encourage more people to take an overdose. It should, however, reduce the likelihood of an accidental overdose being taken from severe pain and increase the chance that if a patient's family knows of the overdose they will encourage him or her to seek prompt medical advice.

The pharmaceutical industry is in a pivotal position to address the problem of the continuing high mortality from paracetamol overdose as the addition of an antidote, such as methionine, to all available preparations might prevent every death that currently occurs. At present paracetamol-methionine combinations are costly, little publicised, and rarely prescribed. Adding methionine to all preparations of paracetamol might increase prices and therefore reduce sales. Another solution might be to develop non-hepatotoxic derivatives of paracetamol. It will indeed be tragic if the mortality from paracetamol overdose over the next quarter of a century proves to be as high as that of the last.

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Endometriosis

Should not be treated just because it's there

Endometriosis is a fascinating example of how a new diagnostic technique has transformed the understanding of a disease. Because the laparoscope has enabled easy, safe, detailed, and repeatable visualisation of the pelvis we now know that endometriosis has various manifestations and may even be present in otherwise normal peritoneum. Recent reports have argued that the presence of ectopic endometrium may be physiological and should be considered to be pathological only if associated with symptoms or signs of progression and tissue damage.^{1,2}

Endometriotic implants probably evolve from active to inactive disease, and these stages are recognisable visually.³ Histological techniques can show whether an endometriotic deposit is active and infiltrating the surrounding tissue or is superficial and inactive.⁴ The pathogenesis of the disease has always been controversial, but considerable circumstantial evidence exists to support the suggestion that it is due to implantation of endometrium that has been refluxed down the fallopian tube at menstruation.⁵ It is logical to hypothesise that the implantation of refluxed endometrium will be more likely to occur with increased exposure to menstruation: women now experience over 450 menstruations during their reproductive lifetime rather than the 30 to 50 that would be expected without contraception and with long periods of lactation. Changes in social habits, which increase exposure of the pelvis to menstruum, and a new diagnostic technique may therefore have combined to create an increase in the incidence of endometriosis.

The true prevalence of the visual finding of endometriosis cannot be determined at present because such studies require random operative intervention and are therefore unethical. Vessey *et al* report an increasing incidence with age, which peaks at about 6 per 1000 woman years between 40 and 44

(p 182).⁶ They also show a protective effect of pregnancy and current use of the contraceptive pill. These data agree with those of Mahmood and Templeton⁷ and support the hypothesis that the incidence of the disease is related to exposure to menstruation. While an individual endometriotic implant may change with time, no evidence exists that the disease will inevitably disappear. In the three studies that have reported the natural course of the disease in placebo arms of trials of medical treatment the disease progressed in about half the patients.⁸⁻¹⁰ In the other half the disease either remained the same, improved, or disappeared. Increased disease was not necessarily symptomatic; predicting in which patients the disease would get worse was not possible.

Endometriosis should therefore not be treated simply because it is there. This is further supported by evidence that medical treatment works only temporarily, with the disease recurring once stimulation by ovarian steroids returns.¹¹ Endometriosis is more common in subfertile women and women with pelvic pain,⁷ and logically these should be the two main indications for treatment. Unfortunately, none of the published randomised trials have shown that medical treatment improves fertility.¹² No justification therefore exists for treating subfertile women with contraceptive drugs, and the endometriosis should be considered to be coincidental unless it has caused tubal and ovarian damage that requires repair. There are no randomised studies of the efficacy of surgical ablation of endometriosis either at laparotomy or at laparoscopy on future fertility. Until this efficacy has been shown surgery cannot be recommended.

Currently, therefore, the only clear recommendation for treatment is in symptomatic patients. Classically, endometriosis is associated with cyclical pelvic pain and dyspareunia. Signs include the presence of a pelvic mass,

tenderness, and nodules on the uterosacral ligaments. The diagnosis should be verified laparoscopically before treatment is begun. Considerable degeneration of the endometriosis occurs after two months of medical treatment, and symptoms should therefore diminish. Uncontrolled evidence suggests that laparoscopic ablation of endometriotic implants improves symptoms.¹⁴ Successful surgical and medical treatments are both followed by an appreciable rate of recurrence.

Because the denominator for the visual diagnosis of endometriosis has changed recently, the true incidence and prevalence of the disease are unknown. Pain is the main indication for treatment, and the disease should be regarded as chronic and relapsing rather than as an acute phenomenon treatable by a single medical or surgical intervention.

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Maintaining the treatment of mentally ill people in the community

Some compulsion is necessary, but for supervision, not treatment

Neglected social issues often attract the serious attention of the public and the government only as a result of a tragic and dramatic incident. The case of the mentally ill young man who climbed into an enclosure at London Zoo on 31 December and was mauled by a lion is the most recent example.¹ The Secretary of State, Virginia Bottomley, at once committed herself to finding an urgent solution to the problem of maintaining the treatment of discharged patients suffering from chronic mental illness, who can all too easily be missed by current community psychiatric services.

This matter has preoccupied mental health workers for many years. The Royal Commission on Mental Illness and Mental Deficiency introduced the concept of guardianship,² and the Mental Health Act 1959 gave the guardian wide powers of control. In effect, these were the same as the general powers of a parent over a child of less than 14 years. Such guardianship was seen as a way of protecting vulnerable people from exploitation, ill treatment, or neglect. The use of guardianship was never widely taken up, however, and in 1978 a total of 138 people were subject to it, of whom only 37 were mentally ill. The powers of control were considered too extensive and paternalistic.

Alternative approaches were subsequently proposed. In 1977 the British Association of Social Workers suggested community care orders.³ A white paper considered a changed form of guardianship, and ultimately the Mental Health Act 1983 incorporated a revised guardianship order with severely limited powers of control. Experience during the past nine years indicates that in its new form guardianship has not gained popularity, and many social workers consider both that it is unenforceable and that it may be an unethical constraint on individual freedom.⁴

Until 1985 many psychiatrists ensured the supervision in the community of patients who were known to default from treatment by granting them leave of absence. Detained under a section of the Mental Health Act in the first place, these patients had responded to treatment in hospital, and their leave was subject to a requirement that treatment should be continued outside hospital. Just before the section expired the patient would be readmitted, the detention order would be renewed, and the patient would again be given leave. This

practice ended when it was declared unlawful by judicial review in 1985 (*R v Hallstrom ex parte W*),⁵ although under Scots law it continues with monitoring by the Mental Welfare Commission for Scotland.

There have since been a series of proposals to re-establish some form of compulsory treatment in the community from the Mental Health Act Commission (in 1986⁶ and again in 1988⁷), the Royal College of Psychiatrists (1987),⁸ and the British Medical Association (1989).⁹ None of these proposals found sufficient support to press the case forward, and at its conference in York in 1991 the Mental Health Act Commission voted against any specific recommendation.⁴ In other jurisdictions community treatment orders have been introduced with varying degrees of success.^{10 11}

Except for MIND most of the voluntary groups, such as the National Schizophrenia Fellowship and SANE, have expressed more positive enthusiasm for some measure of control, concerned that community care is too often an unfulfilled ideal that can become an impossible burden on relatives. The reluctance of all these campaigning bodies to reach a conclusion, however, has reflected a lack of consensus among their members, particularly for the proposal to enforce treatment in the community when the patient refuses consent. The suggestion for a community treatment order was rejected by some, on the grounds that it would infringe civil liberties, there was insufficient research to justify this extra measure,^{12 13} the existing legislation provided a sufficient framework to give the necessary powers to deal with the problem, and changing the law might divert attention from the real need to provide resources to support an acceptable programme of community care.¹⁴

A working group of the Royal College of Psychiatrists has been taking a fresh look at the problem, and its report was endorsed by the college this week. It agrees that compulsory treatment in the community is unacceptable, but accepts that the "revolving door" patient who regularly defaults from treatment presents a genuine problem of management. The report recommends a new order, applicable only to patients with a history of non-compliance, which would provide for compulsory supervision of the patient in the community. Should the patient cease to accept treatment voluntarily and