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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Department of Urology,
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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

on the letter by Dr. F. N. I. Fawzy and others (8 April, p. 114).

It would be unfortunate if we once more became rigid in our treatment methods, long a problem in psychiatry. The treatment of six patients with dosages of 75 mg per week hardly constitutes a refutation of other statements of the efficacy of higher dosages. I have patients who receive 12.5 mg every two weeks and are maintained on this, but also have a patient who requires 125 mg each week, and if this is spaced to 10 days his chronic hallucinations interfere completely with his functioning. I have also seen an acutely excited patient who, owing to a misinterpretation of an order, received 100 mg four times daily for four days, at which time his mental status had improved markedly and he showed no side effects whatsoever.

These facts are mentioned to emphasize the wide dosage range that may be employed. The ever-increasing interest in tardive dyskinesia suggests that the most desirable treatment is the least amount of medication spaced as far apart as possible. However, patients who have failed to respond to orthodox treatment do merit a trial on high dosages of phenothiazines whether orally or parenterally.—I am, etc.,

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Twins and Cancer

SIR,—There is a biochemical aspect of Mrs. Jean Fedrick's and Dr. Eva D. Alberman's interesting article (27 May, p. 485) which seems to warrant comment.

The incidence of twins in the 20 cases of cancer was 10%, and the incidence of cancer in the estimated 107 pairs of twins was 1.9%. These figures contrast with percentages of 0.62, and 0.12, in the general populations of 17,204 (mothers), and 16,750 (children), respectively, and are therefore approximately a sixteenfold increase.

This may, of course, just be another example of the extremes that go to make up any "average", but having completed a survey of 54 pairs of twins (of school-entrance age) with special reference to their family history of cancer, and having noted that the mortality from cancer of the grandparents was 38%, compared with 22% for a control series (that is a difference of 70%), one wonders if further inquiry into a possible association is indicated.—I am, etc.,

R. A. STRANG

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Rehabilitation Services

SIR,—We should like to comment on some of the points raised by Dr. H. L. F. Currey (15 July, p. 172).

It is, we believe, now generally accepted that the term "physical medicine" is inappropriate in the context of modern medicine, carrying as it does the unfortunate impression of a purely therapeutic specialty concerned with the prescription of physical methods of treatment. Indeed, our association is at present taking active steps to delete the words "physical medicine" from its title.

Since the formation of our association in 1943 the majority of its members have carried out the role outlined in Dr. Currey's letter—that is, combining clinical rheumatology with the administrative control of the ancillary remedial services. Some have become predominantly interested in rehabilitation and have made major contributions to the advancement of this subject. We believe that it is also generally accepted by the medical profession that every clinician, in whatever discipline, should be responsible for the rehabilitation of his own patients. We feel strongly that the interests of the patient and of medicine as a whole are best served if a clinician has overall responsibility for the services concerned. By the very nature of the diseases with which he deals, the rheumatologist must necessarily have the expert knowledge needed for this, but as Dr. Currey says there are many other specialties from which doctors may be recruited to take charge of rehabilitation services.

It is clearly as important that there should be academic centres of rheumatology devoting their whole time to clinical work and research as that there should be specialized rehabilitation centres devoted entirely to the rehabilitation and resettlement of the disabled. Apart from these highly specialized units, the majority of remedial departments in the hospital service should, we believe, be under the charge of one who is primarily a clinician, for only in this way will doctors of sufficient calibre be recruited to undertake this important role. The rheumatologist is as well equipped as any clinician to do this.—We are, etc.,

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President

D. R. L. NEWTON
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Vice-presidents
British Association of Physical
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Training of Surgeons

SIR,—The training of a surgeon can be subdivided arbitrarily into two parts—theory and practice. To appraise the first we have the Fellowship, and the second is simply recorded as testimonials between consultants.

At the moment surgical trainees may be acting as busy registrars in hospitals at the periphery, while at the same time attempting to learn their Fellowship work. This is a most difficult and unenviable task. Surely this examination should be taken from within a teaching hospital. Herein are facilities for acting as anatomy demonstrator and joining in with the teaching of undergraduates, and attending lectures, specialized clinics, and so forth.

The second, practical part should be the training in surgical procedures by surgeons who have wide general experience. This should be carried out in the regional or district general hospitals. At the moment the reverse is taking place—namely, practice before adequate theoretical training. This is unsound.

The training of young surgeons could be divided into six or eight years, with a rise in salary every year, and the grade be described as registrar with the seniority in the number of years of training in that

grade. The description "senior registrar" should be discarded. It was simply a device to control the numbers in training.

Research should be encouraged after this basic training with posts paid at the top registrar level with minimum clinical demands. Too often the young doctor is imposed upon to act as a busy clinician as well as engaging on work that demands the whole of his mental effort. These changes if implemented would lighten immeasurably the heavy burden that our young doctors carry.—I am, etc.,

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Sickle Cell and Altitude

SIR,—Further to our earlier letter (25 March, p. 803), we understand that it has not been possible to perform further studies to confirm the diagnosis of the sickle-cell trait in Case 1 of our article (4 December 1971, p. 593).

This case was irrelevant to the main theme of our paper, which was to draw attention to the dangers of sickle-cell disease in pressurized aircraft. Furthermore we would not wish this case to confuse the discussion of the relevance of the sickle-cell trait to flight in unpressurized aircraft, when better substantiated cases are available (25 March, p. 803).

We therefore wish to withdraw this case.—We are, etc.,

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Conquest of General Paralysis

SIR,—Dr. J. Purdon Martin (15 July, p. 159) deserves gratitude for reminding us of the introduction of malarial treatment of general paralysis into Britain 50 years ago and its subsequent replacement by penicillin. Although malarial therapy is only of historical interest today it revolutionized the treatment of the major mental disorders, and its repercussions are still with us. The idea of curing mental illness by another disease state caught on in psychiatry. Insulin coma treatment of schizophrenia was introduced in Vienna under Wagner-Jauregg's successor, to be soon followed by various types of convulsive therapy for depressive illness.

For the sake of historical accuracy I should like to correct an error in Dr. Purdon Martin's excellent article. Wagner-Jauregg was not "professor of neurology." His official title was "professor of psychiatry and neuropathology," the latter term meaning neurology. As in most continental universities, psychiatry and neurology formed a single joint clinical specialty in Vienna. The two subjects were separated only last year when special chairs for psychiatry and neurology were established. The same development is taking place in other continental universities.—I am, etc.,

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Sheffield 11