

Caldwell, I have had no case of sepsis in a series of 21 implant operations. One stimulator became faulty and required replacement; one frail patient suffered wound dehiscence but responded to resuture with no sepsis problems. The results are far from discouraging.

Your leader refers to difficulty in predicting success, and quotes my work as supporting L. Edwards in showing that no objective method is available. This is not the case. My paper at Exeter demonstrated that the standard technique then employed elsewhere was unreliable, and described a reliable diagnostic and prognostic procedure, developed with David Rowan, principal physicist, Regional Department of Physics and Bio Engineering, my co-worker. We employ a urethral pressure profile measurement coupled with continuous intravesical pressure measurement, and are satisfied that the technique is reliable.^{5,6} Individuals who show a deteriorating urethral profile with increasing bladder volume can be expected to respond to pelvic floor stimulation. Successful control of incontinence by an external electrode is also a valuable guide for the use of an implant electrode. Our policy is to offer an implant to any patient who requires long-term stimulation for control. Some of these implanted patients have subsequently become "cured"—that is, now are dry without stimulation some months after the operation. As to the disappointment suffered by a patient when a device is less successful than expected, this is no greater than after more drastic but unsuccessful major repair procedures.

Our experience indicates that an easy, reliable prognostic technique is available, and that patients who respond to an external stimulator but require long-term treatment should be offered an implant stimulator.

May I also give the correct title of our new society listed in the references as "European Continence Society." This should be International Continence Society (I.C.S.).

I wish to thank Mr. L. S. Scott for his encouragement in this work.

—I am, etc.,

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¹ Glen, E. S., *British Medical Journal*, 1970, **2**, 650.
² Glen, E. S., *British Journal of Surgery*, 1971, **58**, 249.

³ Glen, E. S., *Journal of Pediatric Surgery*, 1971, **6**, 138.

⁴ Glen, E. S., *Scottish Medical Journal*, 1971, **16**, 120.

⁵ Glen, E. S., Rowan, D., *Biological Engineering Society 46th Scientific Meeting*, 1972, Liverpool.

⁶ Glen, E. S., Rowan, D., *Scientific Exhibit, American Urological Association*, 1972, Washington D.C.

School Refusal

SIR,—Dr. Lionel Hersov (8 July, p. 102) gives a comprehensive survey of the complex problems of school failure in general and school phobia in particular. As he implies, school phobia is not a good term, but a better one is hard to come by.

A group of children who need special attention and who are, perhaps, increasing in number are the timid, inadequate 11-year-olds, usually not very able, transferring from junior to senior school. They come from the relatively well-structured environment of the small junior school, usually with the same teacher throughout the year and with little movement about the school.

In the large comprehensive school they have to cope with as many teachers as subjects, have to find their way about the buildings, and, unlike the neighbourhood quality of their junior school, will have to make relationships with a mass of children from different schools and neighbourhoods. Their common complaint is "I got lost, I get confused" and some of these children give up before the end of their first day. To identify this group before entry may be difficult, but perhaps this could be helped by having a reception-type class where a sorting out process would go on during the first term and a better adjustment made to what will be, to some children, a rather overwhelming experience.

Regarding treatment, day patient care can often be effective providing as it does the necessary hospital support and teaching, while maintaining the child in his home and neighbourhood.—I am, etc.,

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Problems with Asthma

SIR,—Drs. F. O. Wells and C. J. Stewart (1 July, p. 37) have demonstrated some interesting problems in managing their fatal case of asthma. Both practitioner and physician seem clear that infection was not of prime importance. Similarly the only demonstrable allergy, to *Candida albicans*, was probably the result of earlier treatment, although multifactorial, psychogenic factors are agreed to be particularly important.

Dr. Wells described his patient's ambivalence towards work. Did this attitude characterize his other relationships? Certainly there are grounds for saying that he became ambivalent, if not covertly hostile, to his doctors (lack of confidence, refusal of treatment, uncooperative). Nor was this owing to their lack of concern for his illness.

It can be reasonably assumed that he found open discussion of his angry feelings too painful or dangerous; he resorted to denial, and subconsciously to sadomasochistic displacement, not only towards his doctors, but more important, on to his own body in breathing distress. This reaction resembles the more obviously sadomasochistic behaviour, the syndrome of delicate self cutting, in that any unsupported effort to resolve interpersonal difficulties by separate activity brings on acute anxiety and a recurrence of overt illness.¹ Denial of personal problems resulted in the patient visiting an ophthalmologist when a psychiatrist would have been appropriate.

Bastiaans² has suggested that we pay particular attention to frustrated drives leading to unresolved aggressive feelings and regressive behaviour. However, little has been described of this patient's real life roles and his fantasied ideals. Psychosomatic asthmatics may conform to the psychoanalytic stereotypes,³ but often their difficulties are unique. They often feel unescapably tied to a set of impossible parental or marital attitudes and relationships.⁴ They feel suffocated and entrapped, often by their own ideals. These problems become buried as they become conditioned by stress to fear of wheezing and ambivalent fear of death, the tension of which contributes to

further wheezing. This aspect is well treated by behaviour therapy.^{5,6}

My plea is that we strive constantly to wear two hats in psychosomatic disease⁷—medical awareness and psychosocial awareness. Between the acute episodes is the opportunity to know the human being in his life-situation.—I am, etc.,

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¹ Pao, P., *British Journal of Psychology*, 1969, **42**, 195.

² Bastiaans, J., *Journal of Psychosomatic Research*, 1969, **13**, 307.

³ Sim, M., *Guide to Psychiatry*. London, E. S. Livingstone, 1968.

⁴ Titchener, J. L., Riskin, J., and Emerson, R., *Psychosomatic Medicine*, 1960, **22**, 127.

⁵ Moore, M., *Journal of Psychosomatic Research*, 1955, **9**, 257.

⁶ Philipp, R. L., Wilde, G. J. S., and Day, J. H., *Journal of Psychosomatic Research*, 1972, **16**, 193.

⁷ Williams, D. A., Lewis-Fang, E., Rees, L., Jacobs, J., and Thomas, A., *Acta Allergologica*, 1958, **12**, 376.

Diabetic Amyotrophy

SIR,—Dr. A. Singer (15 April, p. 170) suggests that chronic occlusive peripheral vascular disease might have been directly responsible for the muscle wasting seen in the patients with diabetic amyotrophy who formed the basis of our follow-up study (11 March, p. 656). The evidence does not support such a contention. Firstly, there was little evidence of peripheral vascular disease. None of the 12 patients complained of intermittent claudication, and none had trophic changes in the legs. Five patients, including the one with the most severe muscle wasting, had normal peripheral pulses; one had three out of four foot pulses palpable, and two had both dorsalis pedis pulses palpable though no posterior tibial pulse. In three cases the records were incomplete.

Secondly, the electrophysiological evidence, which we presented, clearly demonstrated that the wasting and weakness were neurogenic in origin with signs of muscle denervation. The slowing of motor conduction velocity and absence of lateral popliteal nerve action potentials were further proof of the presence of peripheral neuropathy in our patients. There is therefore no reason to suggest that the muscle wasting was a direct trophic effect of muscle ischaemia.

In published studies of patients with severe chronic occlusive peripheral vascular disease,¹⁻³ muscle wasting is not common, and when present can usually be attributed to an ischaemic neuropathy.—We are, etc.

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¹ Hutchinson, E. C., and Liversedge, L. A., *Quarterly Journal of Medicine*, 1956, **25**, 267.

² Miglietta, O., *Archives of Neurology*, 1966, **14**, 448.

³ Eames, R. E., and Lange, L. S., *Journal of Neurology, Neurosurgery and Psychiatry*, 1967, **30**, 215.

Large Doses of Fluphenazine Enanthate

SIR,—I read with interest the correspondence concerning large doses of fluphenazine enanthate and would like to comment