clearly a need for more research in this area. The protective effects of vitamin B12 would also nearly appear to be as yet unsubstantiated.—I am, etc.,

K. F. STANDAGE.

Bexley Hospital, Kent.

*Both patients with schizophrenia had low folates.

Sir,—I was interested to read both the paper by Dr. C. Neubauer (27 June, p. 759) and also your leading article on the subject of serum folate and vitamin B12 levels and epilepsy (p. 141).

I have been involved in two recent research projects on this subject.1 2 I rather envy Dr. Neubauer’s finding of therapeutic benefit from the administration of both folic acid and vitamin B12 to his patients. It was in the hope of arriving at just such a conclusion that we undertook the second piece of research mentioned above. Knowing full well the fallacies of personal assessments of benefit that often result when undertaking a therapeutic programme, the efficacy of which one wishes to see established, we took the precaution of carrying out the drug trial under double-blind conditions, and also had a definite system of assessing behaviour. Dr. Neubauer appears to have overlooked these precautions, and perhaps therein lies the difference between his positive findings of therapeutic benefit, and our own less happy negative findings.

However, there is another important factor in that Dr. Neubauer administered both folic acid and vitamin B12 whereas we confined ourselves to giving only the former; it may well be that the combined administration does confer some superiority, and certainly the analogy of precipitation of subacute combined degeneration of the spinal cord when folic acid alone is given to some patients with megaloblastic anaemia is interesting. However, I think more rigorous proof is required before allowing the conclusion to pass unchallenged.

In your leading article you refer to antagonistic effect between folic acid and vitamin B12 in epilepsy as well as subacute combined degeneration. I think this effect is not established, however. For instance, in our research we did not find that the administration of folic acid alone to our epileptics led to any increase in the frequency or severity of their fits. Furthermore, there was no apparent tendency in our drug trial for serum vitamin B12 level to fall as folic acid therapy continued.

Although we found in the first of our research projects that there was a definite, though diagnostically indeterminate, relationship between low serum folate and mental illness in epileptic patients, there was no such relationship with lowered serum vitamin B12 levels. A lowered serum vitamin B12 level was very much less common than a low serum folate in mentally ill epileptics, and in only one patient was a finding of lowering of both levels recorded.—I am, etc.,

R. P. SMITH.

Stanley Royd Hospital, Wakefield, YO32.

REFERENCES


Burdens of Cerebrovascular Disease

Sir,—I feel the article by Professor R. M. Acheson and Dr. A. S. Fairbairn (13 June, p. 621) is incorrectly titled. A better title would be “The Burden on the Hospital Service of Cerebrovascular Disease.”

Total incidence of cerebrovascular disease is calculated by adding home deaths to hospital morbidity. This leads to an underestimate of incidence by the number of cases treated at home who either live for more than one year or who die within one year from some other cause. The authors state that “no information is at present available about this group (those treated at home who recover), so that it must be ignored.”

I see no reason why this group should be ignored, and it is at present being studied in a defined community in South Wales by ordinary epidemiological methods. Our present results suggest that 60% of all “clinical” strokes never go to hospital, and that they are similar as regards severity and case fatality to those who are hospitalized. The indications for hospitalization in this area appear to be mainly physical, and the form of management is very open to criticism. Their comparison with Middlesbrough County is surely inappropriate. Middlesbrough County is a correct study of total incidence. Any agreement must be coincidental.

Record linkage is a wonderful tool. When it covers general practice as well as hospitals it will be possible to use it for community epidemiology. Until then the usual methods seem safer.—I am, etc.,

A. L. COCHRANE.

Barry, Glam.

Costs of Screening Programmes

Sir,—Your leading article (6 June, p. 553) on phenylketonuria is timely, stressing as it does the need to review the organization which must be set up to deal with cases detected by screening programmes. We believe that it might be appropriate, too, for some central department at this time to review aspects of the screening programme itself, particularly those details relating to recording and reporting of results. The price of communication will be far from negligible in the final cost/benefit analysis which, surely, must soon be undertaken.

The cost of collection and reporting at this hospital is shown in the weekly figures which follow:

<table>
<thead>
<tr>
<th>Costing of Guthrie Test (about 70 tests per week)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of Collection of Specimens</td>
</tr>
<tr>
<td>Cost of Tests (laboratory cost)</td>
</tr>
<tr>
<td>Cost of Recording and Reporting</td>
</tr>
<tr>
<td>Cost of Instruction to Midwives and others</td>
</tr>
<tr>
<td>Total Cost + 10%</td>
</tr>
</tbody>
</table>

The cost of test materials and laboratory personnel is negligible in comparison with the costs of collection, recording, and reporting—tasks which fall largely on the nursing and secretarial staff. Our costing exercise, of course, does not take into account further expenditure on babies born at this hospital who for one reason or another (mainly early discharge) must be followed up by the medical officer of health.

Your leading article states that the result of the test, even if negative, should be given to the parents. While no doubt a courteous and humane gesture, this would add considerably to the burden on the visiting parents who provide their own stamped addressed envelopes for the information. It has not been our practice here; nor is it customary for the results of laboratory procedures to be communicated directly to the patient, save at the discretion of the patient’s own doctor. You also state that the laboratory should inform the midwife or health visitor as well as the medical officer of health, the family doctor, and the consultant paediatrician if two tests are positive. We cannot see what purpose is served by the laboratory directly informing the midwife or the health visitor, even when it is possible speedily to locate the originator of the test, and, again, this runs counter to customary practice. It must also add to the cost, although probably not greatly, as the numbers involved are small. By the time two positive tests have been reported it is most unlikely that the child will be under the care of a midwife, and we have little doubt that the medical officer of health would ensure that his staff were informed in any event. Costly duplication of information should be avoided, in our view.

If other screening programmes are to be introduced on a national scale, surely it is only wise to review critically the expenditure on this one, cutting it wherever possible by encouraging a truly national practice, and by discouraging unnecessary communications, be they reports, letters, or telephone calls?

We are indebted to Miss K. Kovari and to the Treasurer, Queen Charlotte’s Maternity Hospital for calculations of cost.—We are, etc.,

ROSALIND HURLEY.
A. P. NORMAN.
Queen Charlotte’s Maternity Hospital, London W.6.

Cancer and the Pill

Sir,—I have seen over the last two years four cases of breast carcinoma where the diagnosis was made following the completion of the pill. In each case the pill was stopped and the patient was launched on the contraceptive pill.

Many women are taking the pill for the first time at an age when the incidence of breast carcinoma starts to rise steeply. Much has been written about the thromboembolic risks, and the appropriate modifications in hormone dosage have been made; however, we cannot be sure that the carcinoma risk is much more important? Our ignorance of the possible links between hormone imbalance and breast and uterine carcinoma is virtually complete. It is therefore a profound relationship in susceptible cases, and hints about this are only now coming...
to light through the work of the team at the Imperial Cancer Research laboratories and others.

It is probable that the enormous social convenience of the pill—and the first true emancipation of women that has occurred—areclouding your judgement to the true risks. It is striking that the possible induction of carcinoma is barely mentioned in the countless discussions on the pill that can be read in the non-medical press. Have the sociologists (and the drug houses) won the argument yet again before the problem has even been properly formulated, let alone solved?—I am, etc.,

PAUL STRICKLAND,
Regional Radiotherapy Centre, Mount Vernon Hospital, Northwood, Middlesex.

REFERENCES

Diagnosis of Pulmonary Embolism

SIR,—I was interested in the Clinical Progress article (27 June, p. 773) on the diagnosis of pulmonary embolism. I refer particularly to the final paragraph on the mainstays of diagnosis "in an acutely ill patient."

I have recently been rather worried by some six cases of acute pulmonary embolism in young, fit patients, four of whom have walked down to the surgery complaining only of a little pain in the chest. Only one out of the six showed any tachypnoea. All were of sufficient severity to be treated with anticoagulants. None of them had leg or abdominal signs.—I am, etc.,

S. B. TWIVY.
Dontable, Beds.

House-dust and Asthma

SIR,—The connexion between house-dust and asthma (30 May, p. 501) was noted as long ago as 1698 when Sir John Floyer referred to it in his "Treatise on Asthma." During the past six years evidence has accrued that the major antigenic component of house-dust is derived from the mite Dermatophagoides pteronyssinus, whose main source of food is shed human epidermal scales. In this connexion bed-making is notorious for provoking allergic respiratory symptoms (streening, asthma). Maunsell et al.1 found that the mite content of house-dust varied according to its size of collection, being greatest in dust from mattresses.

It is interesting, therefore, to see what observations Ramazzini, the father of occupational medicine, made on the effect on the lungs of dust from old mattresses and clothes. Bernardino Ramazzini, born in 1633, was professor of medicine at Modena from 1671 to 1700, and thereafter held the chair at Venice. In 1700 the first edition of his De Morbis Arificium (Disease of Workers) was published. The following extract is taken from the 1713 edition, the translation from the Latin being slightly modified from that of Wright.2

"It is the custom, in Italy at least, for Jews to remake wool mattresses in which the wool has been packed by several years of daily use on beds, so that they are too hard. They lay the wool on hurdles of wicker-work, beat it with sticks, and shake it thoroughly, thus they make the mat-tresses softer and more comfortable to lie on. . . . In shaking and combing it they take in by the mouth a great deal of foul dust. This causes serious ailments, a harassing cough, dyspnoea, and a disordered stomach. . . . I consider that it is not this dust from old wool that is so deadly as that which rises from the impurities left in it by the bodies of those who have lain on the mat-tresses.—I am, etc.,

BERNARD J. FREEDMAN,
Dulwich Hospital, London S.E.22.

REFERENCES
3 Ramazzini, J., De Morbis Artificium, 1713, translated by Wright, W. C., Chicago, University of Chicago Press, 1940.

Who Should Do Psychotherapy?

SIR,—In asking this, and other pertinent questions, your leader writer (13 June, p. 604) referred to the outcome of four different referrals to psychiatric units from my practice over a five-year period,3 and in doing so appears, probably inadvertently, to be using what I described as the "some-what disappointing" results as evidence to support the suggestion that psychotherapy is not of any great value.

I am pleased to be recognized as "a by no means unfriendly critic," but would be grateful for a little space in which to emphasize that the results of my study did nothing to support Eysenck's view that psychotherapy is of no value—but they do show up very clearly the existing shortage of personnel, including both of staff attached to the psychiatric units and the shamefully poor administration of this sector of the National Health Service. That many of my patients did so badly was because of the disgracefully long wait for their initial consultation, and the further six to nine months delay before they could expect to be put in the psychotherapeutic group recommended for them. This is not a criticism of my own competence or of the patients' problems, but of the conditions under which they have to work.

As your leader-writer states, there is a growing volume of published evidence on the usefulness and value of properly organized psychotherapy in a variety of different groups of patients, so that Eysenck's "bomb" is turning out to be little more than a piece of casuistical fluff. Indeed, as pointed out in the paper on psychiatric referrals,4 the results even of the superficial psychotherapy that can be expected from a family doctor are far better in many patients than can be expected from traditional medical treatment, including all the most up-to-date tranquillizers. Follow-up of several of those patients whose results were "somewhat disappointing" showed that they benefited from properly given psychotherapy either by myself, or by psychotherapists consulted privately. This leads on to the suggestion, quoted by you and furthered in the U.S., as well as providing a forum for further discussion of, all those problems associated with the patient-doctor relationship. In this way perhaps we may find ways and means of improving the quality of our medical care for the large majori-ty of our patients who require some form of psychotherapy as part of their treatment.

There is no doubt in my mind, after applying these ideas in my practice for nearly 20 years, that large numbers of patients with psychosomatic disorders, as well as those with frank psychoneurotic problems who ordinarily would not dream of consulting a psychiatrist or psychotherapist, can and do benefit enormously from simple or minor psychotherapy that is well within the competence of the family doctor. This not only helps the patient, but also makes the doctor's work more enjoyable. It also reduces considerably the need for constantly having to refer patients to hospital outpatient clinics for innumerable and unneces-sary investigations into their illnesses which are based not on pathological changes but on emotional disorders.

I am convinced that if we could improve our standard of medical practice in this way we would save the Health Service millions of pounds each year by avoiding so much unnecessary hospital investigation—and at the same time improve the status of the family doctor in the eyes of the public.—I am, etc.,

PHILIP HOPKINS.
London N.W.3.

REFERENCE

Gold Therapy in Rheumatoid Arthritis

SIR,—Regarding the medical memorandum about the nephritic syndrome and gold therapy (27 June, p. 772) I notice that the dosage of gold aurothiomalate given to the patient...