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

to light through the work of the team at the Imperial Cancer Research laboratories¹ and others.

It is probable that the enormous social convenience of the pill—and the first true emancipation of women that has occurred—are clouding our judgement to the true risks. It is striking that the possible induction of carcinoma is barely mentioned in the countless discussions on the pill that can be read in the non-medical press. Have the sociologists (and the drug houses) won the argument yet again before the problem has even been properly formulated, let alone solved?—I am, etc.,

PAUL STRICKLAND.

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Northwood, Middx.

REFERENCE

- ¹ Imperial Cancer Research Fund, *Annual Reports*, London, 1964/69.

Diagnosis of Pulmonary Embolism

SIR,—I was interested in the Clinical Progress article (27 June, p. 773) on the diagnosis of pulmonary embolism. I refer particularly to the final paragraph on the mainstays of diagnosis “in an acutely ill patient.”

I have recently been rather worried by some six cases of acute pulmonary embolism in young, fit patients, four of whom have walked down to the surgery complaining only of a little pain in the chest. Only one out of the six showed any tachypnoea. All were of sufficient severity to be treated with anticoagulants. None of them had leg or abdominal signs.—I am, etc.,

S. B. TWIVY.

Dunstable, Beds.

House-dust and Asthma

SIR,—The connexion between house-dust and asthma (30 May, p. 501) was noted as long ago as 1698 when Sir John Floyer referred to it in his “Treatise on Asthma.” During the past six years evidence has accrued that the major antigenic component of house-dust is derived from the mite *Dermatophagoides pteronyssinus*,¹ whose main source of food is shed human epidermal scales. In this connexion bed-making is notorious for provoking allergic respiratory symptoms (sneezing, asthma). Maunsell *et al.*² found that the mite content of house-dust varied according to its size of collection, being greatest in dust from mattresses.

It is interesting, therefore, to see what observations Ramazzini, the father of occupational medicine, made on the effect on the lungs of dust from old mattresses and clothes. Bernardino Ramazzini, born in 1633, was professor of medicine at Modena from 1671 to 1700, and thereafter held the chair at Venice. In 1700 the first edition of his *De Morbis Artificum* (*Disease of*

Workers) was published. The following extract is taken from the 1713 edition, the translation from the Latin being slightly modified from that of Wright.³

“It is the custom, in Italy at least, for Jews to remake wool mattresses in which the wool has become packed by several years of daily use on beds, so that they are too hard. They lay the wool on hurdles of wicker-work, beat it with sticks, and shake it thoroughly; thus they make the mattresses softer and more comfortable to lie on. . . . In shaking and combing it they take in by the mouth a great deal of foul dust. This causes serious ailments, a harassing cough, dyspnoea, and a disordered stomach. . . . I consider that it is not this dust from old wool that is so deadly as that which rises from the impurities left in it by the bodies of those who have lain on the mattresses. . . .”—I am, etc.,

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London S.E.22.

REFERENCES

- ¹ Voorhorst, R., Spijksma-Boezen, M. I., and Spijksma, F. T., *Allergie und Asthma*, 1964, 10, 329.
² Maunsell, K., Wraith, D. G., and Cunningham, A. M., *Lancet*, 1968, 1, 1267.
³ Ramazzini, B., *De Morbis Artificum*, 1713, translated by Wright, W. C., Chicago, University of Chicago Press, 1940.

Who Should Do Psychotherapy?

SIR,—In asking this, and other pertinent questions, your leader writer (13 June, p. 617) refers to the survey of the outcome of referring patients to psychiatric units from my practice over a five-year period,¹ and in doing so appears, probably inadvertently, to be using what I described as the “somewhat disappointing” results as evidence to support the suggestion that psychotherapy is not of any great value.

I am pleased to be recognized as “a by no means unfriendly critic”, but would be grateful for a little space in which to emphasize that the results of my survey did nothing to support Eysenck’s view that psychotherapy is of no value—but they do show up very clearly the appalling shortage of staff attached to the psychiatric units and the shamefully poor administration of this sector of the National Health Service. That many of my patients did so badly was because of the disgracefully long wait for their initial consultation, and the further six to nine months delay before they could expect to be put in the psychotherapeutic group recommended for them. This is not a criticism of my consultant psychiatric colleagues, but of the conditions under which they have to work.

As your leader-writer states, there is a growing volume of published evidence on the usefulness and value of properly organized psychotherapy in a variety of different groups of patients, so that Eysenck’s “bomb” is turning out to be little more than a damp squib. Indeed, as pointed out in the paper on psychiatric referrals,¹ the results even of the superficial psychotherapy that can be expected from a family doctor are far better in many patients than can be expected from traditional medical treatment, including all the most up-to-date tranquillizers. Follow-up of

several of those patients whose results were “somewhat disappointing” showed that they benefited from properly given psychotherapy either by myself, or by psychotherapists consulted privately. This leads on to the suggestion, quoted by you and favoured in the U.S.A., that this type of treatment should be given by psychologists and trained counsellors. This could well be the answer for many patients.

However, it is still my view that the majority of patients requiring treatment by one of the several psychotherapeutic methods would best be treated by their own family doctors, if only proper training could be given to, and the necessary skills learned by, these doctors. They have a feeling of inability to deal with a large proportion of the suffering they meet in their patients, so that that terrible term “trivia” is applied to much of their patients’ illnesses, and where once a doctor would have talked about his enjoying a busy practice he now talks about his heavy “work-load”.

Balint’s work on this subject has done much for many of us, as is now shown by the development in Belgium, France, and Switzerland—and recently in Great Britain—of medical societies of Balint groups, whose primary aims include the encouragement of further research into, as well as providing a forum for further discussion of, all those problems associated with the patient-doctor relationship. In this way perhaps we may find ways and means of improving the quality of our medical care for the large majority of our patients who require some form of psychotherapy as part of their treatment.

There is no doubt in my mind, after applying these ideas in my practice for nearly 20 years, that large numbers of patients with psychosomatic disorders, as well as those with frank psychoneurotic problems who ordinarily would not dream of consulting a psychiatrist or psychotherapist, can and do benefit enormously from simple or minor psychotherapy that is well within the competence of the family doctor. This not only helps the patient, but also makes the doctor’s work more satisfying. It also reduces considerably the need for constantly having to refer patients to hospital out-patient clinics for innumerable and unnecessary investigations into their illnesses which are based not on pathological changes but on emotional disorders.

I am convinced that if we could improve our standard of medical practice in this way we would save the Health Service millions of pounds each year by avoiding so much unnecessary hospital investigation—and at the same time improve the status of the family doctor in the eyes of the public.—I am, etc.,

PHILIP HOPKINS.

London N.W.3.

REFERENCE

- ¹ Hopkins, P., and Cooper, B., *British Journal of Psychiatry*, 1969, 115, 1163.

Gold Therapy in Rheumatoid Arthritis

SIR,—Reading the medical memorandum about the nephrotic syndrome and gold therapy (27 June, p. 772) I notice that the dosage of gold aurothiomalate given to the patient