrow test, it is noteworthy that of 307 patients, 84 had stage III or IV disease, in whom we may assume that metastases were certainly present. Their test gave a sensitivity of only 43%.

R W BLAMEY
J F R ROBERTSON
A P LOCKER

City Hospital,
Nottingham NG5 1PB

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Disciplining doctors

SIR,—I would echo Dr David Roy's comments (7 November, p 1190) that as a system for disciplining doctors the HM(61)112 procedure is bad for the patients (who are deprived of the skills of the suspended doctor), bad for the National Health Service (over £30m spent on these procedures since this government first came into office), and bad for the doctors.

Chief among the problems is the time it takes to resolve a case. It is absurd that one doctor had to go to the High Court one year after his suspension to find out what he was accused of. Equally it is monstrous that a doctor can be suspended for years only to be told eventually that all accusations against him are withdrawn. The stress that such a prolonged suspension creates is destructive to both the doctor and his family, and no amount of financial settlement can make adequate recompense.

The central difficulty is that district medical officers, who in teaching districts are responsible for the initial suspensions, have little or no training in deciding the professional competence of a highly trained consultant or how to assess whether there is a *prima facie* case against him. In the mean time the present adversarial system means that much time is then lost while opinion is canvassed and evidence is sought that could justify the HM(61)112 process.

There are bodies who regularly determine and certify the professional competence of doctors and specialists—the General Medical Council and the royal colleges and faculties. If we are to regulate our own profession then the royal colleges must be concerned in cases of alleged professional incompetence, if only to act as a preliminary screener for the GMC to determine if there is a *prima facie* case. The disciplinary committee of the General Medical Council is well experienced in judging the professional competence and conduct of doctors.

Written statements containing all allegations imputing a doctor's competence should be obtained within days of the original suspension and copies submitted to both the suspended doctor and the appropriate royal college or faculty, with the objective that the case should be resolved within six months. There is an old legal adage that justice deferred is justice denied. Failure to establish the date of any hearing or inquiry within six months of the original suspension should result in the automatic reinstatement of the suspended doctor. Such a system would save the NHS millions of pounds and the suspended doctor and his family much anguish. Given the virtual monopoly employer status of the NHS, the evidence justifying dismissal of a hospital doctor should be solid and unequivocal, and as such it should not take a competent administration long to gather.

Dr Roy suggested that there may be as many as 40 doctors suspended under HM(61)112 procedures. Defending these doctors will cost the profession over £1m, but the defence costs are not reimbursed even if the doctor is found innocent or the case is dropped. This is another of the injustices of the present system and one of the reasons why the subscriptions to our defence organisations are so high. If the system were streamlined and the medical profession self regulatory then the reduced defence expenditure would be tolerable, but not while we are at the mercy of a meandering bureaucratic system, a process that one eminent judge described as making legal systems look like Toytown.

Another major criticism of the present system is that there are virtually no checks on maladministration in disciplinary processes. The Health Service Commissioner should be able to investigate