Caldwell, I have had no case of sepsis in a series of 21 implant operations. One stimulator became faulty and required replacement; one frail patient suffered wound dehiscence but responded to resuture with no sepsis problems. The results are far from discouraging.

Your leader refers to difficulty in predicting success, and quotes my work as supporting L. Edwards in showing that no objective method is available. This is not the case. My paper E.

... was standardised Regional and measurement, increasing use is expected, but perhaps this could be helped by having a reception-type class where a sorting out process would go on during the first term and a better adjustment made... We refer to some children, a rather overwhelming experience.

Regarding treatment, day patient care can often be effective providing as it does the necessary hospital support and teaching, while maintaining the child in his home and neighbourhood... I am, etc.

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Problems with Asthma

Sir,—Dysp. F. O. Wells and C. J. Stewart (1 July, p. 37) have demonstrated some interesting problems in managing their fatal case of asthma. Both practitioners and physician seem clear that infection was not of prime importance. Similarly the only demonstrable allergy, to Candida albicans, was probably the result of earlier treatment, although multifactorial, psychogenic factors are agreed to be particularly important.

Dr. Wells described his patient's ambivalence towards work. Did that attitude characterise his other relationships? Certainly there are grounds for saying that he became ambivalent, if not covertly hostile, to his doctors (lack of confidence, refusal of treatment, uncooperative). Nor was this owing to their lack of concern for his illness. It can be reasonably assumed that he found open discussion of his angry feelings too painful or dangerous; he resorted to denial, and subconsciously to sadomasochistic displacement, not only towards his doctors, but more important, on to his own body in a neurotic ritual. This reaction resembles the more obviously sadomasochistic behaviour, the syndrome of deliberate self cutting, in that any unsupported effort to resolve interpersonal difficulties by separate activity brings on acute anxiety and a recurrence of overt illness.1 Denial of personal problems resulted in the patient visiting an ophthalmologist when a psychiatrist would have been appropriate.

Bastian2 has suggested that we pay particular attention to frustrated drives leading to unresolved aggressive feelings and regressive behaviour. However, little has been written of the patient's real life roles and his fantastied ideas. Psychosomatic asthmatics may conform to the psychosomatic stereotypes, but often their difficulties are unique. They often feel unacceptably tied to a set of impossible parental or marital attitudes and relationships. They feel suffocated and entrapped, often by their own ideals. These problems become buried as they retreat to stress of wheezing and ambivalent fear of death, the tension of which contributes further wheezing. This aspect is well treated by behaviour therapy.3

My plea is that we strive constantly to wear two hats in psychosomatic disease—medical awareness and psychosocial awareness. Between the acute episodes is the opportunity to know the human being in his life-situation—I am, etc.

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Diabetic Amyotrophy

Sir.—Dr. A. Singer (15 April, p. 170) suggested that chronic occlusive peripheral vascular disease might have been directly responsible for the muscle wasting seen in the patients with diabetic amyotrophy who formed the basis of our follow-up study (11 March, p. 656). The evidence does not support such a contention. Firstly, there was little evidence of peripheral vascular disease. None of the 12 patients complained of intermittent claudication, nor had trophic changes in the legs. Five patients, including the one with the most severe muscle wasting, had normal peripheral pulses; one had three out of four pulses palpable, and two had both dorsalis pedis pulses palpable though no posterior tibial pulse. In three cases the records were incomplete.

Secondly, the electrophysiological evidence, which we presented, clearly demonstrated that the wasting and weakness were neurogenic in origin with signs of muscle denervation. The slowing of motor conduction and absence of axonal potential nerve action potentials were further proof of the presence of peripheral neuropathy in our patients. There is therefore no reason to suggest that the muscle wasting was a direct trophic effect of muscle ischaemia.

In published studies of patients with severe chronic occlusive peripheral vascular disease,4 5 muscle wasting is not common and when present can usually be attributed to an ischaemic neuropathy.—We are, etc.

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1 Hutchinson, E. C., and Liversedge, I. A., Quarterly Journal of Medicine, 1936, 26, 267.
2 Miglietta, O., Archives of Neurology, 1964, 14, 30.

Large Doses of Fluphenazine Enanthate

Sir,—I read with interest the correspondence concerning large doses of fluphenazine enanthate and would like to comment...