nently successful.⁸ On the other hand, sedative antihistamines such as trimeprazine tartrate are only moderately effective in helping to re-establish a normal sleep pattern in infants and toddlers, whereas behavioural methods are highly effective.^{9,10}

The use of drugs to control physically aggressive and self mutilating behaviours, especially in mentally handicapped children, is more controversial, as is the use of psychotropic drugs to treat anxiety in children. The concern is that we will resort to drugs as a form of social control rather than attempting to alter the conditions that produce the behaviour. Few controlled trials have been conducted of drug treatments for aggressive, non-hyperactive children with conduct disorder. A recent review concluded that both haloperidol and lithium carbonate were useful in resistant cases,^{11,12} and antidepressants may be effective for any accompanying depressive symptoms. The authors emphasise that, as with all childhood psychiatric disorders, "there is virtually no situation in which an aggressive child or adolescent should be treated only pharmacologically."¹¹

Imipramine in high dosage was found to be better than placebo for school phobia in one controlled study,¹³ but a trial of clomipramine in lower dosage for the same condition found that it was effective only when depressive symptoms were present and then only for a short period.¹⁴

Emotional and conduct disorders, which between them account for 90% of the psychiatric disorders seen in childhood, are best treated by a comprehensive approach based on family and individual psychotherapy and behaviour therapy with drugs used sparingly and judiciously only as adjuncts. The authors of one recent review of drugs for problem children reinforced Eisenberg's earlier principles¹⁵ that there should be a firm indication for use, the drug should be a well tried one, its dose should be tailored for each child, and it

should be used only for a limited time with frequent monitoring.¹⁶ In our present state of knowledge psychotropic drugs should be prescribed sparingly and under the supervision of specialists. While these drugs have a definite role in treating some childhood psychiatric disorders, we need more and better quality research to break the current cycle of "limited data, limited use, potential misuse, and limited benefits."¹⁷

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Stress: another chimera

An unreliable word best used sparingly

Doctors in all medical specialties are affected by stress to some extent: people complain of it, doctors diagnose it, medical work even seems to generate it.^{1,3} But scepticism persists about its meaning, its measurement, and its management. So what is it?

Firstly, from a general perspective stress is a fashionable term denoting usually disagreeable stimuli. It also encompasses the physiological, behavioural, and subjective responses to these stimuli: or, indeed, the whole "stressful situation." Four main, overlapping, types of stress can be recognised: acute (an assault); sequential, where one event initiates others that occur over a period (bereavement); chronic intermittent (conflicts with neighbours); and chronic (being disabled).

The more intimate the stress, such as loss of a close friend or relative, and the greater the magnitude of stress or number of stresses the more likely the occurrence of diverse ill effects. At the same time some people seem to flourish on stress. A certain amount of stress is claimed to be desirable, to provide the stimulation and motivation to overcome obstacles that may prevent us reaching our goals or to alleviate boredom.

The ability to perceive or withstand stress seems to vary widely. Warning signs that stress is getting the better of someone include irritability, changes in sleep and eating

patterns, difficulty concentrating and making decisions, and worrying or getting angry about trivia. Symptoms suggestive of disease of various organ systems may also be present. Swept along with too much to do and too little time and unable to relax, stressed people become exhausted until, failing to cope, they reach breaking point.

According to self help guides, coping with stress requires a range of personal adjustments^{4,7}: recognition of personal causes and effects of stress; regular nutrition and exercise; limitation of alcohol, tobacco, and drugs; relaxation; reduction of stress in relationships, at work, and during leisure; practical management of anxiety, time, and activities; and development of problem solving strategies and social supports.

From a more specific focus, however, stress is very ill defined. Although much scientific and medical research has been concerned with stress and stress related topics, none of this intriguing work adequately explains variability in individual responses, disease specificity, or the onset of disease.^{8,11} Medical lexicographers have concluded that the term is clearly overstretched and should be used sparingly.¹²

One method of restricting its use within medical settings might be to confine it to categories from standard diagnostic classifications. This is by no means a perfect solution. A draft

of the forthcoming 10th revision of the *International Classification of Diseases* contains a list of reactions to severe stress and adjustment disorders.¹³ Two examples provide sufficient illustration.

Acute stress reaction comprises exposure to an exceptional medical or physical stress followed by the onset, within one hour, of generalised anxiety or any two of the following: social withdrawal, narrowing of attention, apparent disorientation, anger or verbal aggression, despair or hopelessness, inappropriate or purposeless overactivity, and uncontrollable and excessive grief. Treatment is supportive and non-specific and the prognosis is favourable.

Post-traumatic stress disorder includes brief or prolonged exposure to an exceptional mental or physical stress followed within six months by persistent remembering or reliving of the stress; by intrusive flashbacks, vivid memories, recurring dreams; or by distress when exposed to (or avoiding) circumstances associated with the stressor. These features are accompanied by either psychogenic amnesia or persistent increased psychological sensitivity and arousal with at least two of the following: difficulty in falling or staying asleep, irritability, difficulty concentrating, distractibility or increased restlessness and apprehension. Again, treatment is supportive and non-specific, though the long term outlook is uncertain.

Thus at a popular level stress is a vigorous concept that has engendered a prosperous industry dedicated to its relief, while in scientific and medical contexts the concept languishes

with dubious reliability and validity. Fifty years ago the stress hypothesis began displacing obscure focuses of infection as an antecedent of a variety of life's ills. As Susser has remarked: "Many excellent sets of teeth and many pairs of tonsils were sacrificed to that hypothesis. We can count ourselves fortunate that the stress hypothesis does not require surgical intervention."¹⁴

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Hepatic and portal vein thrombosis

Closely associated with chronic myeloproliferative disorders

Until recently most cases of hepatic vein thrombosis were considered to be idiopathic—although occasional cases were linked to underlying diseases such as myeloproliferative disorders, systemic lupus erythematosus, paroxysmal nocturnal haemoglobinuria, and antithrombin III deficiency. As a result of advances in the early diagnosis of chronic myeloproliferative disorders,¹ recent evidence now suggests that most patients who develop hepatic vein thrombosis have an associated, occult chronic myeloproliferative disorder.^{2,3}

The chronic myeloproliferative disorders are distinguishable clinical entities that have a common origin from a single malignant haemopoietic stem cell. These disorders have long been known to be associated with thrombosis, particularly in untreated polycythaemia vera and myelofibrosis, in which the incidence of postoperative thrombosis can rise to 75%.⁴ The risk is less in essential thrombocythaemia and chronic granulocytic leukaemia.^{5,6} Thromboses commonly affect the cerebral and coronary arteries, but there is also a high incidence of intra-abdominal thrombosis in the inferior vena cava or in the splenic, hepatic, portal, mesenteric, and renal vessels.⁷

The diagnosis in polycythaemia vera is confirmed by an increased red cell mass, the presence of splenomegaly, a normal arterial oxygen saturation, and high white cell and platelet counts, leucocyte alkaline phosphatase activities, and serum concentrations of vitamin B-12. Treatment with phlebotomy and myelosuppressive drugs is effective and symptom free survival for 10-20 years common. In myelofibrosis there is leucoerythroblastosis and the bone marrow shows typical collagen-reticulin fibrosis. In some patients with myelofibrosis the disease does not progress and they may

survive many years, but most need chemotherapy to control splenomegaly and blood transfusions for anaemia.

There are several different causes of polycythaemia, and in some cases the aetiology is initially unclear. Over a period of years, however, two fifths of patients develop recognisable polycythaemia vera.⁸ More recently cytogenetic analysis and in vitro haemopoietic stem cell cultures have identified clonal bone marrow characteristics and colony culture growth patterns that have made it possible to identify chronic myeloproliferative disorders at an even earlier stage.¹⁻³ In these occult cases the usual clinical or haematological features of chronic myeloproliferative disorders may develop later.

Recent reports showing that up to three quarters of patients with hepatic vein thrombosis have associated occult forms of myeloproliferative disorder^{2,3} may also explain why hepatic vein thrombosis can recur after successful liver transplantation.⁹ Patients with thromboses associated with myeloproliferative disorders should be treated with anticoagulant drugs, initially heparin and in the longer term warfarin or low dose aspirin.¹⁰ If thrombosis recurs—and there are no contraindications such as oesophageal varices, thrombocytopenia, or severe liver dysfunction—lifelong treatment with anticoagulants should be considered.

The cause of thrombosis in chronic myeloproliferative disorders has been the subject of a longstanding debate. Infiltration of the hepatic portal tracts with extramedullary haemopoietic tissue might predispose to thrombosis in the hepatic or portal vein. In polycythaemia vera there is a prethrombotic state in which the raised packed cell volume and increased blood viscosity lead to a low grade disseminated intravascular coagulation and activated fibrinolysis.¹¹⁻¹³ These