Dysuria in Women

SIR,—The interesting paper by Dr. W. E. Waters and others on the clinical significance of dysuria in women (27 June, p. 754) fails to mention the possibility of any gynaecological cause of the symptom. The question of a gonococcal urethritis must always be borne in mind as a possible diagnosis in a woman complaining of sudden dysuria, and particularly so at the present time when the incidence of V.D. is rising so sharply.—I am, etc.,

JEAN HERRING.

Dundee.

Maintenance Digoxin

SIR,—Dr. J. L. C. Dall (20 June, p. 705) is right to draw attention to the dangers attending the use of digoxin and to question the tradition of once on digoxin, always on digoxin. I wonder, however, whether he has followed up his patients when they have left hospital.

Three of my elderly patients recently admitted to hospital had their digoxin discontinued apparently without ill effects, but within a short time of their returning home and resuming even modified activity developed clinical evidence of left ventricular failure, which was not controllable by diuretics (with or without potassium supplements). They responded, however, very well to digoxin, and are once again on a maintenance dose.—I am, etc.,

RONALD MULROY.

Chapelthorpe,
near Wakefield, Yorks.

Ergotamine Tartrate in Migraine

SIR,—Professor J. Chassar Moir (6 June, p. 599) claims to detect a probable fallacy in the method of assessment used in the controlled clinical trial of ergotamine tartrate (9 May, p. 325). However, the trial did not assume the effect of therapy would be evident at any particular time. It simply recorded the overall response to the tablets. With regard to the route of administration, a widely accepted method was employed as over two million tablets of ergotamine tartrate were prescribed in England and Wales in 1968. If given by injection the results may well be different, but it is likely that injection would also alter the placebo response.

Dr. D. S. Freestone (6 June, p. 599), Dr. W. P. Maclay (20 June, p. 736), and Dr. R. T. D. Fitzgerald (27 June, p. 792) raise the problem of dosage, which is always difficult in a double-blind controlled trial. The recommended doses of ergotamine do vary widely but the *British National Formulary* gives 1 to 2 mg., and Sir Derrick Dunlop gives a maximum dose of 4 mg. in a day.¹ In a previously published trial 1 or 2 mg. of sublingual ergotamine tartrate was given.² In view of these dosages, and also the side-effects experienced in the trial, it certainly seems reasonable to have tested the effect of 2 or 3 mg. first.

Dr. Freestone suggests that a "clinical-pharmacological measure" would be preferable to "purely subjective clinical assess-

ments." While an objective test would be a useful addition, therapy in migraine is given solely for symptomatic benefit. The main assessment of any treatment should therefore be based on symptoms. Dr. Maclay stresses the importance of the severity of the headaches. Before the trial an assessment of the severity was made. There was no evidence that those with more severe headaches had a better response to ergotamine. In fact 45 of the 88 women had consulted a doctor because of their headaches; the response to ergotamine in these women did not differ from that of the others. The tablets were to be taken "as early as possible in each attack." Subjects were advised to take them at the beginning of any premonitory symptoms.

The paper describes the method of selection of these women and, although the definition of migraine presents many difficulties, it seems likely that the majority would be diagnosed as migraine by most clinicians. One of the reasons for the trial was to test the suggestion that the response to ergotamine is helpful in the diagnosis of migraine. I therefore disagree that this trial was unjustifiable. Perhaps Dr. Maclay, who did not disclose his possible biases in his letter, would tell us the right dosage of the right drug and how to select the right patients, and give evidence from controlled clinical trials for his statements?—I am, etc.,

W. E. WATERS.

M.R.C. Epidemiological Research Unit,
Cardiff.

REFERENCES

- 1 Dunlop, D., in *Background to Migraine: Second Migraine Symposium*, ed. R. Smith, p. 72. London, Heinemann, Medical, 1969.
- 2 Crooks, J., Stephens, S. A., and Brass, W., *British Medical Journal*, 1964, 1, 221.

Timely Testimonials

SIR,—Testimonials play an important part in hospital appointments. Requests for these are usually franked with a fourpenny stamp for second class mail, accompanied by an addressed envelope for the reply, also bearing a fourpenny stamp. I have again just added a penny stamp to a reply envelope in the hope that my testimonial will (by promotion to first class mail) just beat the starter's pistol for the meeting on Monday—it is already Friday evening and this is a small country village.

As testimonials can be important factors at appointment boards, and influence the careers of men and women of much importance to the community, they should either be requested in ample time or be sent by first class mail or—better still—both.—I am, etc.,

J. C. HAWKSLEY.

Marlborough,
Wilts.

Cataracts

SIR,—I should like to congratulate Mr. P. D. Trevor-Roper on his article "Cataracts" (4 July, p. 33), written with all his customary skill in exposition and elegant use of the language. However, I disagree with the emphasis in his statement that unilateral cataracts need not normally be removed.

The fitting of a contact lens after such a surgical procedure is usually well tolerated, and even elderly patients can wear the lenses with benefit. The prospect may seem daunting at first but the rewards are considerable in the restoration of binocular function, and the numbers of successful and grateful patients can be high. Certainly the attempt is always worthwhile because it is free of significant risk, and the alternative is suppression of the cataractous eye and subsequent divergent squint.

Indeed, contact lens fitting is worthy at least of consideration in many postoperative cataract cases, because it is thus possible to obviate the distressing effects of aphakic spectacles, so ably described in the article.—I am, etc.,

WILLIAM WALLER.

London W.1.

Hazards of Temperature Taking

SIR,—The most convenient place to take a baby's temperature (4 July, p. 4) is the groin, with the baby lying on its side in the cot or sitting on mother's lap. If you hold its arm down for two minutes to take the axillary temperature it is going to scream or cry. I have never found any necessity yet to put a thermometer in a child's rectum.—I am, etc.,

R. F. DIVECHA.

Hove, Sussex.

Folate and Vitamin B₁₂ in Epilepsy

SIR,—The advent of a new therapy in medicine may provoke varying reactions. One area in which caution has usually been shown to be justified is the pharmacotherapy of epilepsy. Dr. C. Neubauer (27 June, p. 759) is being unfair in asking us to accept the value of combined vitamin B₁₂ and folic acid replacement without revealing how his conclusions were derived. One would imagine that the measurement of cognitive and behavioural changes in children would present considerable problems, yet he has not mentioned how this was attempted or by whom observations were made.

I examined the case notes of 24 patients admitted to the epilepsy unit of the Maudsley Hospital during a nine-month period, but was able to find no significant relationship between serum folic acid levels and factors such as age, amount, or type of anticonvulsant medication and fit frequency. No significant differences were apparent between the following sub-groups:

Epileptic: Subcortical 6, temporal 8, Generalized 6, Other or not known 4.

Psychiatric: Affective 5, and Schizophrenic 2,* organic behaviour/personality disorders 5, normal 3.

In recent years increasing attention has been directed at the undesirable consequences of major convulsions in childhood, and many clinicians still regard them as important in the causation of "epileptic deterioration" in adults. I would urge caution before accepting into common usage any treatment which is likely to increase the frequency of fits. Although Dr. Neubauer's report has important implications, there is

clearly a need for more research in this area. The protective effects of vitamin B₁₂ would similarly appear to be as yet unsubstantiated.—I am, etc.,

K. F. STANDAGE.

Bexley Hospital,
Bexley, Kent.

*Both patients with schizophrenic symptoms had low folates.

SIR,—I was interested to read both the paper by Dr. C. Neubauer (27 June, p. 759) and also your leading article on the subject of serum folate and B₁₂ levels and epilepsy (p. 744).

I have been involved in two recent research projects on this subject.^{1 2} I rather envy Dr. Neubauer's finding of therapeutic benefit from the administration of both folic acid and vitamin B₁₂ to his patients. It was in the hope of arriving at just such a conclusion that we undertook the second piece of research mentioned above. Knowing full well the fallacies of personal assessments of behaviour improvement when undertaking a therapeutic programme, the efficacy of which one wishes to see established, we took the precaution of carrying out the drug trial under double-blind conditions, and also had a definite system of assessing behaviour. Dr. Neubauer appears to have overlooked these precautions, and perhaps therein lies the difference between his positive findings of therapeutic benefit, and our own less happy negative findings.

However, there is another important factor in that Dr. Neubauer administered both folic acid and vitamin B₁₂, whereas we confined ourselves to giving only the former; it may well be that the combined administration does confer some superiority, and certainly the analogy of precipitation of subacute combined degeneration of the spinal cord when folic acid alone is given to some patients with megaloblastic anaemia is interesting. However, I think more rigorous proof is required before allowing the conclusion to pass unchallenged.

In your leading article you refer to antagonistic effect between folic acid and vitamin B₁₂ in epilepsy as well as subacute combined degeneration. I think this effect is not established either. For instance, in our research we did not find that the administration of folic acid alone to our epileptics led to any increase in the frequency or severity of their fits. Furthermore, there was no apparent tendency in our drug trial for serum vitamin B₁₂ level to fall as folic acid therapy continued.

Although we found in the first of our research projects that there was a definite, though diagnostically indeterminate, relationship between low serum folate and mental illness in epileptic patients, there was no such relationship with lowered serum vitamin B₁₂ levels. A lowered serum vitamin B₁₂ level was very much less common than a low serum folate in mentally ill epileptics, and in only one patient was a finding of lowering of both levels recorded.—I am, etc.,

R. P. SNAITH.

Stanley Royd Hospital,
Wakefield, Yorks.

REFERENCES

- 1 Snaith, R. P., Mehta, S., and Raby, A. H., *British Journal of Psychiatry*, 1970, **116**, 179.
- 2 Ralston, A. J., Snaith, R. P., and Hinley, J. B., *Lancet*, 1970, **1**, 867.

Burden of Cerebrovascular Disease

SIR,—I feel the article by Professor R. M. Acheson and Dr. A. S. Fairbairn (13 June, p. 621) is incorrectly titled. A better title would be "The Burden on the Hospital Service due to Cerebrovascular Disease." Total incidence of cerebrovascular disease is calculated by adding home deaths to hospital morbidity. This leads to an underestimate of incidence by the number of cases treated at home who either live for more than one year or who die within one year from some other cause. The authors state that "no information is at present available about this group [those treated at home who recover], so that it must be ignored."

I see no reason why this group should be ignored, and it is at present being studied in a defined community in South Wales by ordinary epidemiological methods. Our present results suggest that 60% of all "clinical" strokes never go to hospital, and that they are similar as regards severity and case fatality to those who are hospitalized. The indications for hospitalization in this area appear to be mainly social.

This means that there must be considerable error in Professor Acheson and Dr. Fairbairn's estimate of incidence. Their measurement of case fatality is similarly subject to error—both in the number of cases and in the number of deaths. Similarly their breakdown by marital status, if hospitalization is mainly for social reasons and those surviving at home are omitted, is very open to criticism. Their comparison with Middlesex County is surely inappropriate. Middlesex County is a correct study of total incidence. Any agreement must be coincidental.

Record linkage is a wonderful tool. When it covers general practice as well as hospitals it will be possible to use it for community epidemiology. Until then the usual methods seem safer.—I am, etc.,

A. L. COCHRANE.

Barry, Glam.

Costs of Screening Programmes

SIR,—Your leading article (6 June, p. 553) on phenylketonuria is timely, emphasizing as it does the need to review the organization which must be set up to deal with cases detected by screening programmes. We believe that it might be appropriate, too, for some central department at this time to review aspects of the screening programme itself, particularly those details relating to recording and reporting of results. The price of communication will be far from negligible in the final cost/benefit analysis which, surely, must soon be undertaken.

The cost of collection and reporting at this hospital is shown in the weekly figures which follow:

Costing of Guthrie Test (about 70 tests per week)			
	£	s	d
Cost of Collection of Specimens	15	14	10
Cost of Tests (laboratory cost)	1	19	6
Cost of Recording and Reporting	4	18	10
Cost of Instruction to Midwives and others	2	9	3
Total Cost + 10%	27	13	0

The cost of test materials and laboratory personnel is negligible in comparison with the costs of collection, recording, and

reporting—tasks which fall largely on the nursing and secretarial staff. Our costing exercise, of course, does not take into account further expenditure on babies born at this hospital who for one reason or another (mainly early discharge) must be followed up by the medical officer of health.

Your leading article states that the result of the test, even if negative, should be given to the parents. While no doubt a courteous and humane gesture, this would add considerably to the expense, even if parents provide their own stamped addressed envelopes for the information. It has not been our practice here; nor is it customary for the results of laboratory procedures to be communicated directly to the patient, save at the discretion of the patient's own doctor. You also state that the laboratory should inform the midwife or health visitor as well as the medical officer of health, the family doctor, and the consultant paediatrician if two tests are positive. We cannot see what purpose is served by the laboratory directly informing the midwife or the health visitor, even when it is possible speedily to locate the originator of the test, and, again, this runs counter to ordinary practice. It too must add to the cost, although probably not greatly, as the numbers involved are small. By the time two positive tests have been reported it is most unlikely that the child will be under the care of a midwife, and we have little doubt that the medical officer of health would ensure that his staff were informed in any event. Costly duplication of information should be avoided, in our view.

If other screening programmes are to be introduced on a national scale, surely it is only wise to review critically the expenditure on this one, cutting it wherever possible by encouraging a truly national practice, and by discouraging unnecessary communications, be they reports, letters, or telephone calls?

We are indebted to Miss K. Kovari and to the Treasurer, Queen Charlotte's Maternity Hospital for calculations of cost.—We are, etc.,

ROSALINDE HURLEY.

A. P. NORMAN.

Queen Charlotte's Maternity Hospital,
London W.6.

Cancer and the Pill

SIR,—I have seen over the last two years four cases of breast carcinoma where the disease seems to have started soon after the patient was launched on the contraceptive pill.

Many women are taking the pill for the first time at an age when the incidence of breast carcinoma starts to rise steeply. Much has been written about the thromboembolic risks, and the appropriate modifications in hormone dosage have been advised and largely heeded. But may it not be that the carcinoma risk is much more important? Our ignorance of the possible links between hormone imbalance and breast and uterine carcinoma is virtually complete. It is likely that there is a profound relationship in susceptible cases, and hints about this are only now coming