limited results may have been "the persistence of a psychodynamic disorder."

Desensitization would not have been rated as disappointing had you referred to a survey³ (admittedly retrospective) on the treatment of 124 consecutive phobic patients (63 of whom suffered from the agoraphobic syndrome) treated by this method. It was noted that in 28% of the patients the phobic symptom appeared to be perpetuated by psychodynamic factors. The addition of interpretative psychotherapy to desensitization in this group increased the improvement rate to 91% from 73% of those patients who were treated by desensitization alone.

I am in no doubt that either flooding, if a nurse therapist is available, or desensitization combined with insight psychotherapy is the treatment of choice for agoraphobia, whether severe or mild.—I am, etc.,

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¹ Marks, I. M., Birley, J. L. T., and Gelder, M. G., *British Journal of Psychiatry*, 1966, 112, 757.

² Gelder, M. G., and Marks, I. M., *British Journal of Psychiatry*, 1966, 112, 309.

³ Friedman, D. E., and Lipsedge, M. S., *British Journal of Psychiatry*, 1971, 118, 87.

SIR,—I should like to take issue with your leading article (26 October, p. 177), which suggests that agoraphobics should carry "a tablet of an effective anxiolytic in the purse or pocket" in order to take one when encountering a stress situation.

The danger of this sort of management is that the patient becomes irreversibly dependent on his tablets. His agoraphobia is reinforced by the implication that he cannot possibly face stress without taking a tablet, since the two phenomena of taking a tablet and facing stress become inextricably intertwined. It is then impossible to wean the patient from his tablets, for any attempt to make him do without them in the context of immediately impending stress will heighten the psychological stress of the occasion. The situation is analogous to the stage of alcoholism in which the patient needs some "Dutch courage" to face stress—at first he needs his drink for only major traumatic situations, but before very long he cannot even answer the door without a stiffener.

The alternative and more satisfactory regimen is to treat the patient with high regular dosage of benzodiazepines whether he is facing stress or not. The aim should be to achieve the minimum dose which abolishes all (or nearly all) symptoms so that the patient can lead a normal life. When this has been done and the patient has seen it done and has regained his confidence the tranquillizer should be gradually withdrawn over several months. In this way the cause (that is, taking a tablet) and effect (that is, allowing him to cope with stress) are sufficiently separated for conditioned learning not to occur, and it is often possible to achieve a complete withdrawal of medication.—I am, etc.,

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Value of Hospital Case Notes

SIR,—I would be a more enthusiastic supporter of Mr. D. F. E. Nash's (19 October,

p. 165) condemnation of the remarks of a general practitioner on B.B.C.4 if I did not live in an area where hospital case notes are kept not just from the patient but also from his own general practitioner. The medical staff of St. Mary's Hospital, London W.2 and W.9, passed a resolution to this effect and have confirmed that this shall continue in spite of a protest from the local medical committee. They suggest instead that the G.P. should consult a member of the medical staff. Any G.P. would naturally prefer to do this, but it is difficult enough to find and visit one's patients in the London area as it is. If one has to await the availability of a member of the medical staff it becomes a futile exercise.

I have found it difficult to envisage a motive for this ban. If there is any doubt as to the doctor's identity the patient can always verify it—or if he is in no condition to do that then the doctor can identify himself. I wonder what a member of the St. Mary's medical staff doing a six-monthly follow-up on one of my cases would say if, on seeking information on some intercurrent illness, I told him he would have to make an appointment to see me personally. I would have greater justification for making such a stand than has St. Mary's.

If ever there was an instance of failure to attempt to "overcome the barriers which still exist between those responsible for primary care and those working under similarly difficult conditions in the hospital service" this is it. It is in fact a deliberate step in the opposite direction—and an affront to all general practitioners. I challenge St. Mary's to justify it. It will be insufficient for them merely to ignore this challenge. If they have no reply then let them have the good grace to declare this absurd piece of divisiveness unnecessary. Other hospitals have not found any need for it.—I am, etc.,

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Flupenthixol Decanoate and Some Aggressive States

SIR,—Dr. P. M. O'Flanagan (27 July, p. 258) discusses the use of flupenthixol decanoate in some aggressive states. I have used either this drug or fluphenazine decanoate by intramuscular injection in eight cases of a rather similar nature to those described by Dr. O'Flanagan. The important factor in these cases seem to be that of a very low tolerance to frustration rather than aggression, unless very high demands on the social and medical services can be regarded as aggression.

Seven patients benefited very considerably from this treatment. One patient complained repeatedly about side effects as she had done on all previous medication; the treatment was therefore stopped. All were patients of many years' standing who had been admitted to psychiatric hospitals on at least one occasion. This method was first used for a patient who was quite unable to organize the taking of oral medication. Her tablets were taken at random and often confused with those of her husband. The result was quite unexpected. Her general practitioner, who saw her shortly afterwards, wrote, "I do not know what you gave Mrs. X but it certainly worked a miracle." Though this apparent return to complete normality has not persisted, there has been a very marked

improvement in her condition, maintained over a period of one year. This result led me to try this treatment in other cases. Of the seven patients who benefited, all have shown a marked lessening of anxiety and an improvement in drive. Their rapport with their doctors and social workers has improved considerably as well as that with their friends and family.—I am, etc.,

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La Condition Humaine

SIR,—“What a depressing Personal View” writes Dr. Graham Hunter (12 October, p. 108) of mine (14 September, p. 682); and Drs. James Millar (19 October, p. 165) and N. S. Baber (28 September, p. 807) seem to agree. So do I, but then the truth often is depressing, and a diagnosis does not become suspect because the prognosis is grave or the treatment far to seek. *Pace* Drs. Hunter and Millar I neither said nor implied that I think science has destroyed the spirit of Christianity, that the latter is meaningless and void, or that science and technology are the anti-Christ: I am a Christian myself. I suggest they reread what I wrote. As to Dr. Hunter's Coventry Cathedral and York Minster, I am sure they are very nice and clean but how many people *pray* in them every day, and how many doubtless very dirty people prayed in Chartres and Gloucester cathedrals 500 years ago?

Dr. Hunter says “the problems of pollution, overpopulation, and famine are being tackled as never before.” This is possible as they have never existed before as they do now. However, his view on famine is not one that would appeal to the inhabitants of the Sahel at the moment. As to population, Britain's main sin is a high per caput consumption, so we now have a strong “free-the-pill-in-the-U.K.” movement. Our officially projected increase of population in the next 17 years is just over three million. And the current net weekly increase in world population is almost two million. I think such “tackling” pathetic and irrelevant. Yes, we do sometimes tackle pollution with anti-pollutants of much the same general character as the pollutants, and often more dangerous, but does it occur to Dr. Hunter that if we consumed less we should not be causing the pollution in the first place?

About nuclear weapons Dr. Hunter thinks the problem “has stimulated more responsibility in their handling than I would have thought possible.” Bernard Feld, Professor of Physics at the Massachusetts Institute of Technology wrote (*The Times*, 11 October), that the odds were about three to one on a nuclear device being used in the next 10 years and the chances of a nuclear war before 2,000 A.D. were worse. I share his realism and his gloom. Dr. Hunter says, too, that “as regards foreign doctors in our hospitals, let us never forget the many British doctors serving in foreign (mission) hospitals.” Is he then including under the head of natives in need of missionary activity (and I would not demur to the notion) the peoples of the U.S.A., Canada, and Australasia whose hospitals are as

packed with British graduates as ours are with those of the underdeveloped and underdoctored countries?

Dr. Baber regrets that Ivan Illich (and I) cannot offer a "practical solution." I would find one highly suspect, but of set purpose the piece I wrote began "*La condition humaine*," the title of a 1920s novel by André Malraux about Chinese revolutionary activity, a novel that ended on a note of disillusionment. But *look*, I was trying to imply, at China today: it is the most hopeful country in the world. Dr. Millar asks "Can Adam now replace the fruit and tiptoe through the unmown grass again with Eve, ignorant even of their nakedness?" Facetiousness aside, I suspect—and so, I find, do many young people—that something as radical as that is needed. "When we knew little," he says, in defence of science, "we were not so far from the animals." There speaks *Homo sapiens*, self-styled and self-condemned. By what right, unless one that our ability to destroy an entire species confers upon us, do we look down upon the "animals"? Are we not animals? What other creature has even touched the depths that the human animal has scoured? Dr. Millar says it is not science and technology that are to blame "but our own faults." I agree. But he and Dr. Hunter quite miss my point: until the last few decades man did not have, in the service of his unique human greed, envy, and hatred, weapons whose use might end the species. Man has not changed, but his weapons have: *ergo* man must now change or else. . . .

Finally, I go along in general with Dr. Hunter's suggestion that "each challenge must be met and tackled in a spirit of hope, for it will do no good to despair." But there are items I find myself unable to tackle in any spirit of hope—a thermonuclear weapon about to explode, for instance, and starving children when there is simply no food to give them. Or, rather, my hope then would not be of the temporal kind.—I am, etc.,

S. BRADSHAW

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Prevention of Exercise-induced Asthma by Indoramin

SIR,—Professor S. Bianco and others (5 October, p. 18) claim to have shown that the alpha-adrenoceptor blocking drug indoramin inhibits exercise-induced asthma (E.I.A.) and that this supports the concept of abnormal receptor response as the cause of E.I.A. Before this can be accepted I believe that it is important to point out that their data are open to a different interpretation.

Indoramin is clearly a potent bronchodilator, as they have shown, but this means that the exercise test after the drug had been given was begun with airways of greater calibre than in the control experiments. In this situation it is difficult to compare control and drug tests, but it is certainly not acceptable to claim that the drug blocks E.I.A. because conductance never fell below the level in the control (undilated) tests. When expressed as a percentage of the post-drug value the fall in conductance after exercise in their subjects ranged from 0 to 69%. In the control tests the percentage fall ranged from 38% to 81%. Analysed in this way it would appear that six of their patients

had significant reduction of E.I.A. by the drug and five had almost as much or more E.I.A. compared with control studies.

However, there are further complicating factors in this type of work, such as the major diminution of E.I.A. by placebos¹ and the variability of the response to exercise, especially when a bicycle is used.² No placebos were used in the control studies of Professor Bianco and his colleagues and this must diminish the validity of their conclusions. Perhaps this accounts for the fact that Sly *et al.*³ were unable to prevent E.I.A. with alpha-blockade when proper controls were used. The present authors do not provide any data on the reproducibility of their tests, but in eight of the 11 subjects the resting conductance was lower on the drug-test day before the drug and in the one subject tested twice without drug the fall in conductance appears to have been 60% on one day and 44% on another. This same subject had a 69% fall with 50 mg of indoramin but only 14% with 60 mg of the drug—a quite extraordinary dose-related phenomenon.

While not denying that effective alpha-blockade may cause bronchodilatation in the asthmatic, and may to some extent influence the severity of E.I.A., I do not believe that the study by Professor Bianco and colleagues can justify their statement that indoramin "has been found to prevent the occurrence of exercise-induced bronchoconstriction" or that their work provides any evidence for the pathogenesis of E.I.A.—I am, etc.,

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- 3 Sly, R. M., *et al.*, *Journal of Allergy*, 1967, 40, 93.

Trasylol for Pancreatitis

SIR,—Dr. M. L. Lewis (21 September, p. 741) expresses concern about the statement in your leading article (20 July, p. 133) that aprotinin (Trasylol) was "harmless" with an "absence of side effects." I agree that neither aprotinin nor any other drug should be regarded as completely harmless, though I believe that the concept "harmless" was understood to be relative.

Dr. Lewis presents two cases of pancreatitis in which he associated the use of aprotinin with a deterioration in the course of the disease. I would like to comment on his conclusions with respect to the assumed aggravation of consumption coagulopathy or hypercoagulability because the full spectrum of activity of the drug was not fully considered.

Aprotinin is undoubtedly a very powerful inhibitor of plasmin, which to many haematologists would appear to be a contra-indication for aprotinin in consumption coagulopathy. Other proteinases are, however, inhibited by aprotinin, including those that play an important role in the clotting cascade.¹⁻⁴ Kallikrein has recently been added to this list⁵ and helps to give a better understanding of the antithrombotic action of aprotinin.⁶⁻⁹ It is misleading to consider the action of aprotinin on the coagulation and lysis systems in terms of plasmin inhibition alone. Experimental evidence has shown that fibrin deposits are reduced in both size and

number under aprotinin treatment in shock states associated with disseminated intravascular coagulation.¹⁰ Furthermore, it has been demonstrated^{11,12} that clotting time is prolonged rather than shortened in conditions where activation of clotting takes place. Regarding the shock lung syndrome, there is again evidence that it is either prevented or favourably influenced by aprotinin.¹² Though aprotinin does not aid the dissolution of established fibrin deposits, it may well help to prevent their further formation.

Finally, I would agree with Dr. Lewis that both streptokinase and heparin may have a place, but in this complex situation I feel it would be wrong to advocate their clinical use until experiments along the lines of Blümel¹³ have proved that the risks of further activating proteolysis do not outweigh any possible benefits.—I am, etc.,

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Treatment of Casualties in General Practice

SIR,—A few months ago I was summoned on a Sunday evening from my home to the surgery to suture a small patient who had severely cut her finger. The nearest casualty department is 13 miles (21 km) in either direction. During the course of 30 minutes I cleaned the wound, ascertaining there was no tendon damage, and used an ampoule of sterile suture material. I applied a dressing kept in position by Tubegauze, administered the child's booster of tetanus toxoid, and arranged for our practice sister to remove the sutures after the appropriate time. I tendered a prescription on E.C.10 for the suture material and Tubegauze, which has been returned to me, each item stamped twice by the pricing bureau in Durham.

I should like to therefore give notice that in future I shall think very hard before providing any minor casualty service whatsoever and shall limit my item of service to applying a piece of gauze and strip of Elastoplast and arranging transport to the nearest casualty department. I do not regard injuries such as the one described above as the proper responsibility of a hospital casualty department. In other parts of the world they