cases of coronary heart disease there is no contact with physicians at all, the first recognised occurrence being sudden death. It follows inexorably that prevention is essential. With coronary heart disease, the recent experience of Australia and the United States shows also that prevention is possible, at least in part.

The preventive strategy that concentrates on high-risk individuals may be appropriate for those individuals, as well as being a wise and efficient use of limited medical resources; but its ability to reduce the burden of disease in the whole community tends to be disappointingly small. Potentially far more effective, and ultimately the only acceptable answer, is the mass strategy, whose aim is to shift the whole population’s distribution of the risk variable. Here, however, our first concern must be that such mass advice is safe.

**ADDITION AND REMOVAL**

We may usefully distinguish two types of preventive measure. The first consists of the removal of an unnatural factor and the restoration of “biological normality”—that is, of the conditions to which presumably we are genetically adapted. For coronary heart disease such measures would include a substantial reduction in our intake of saturated fat, giving up cigarettes, avoiding severe obesity and a state of permanent physical inactivity, maybe some increase in the intake of polyunsaturated fat, and therefore we should be prepared to advocate them on the basis of a reasonable presumption of benefit.

The second type of mass preventive measure is quite different. It consists not in removing a supposed cause of disease but in adding some other unnatural factor, in the hope of conferring protection. The end result is to increase biological abnormality by an even further removal from those conditions to which we are genetically adapted. For coronary heart disease such measures include a high intake of polyunsaturates and all forms of long-term medication. Long-term safety cannot be assured, and quite possibly harm may outweigh benefit. For such measures as these the required level of evidence, both of benefit and (particularly) of safety, must be far more stringent.

**References**


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**Dealing with the Disadvantaged**

**Psoriasis**

LINDA A HENLEY

Over one million people suffer from psoriasis and many others carry a predisposition. It is a common skin condition that can occur on any part of the body, at any age, as raised red patches covered with silvery scales. It should be made clear to patients and their relatives that it is definitely neither infectious nor contagious. In simple terms it is only an acceleration of the usual replacement processes of the skin, but the basic cause remains unknown. Hereditary factors are thought to play an important part, with a genetic tendency being triggered off by such things as injury, throat infection, certain drugs, and stress. There are many clinical forms and considerable variations in intensity. Widespread ignorance and the real or imagined reactions of non-sufferers may also lead to a withdrawal from society and to feelings of isolation and depression. Permanent cures are not yet possible, although many people are helped by treatment.

Useful points

The following points may be useful when dealing with psoriatics:

1. It is important that the patient understands in simple terms what is happening to his skin. The word “psoriasis” is difficult to pronounce and spell and often in itself causes distress.
2. The patient should not be told that it is incurable and that he or she must live with it before an explanation of the condition is given and time has been allowed for the facts to be absorbed.
3. Often the patient is worried when technical terms are used, such as exfoliate, remission, epidermis. Many mothers are terribly upset to hear guttate. Care should be taken to use simple terms and to make sure that the patient understands.
4. Many psoriatics are introverted and depressed about their skins. It is important that they should be made to feel “whole persons” and not just “skins.” A little while spent listening to them will help reduce the stress they are experiencing.
5. Many psoriatics learning of the diagnosis think that they have something rare and feel isolated. They should be told that
psoriasis is a common condition. On a full double-decker bus, at least two people will actually have psoriasis and another five a predisposition to it.

(6) Finally, it is important that they understand how to deal with any prescription given.

The Psoriasis Association

The Psoriasis Association was founded in 1968 and has become an important self-help organisation, providing support and mutual help for sufferers. It is also the main source of information on all aspects of the condition. More research projects into the causes, treatment, and cure of psoriasis are being supported each year with larger grants; community acceptance and understanding have already been increased by publicity and education. The association works continually to improve standards of patient care and has established strong national and international links to achieve this.

Membership is open to anyone, and every member receives the informative national journal “Beyond the Ointment” three times a year. Members may also participate voluntarily in the activities of local groups, which provide social contact and information and raise funds for research and education.

Lesson of the Week

Prognosis for sphincter recovery after operation for cauda equina compression owing to lumbar disc prolapse

S A O’LAOIRE, H A CROCKARD, D G THOMAS

In the 45 years since the neurological complications of ruptured lumbar intervertebral discs became generally recognised it has been known that compression of the cauda equina could result in paralysis of bowel and bladder function.1 Indeed, such compression has been considered the only absolute indication for operation in cases of lumbar disc disease.2 Few reports of cauda equina compression owing to lumbar disc prolapse have been published, and the prognosis for the recovery of bowel and bladder function after surgery has been uniformly gloomy,3-5 though the recovery of motor function has generally been considered likely.

Sphincter paralysis is a rare (2%)6 but potentially disastrous complication of lumbar intervertebral disc prolapse. Patients usually present first in general practice and then in general medical, surgical, or orthopaedic or rheumatology departments. It is therefore extremely important that doctors are aware of the condition so that a neurosurgeon is consulted before the neurological damage becomes permanent. The urgency of the diagnosis and treatment may be compared to that for extradural haematoma in head injury.

Twenty years ago Shepherd1 reviewed the cases that presented to the National Hospital, Maida Vale and suggested that early diagnosis and surgery were important for reducing permanent neurological damage. We therefore reviewed all operated cases of central lumbar disc prolapse at the National Hospitals for Nervous Diseases at Queen Square and Maida Vale since 1960, and those presenting at University College Hospital, to see whether there has been an improvement in prognosis. We concentrated on patients with impaired sphincter function, and use the term “sphincter” loosely, as in previous reports, to include all mechanisms required for normal micturition and defecation.

Clinical findings

We studied 17 men and 12 women, whose ages ranged from 23 to 69 years. All but five had a past history of lumbar disc disease: 11 had had episodes of back pain; 11 had had sciatica and back pain and two of these had had operations for prolapsed lumbar disc at the same level. Seven patients had had an acute onset associated with trauma. All 29 patients presented with back pain, and all but five had sciatica, bilateral in 18 and unilateral in six (fig 1). Of the five patients without sciatica, two had a history of pain shooting into the genitalia and rectum, and the other three had had similar pain at the onset of sphincter disturbance.

Impaired sphincter function (fig 2) had occurred from as little as 24 hours to as long as one year before operation. Complete loss of sphincter control—meaning that catheterisation was required to treat urinary retention (providing objective evidence of a severe lesion) occurred in 13 patients. In all but one of these patients the retention was painless. The other 16 patients were able to micturate by bladder compression, either by breath-holding or by manually compressing the abdomen, and these were classified as having a partial sphincter loss. Twenty patients had weakness in the legs (fig 3), varying