High Finance and Public Health

SIR,—In recent years the financial press has been reporting huge profits from sales of beer, wines, and spirits. The annual turnover of a giant firm is about £300m. There has been especial satisfaction with the export of Scotch whisky, which was 45% up on last year to reach £85m. It is to be hoped that Mr. Crossman, whose department is concerned with public health, will appreciate the seriousness of this situation. In the scale of toxicity of addictive drugs, alcohol is, as the late Lord Brain stated, about the same as the barbiturates. Dr. P. H. Connell, speaking at a meeting on alcoholism recently, has said that, if alcohol were discovered for the first time now, and if we knew as much about it as we do now, its sale would undoubtedly be banned. Alcoholism is in fact classed as fourth in the list of killing diseases. In Scotland, among the admissions of men aged over 40 to mental hospitals, one in three is for alcoholism. The millions spent by the trade in advertising drink to women and teenagers have had their effect. Instead of there being one woman alcoholic to 20 men there is one woman to four men. The biggest increase of alcoholism is among young adults, whose suicide rate is twice that of the over-forties. Studies in Connecticut and Melbourne indicate that among the admissions to general hospitals about 10% to 13% are for diseases caused by alcohol.

At present there is indeed an energetic campaign to persuade the public that alcoholism is a disease. The doctrine is that, just as a diabetic must not take sugar, so some persons must not drink because they are constitutionally candidates for alcoholism. This campaign is supported by some members of the licensed trade, which, be it said to their credit, has otherwise been so generous in supporting hospitals and academic activities. The defect of this policy, however, is its neglect in the prevention of alcoholism. Its aim is to treat established alcoholics. The extent of alcoholism is in fact influenced by the amount of drink manufactured, the amount of advertising, official and unofficial, the number of off-licences and especially on-licences, the retail price, the hours of sale, and Sunday opening. The conditions favouring gigantic sales have been maximal in recent years. Neither Tory nor Labour Cabinets have shared Mr. A. J. Balfour's view that no one could welcome increased sales of drink, nor Mr. Lloyd George's views that led him to close down the distilleries in 1916 as drink was threatening the war effort, or, again, Mr. Attlee's opinion that drink should not be advertised. On the contrary, almost no licences are refused, and supermarkets sell spirits at much reduced prices. There are plans to boost sales of spirits abroad, despite a European convention of 1919 whereby restrictions of the sale of drink to backward peoples were agreed upon. Such people die of drink in the twenties rather than in the fifties or sixties.

Seeing that the banning of alcohol is impossible to enforce at present, as is done with barbiturates or hashish, advice to the young should be directed to minimizing the ill effects of drink. They should be advised either not to drink at all or to drink in as safe a manner as possible. There should be no social pressure on anyone to drink, but alternative non-alcoholic drinks should always be offered as well.

At the moment the Government has just added 4s. to the duty on a bottle of spirits, and this will no doubt cause a temporary drop in sales. Another favourable event has been the B.B.C. discussion of alcoholism on 9 January. However, the gigantic concerns which are planning still more mergers will eventually sell more and more drink through high-pressure advertising and computer-based sales campaigns. This will inevitably lead to a postwar peak of alcoholism. Perhaps it will end with the Government taking over the whole industry. After that, if sanity prevails, advertising will be not in favour of drink but against it. However, are we already too late to prevent the predicted vast increase of alcoholism which is threatening the country in the meantime?—I am, etc.,

A. SPENCER PATERSON.

London W.1.

Intermittent Claudication

SIR,—As pointed out by Mr. M. A. Falconer (28 December, p. 833), neurogenic claudication is not encompassed by the definition of intermittent claudication given in the "Medicine Today" article (7 December, p. 630), though in the course of the article we are, in fact, reminded of the existence of neurological causes of pain and paraesthesiae in the legs. What is unfortunate is that there is no mention of examination of the spine and neurological examination of the legs in an article entitled "Investigation of Intermittent Claudication."

Mr. Falconer states that neurogenic claudication can be completely relieved by laminectomy. I hope he tries simple physical measures (such as lumbar traction) first, because they are often quite successful in relieving this condition.—I am, etc.,

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SIR,—Your contribution on the investigation of intermittent claudication (7 December, p. 630) is remarkable for the lack of emphasis on the need to identify causative or risk factors in the investigation of peripheral vascular disease. It is also remarkable for the same lack of emphasis on constructive conservative treatment and secondary prevention.

Your contributor states: "The best treatment of the mild claudicant in the early stages of his symptoms is to send him away for six months." Apart from a brief word about hypertension there is no word about the associated risk factors which we now recognize, no word about the vital importance of stopping smoking, nor any word about graduated exercises. The impression implicit in your contributor's remarks is that the patient should be sent away and that nothing need be done until the claudication is severe, when surgical "cure" can be offered. And surely it is naive to use the word "cure" when dealing with such a widespread and chronic disease.

In dealing with patients with peripheral vascular disease and intermittent claudication it is the practice in my department in St. Vincent's Hospital to seek out the same risk

factors which are identified with coronary heart disease. We are particularly concerned about cigarette smoking, hypertension, elevated serum cholesterol and triglycerides, abnormal glucose tolerance, and obesity. Our patients are subjected to a vigorous course of secondary prevention by the elimination or correction of such factors. In addition they are instructed in long-term graduated exercises, and are encouraged to return to a normal life and normal activities. It is a pity that there is not a general appreciation of how well co-operative patients will do on such regimen. In such cases claudication will diminish appreciably or resolve. Only a minority who are co-operative fail to improve, and very few indeed progress to the stage where surgery is required.

In writing this letter I am not denying the important place of surgery in the treatment of peripheral vascular disease. I wish, however, to emphasize that peripheral vascular disease, though widely neglected by physicians, is as much a medical as a surgical problem, and that a constructive approach to prevention and conservative treatment will considerably reduce the number of advanced cases requiring elective or emergency surgery. In the context of our present knowledge on causation it is not enough that you should publish an article on the investigation and management of intermittent claudication with such emphasis on surgical alleviation without greater emphasis on the factors that cause the disease and hence on primary and secondary prevention.—I am, etc.,

Dublin.

RISTEÁRD MULCAHY.

SIR,—The recent discussion about arterial disease of the legs (7 December, p. 630) prompts me to record a treatment of this condition which I have been using with apparent success for some years. The treatment consists of the injection of acetylcholine mixed with lignocaine hydrochloride (Xylocaine) into the femoral artery at the groin of the affected limb.

I have treated three females and three males, all of whom had a main arterial block and severe intermittent claudication. They were all between 60 and 70 years of age, and none had diabetes. In every case improvement was quite indisputable. From being forced to stop after a walk of 150 yards (137 metres) or less, all six were able to walk upwards of half a mile (0.8 km.) and some were able to forget their symptoms completely. I have also treated three females with early gangrene of the toes.

The first of these had a sizable area of gangrene on the outer side of the top of a big toe. After daily injections for three weeks the foot became permanently warm and pink, the area of gangrene separated, and perfect healing occurred. The foot remained normal over three years' subsequent observation.

The second case was a diabetic lady needing insulin, and the terminal phalanges of three toes of one foot were gangrenous. Acetylcholine improved the colour and warmth of the foot, and relieved the pain in the toes, but no evidence of healing occurred over a period of six weeks, after which time the patient died of a cerebral thrombosis.

The third case was also a diabetic lady whose diabetes was controlled by tolbutamide. Both feet were white and cold without pulses, and areas of gangrene were present on the tips of six toes. Daily bilateral injections over a month

led to both feet regaining a normal appearance, and to the complete healing of all the areas of gangrene.

I have given doses up to 400 mg. at a time (100 mg. in 1 ml.), but there appears to be no advantage in using more than 100 mg. at a time. I use this routinely now, mixed with some 6 ml. of 1% lignocaine. Injections may be given daily or less often. There is probably no advantage in giving more than one injection daily. Pain down the leg at the time of injection is considerable but not intolerable, and is lessened by giving the injection slowly. If given slowly only minimal quantities of acetylcholine are carried back to heart and lungs, and no bradycardia or bronchospasm of any severity occurs. Slow injection is important, since cardiac arrest can occur with rapid injection. It is, of course, vital to avoid injection of acetylcholine into the femoral vein, and to be certain that the artery has been entered it is advisable to use a syringe with a freely moving plunger so that the blood from the artery enters readily. A disposable syringe has a plunger which is too stiff in its movement to be forced outward by arterial pressure, and this type of syringe is unsuitable. I use a 21 s.w.g. $1\frac{1}{2}$ needle.

It is presumed that acetylcholine is beneficial through improving the collateral circulation in the affected limb. This may be in part due to vasodilator effect, but in view of the apparent permanence of improvement it might be conjectured that some local or spinal vasoconstrictor reflexes, possibly arising in the diseased main vessel, are inhibited and removed and do not recur.

No ill effects have been observed from this therapy, and it is hoped that others may see fit to give it a trial. It is, of course, a matter of common sense to vary the point at which the artery is punctured.—I am, etc.,

R. J. T. WOODLAND.

Paignton,
Devon.

Psoralens

SIR,—In July 1960 S. W. Becker, jun., summarized our knowledge concerning these drugs.¹ He stated that there were many psoralens but only a few had been used clinically. His theme was largely that psoralens are potent controllable photosensitizers which can be used to increase or decrease the effects of sunlight in human skin. Becker described how under their influence the horny layer of the epidermis becomes thicker and more dense and the *stratum lucidum* is also changed; if the skin is then exposed to sunlight so that an erythema is obtained, pigment is retained in the epidermis in a way which does not happen in untreated skin, and sun-tanning is apparently accelerated. But the erythema must be carefully produced. To take psoralens and then expose oneself haphazardly to intense sunlight or to the rays from an ultraviolet ray source may produce a severe blistering dermatitis; damage to the eyes may also occur. Becker therefore deplored the use of psoralens as "sun-tan pills."

My remembrance of this matter was recently quickened when a patient recently showed me a residual oedema of the legs and a good deal of cutaneous damage following the use of psoralens for "sun-tanning." He

had been recommended by a friend to take the tablets during a holiday in France, and the acute reaction which he incurred has cost him four months of invalidism. In practice it seems likely that many take psoralens, then sunbathe, and, possibly from a fortuitous combination of circumstances, get away with it; but in a proportion of cases a very acute generalized dermatitis with blistering and oedema (and perhaps with renal complications) may occur. Therefore it is advisable not to use the drugs casually merely as an aid to "sun-tanning." Other side-effects include nausea, vomiting, insomnia, and mental depression, and some have suspected that psoralens are at least potentially hepatotoxic.—I am, etc.,

London W.1. R. M. B. MACKENNA.

REFERENCE

- ¹ Becker, S. W., jun., *J. Amer. med. Ass.*, 1960, **173**, 1483.

Hypnosis for Asthma

SIR,—The report "Hypnosis for Asthma—a Controlled Trial" (12 October, p. 71) and subsequent correspondence raise a point of very general significance. Dr. B. J. Freedman (2 November, p. 329)—and also Dr. R. J. Walden (14 December, p. 706) by implication—asks "What value can be placed on a patient's personal assessment of his wheezing when under the influence of post-hypnotic suggestion?" It was only an assessment of this kind that gave any clear indication of the therapeutic superiority of hypnosis over the control method. In drug trials the patient's own statement of how he feels may be the most valuable criterion of the effect of treatment. Its essential subjectivity presents no problem in properly designed double-blind trials. In the present case, however, the situation is more difficult because the therapy itself is likely to persuade the patient to say he is better. The situation is akin to a drug trial in which the therapist gives to the treated patient, but not to the control patient, strong suggestions that he will get better.

On the other hand, the patient who feels well is better off than the patient who feels ill, and, as Dr. G. P. Maher-Loughnan (30 November, p. 583) has pointed out in reply, the patient's F.E.V.₁ and V.C. measured once a month may be poor indices of either initial impairment or subsequent progress. When reliable direct observation is impossible there is nothing for it but to use the patients as observers of themselves, but the investigator must realize that his observers may be biased. If necessary he must eliminate the bias or make due allowance for it. The "Hypnosis for Asthma" investigation was rightly criticized by Dr. Freedman for failing to do this.

In most illnesses, that which can be directly observed is but a small part of the whole constellation of events that constitute the illness. The doctor is therefore obliged to rely on information obtained by verbal communication with the patient. Psychologists already know quite a lot about the biases affecting such communication. While it is generally impossible to eliminate these distortions entirely, they can be minimized, and sometimes measured, by adopting appropriate methods. Much more research is needed into these problems, so that better methods of

communication between doctor and patient can be devised. In the meantime we must ensure that all the currently available knowledge is brought to bear upon choosing the most suitable method for each type of inquiry.—I am, etc.,

J. G. INGHAM.

M.R.C. External Staff,
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Management of Depression

SIR,—In the article (7 December, p. 627) on the management of senile psychiatric disorders by Dr. Felix Post, no mention is made of the new tricyclic antidepressant iprindole.

A group of 12 patients in my practice were treated with this drug for four weeks. Each was suffering from a depression of endogenous or of reactive origin. The Max Hamilton Rating Scale was used to measure the initial and final degrees of depression, with a dosage of 30 mg. t.d.s. In the final assessment, with an average initial score of 20 and an average final score of 7.125, four cases were much improved, four cases were improved, in two cases there was no change, and two cases were worse. Side-effects were observed in one patient only and consisted of increased agitation, nausea, and weakness in the legs. The frequency of atropine-like side-effects as occurring with other antidepressants was not noted and generally speaking the response was gradual and sustained.

Professor L. G. Kiloh (28 December, p. 813) states that a high proportion of patients do not take their tablets. Consequently an antidepressant drug with a significant reduction in side-effects could be a welcome addition to the therapeutic armamentarium.—I am, etc.,

D. WAXMAN.

London W.1.

Inhibition of Lactation

SIR,—The results of three of the four early trials of quinnestrol analysed at the colloquium on quinnestrol (Estrovis) in 1966 have been recently discussed in your columns (21 December, p. 769; and 17 January, p. 184). As there is some discrepancy between them, the results of the fourth trial performed at the same time by me at St. George's Hospital furnishes further relevant information. In this, a double-blind trial was performed comparing a single oral placebo with a single 0.8-mg. oral dose of quinnestrol and an intramuscular injection of 45 mg. hexoestrol plus placebo capsule. The treatment in each case was given within two hours of delivery, usually before the patient left the labour ward bed. Fifty patients were randomly selected into each of the three groups. The results are shown in the Table:

Drug	No. Patients	Results			
		Excellent	Fair	Poor	Fail
Placebo only	50	0	1	1	48
Hexoestrol	50	30	7	3	10
Quinnestrol (2 mg.)	50	17 (34%)	6	2	25 (50%)