help us in deciding the extent to which radical prostatectomy has lengthened the patients' lives. Those who hold the views of Dr Fraser and Dr Moon would be doing the urological community (and patients with a prostatic cancer) on both sides of the Atlantic a great service by mounting the sort of controlled trial that would answer this question once and for all.

I do not think I was in fact being unfair about radical prostatectomy in my article. Like Tom Stamey, "I do not know." I am prepared for it to be proved that the advocates for radical prostatectomy are right. I think that the case for radical prostatectomy would be strengthened if those who currently practise the operation also showed that they might be prepared to be proved wrong and having done so set about providing the proof one way or another.

Dr Fraser and Mr Urwin are right to point out that the Veterans Administration studies of hormonal treatment were comparisons between immediate and deferred hormonal therapy. The difference between those studies and that proposed by the Medical Research Council is that the Veterans Administration study protocol does not appear to have contained specific requirements about the treatment that should be instituted when the disease has progressed or indeed when it should be started. Byar himself comments that inconsistencies between the results of study 1 and study 2 probably arose because of differences in the willingness of participating physicians to take the patients "off study"—that is, institute deferred therapy.

Why we feel the Medical Research Council study will give a more definitive answer is because it is comparing the same treatment—that is, orchidectomy—but applied at different times during the course of the disease while the Veterans Administration study compared immediate treatment with defined hormonal modalities against a deferred treatment of a rather non-specific nature. Most of my correspondents seem to agree with Mr Urwin that the proposed Medical Research Council study remains pertinent rather than with Dr Fraser's comments above. I would, however, agree entirely with Dr Fraser that the way forward does depend on our being able to predict the course of the disease. Since we are treating an elderly population it is as important not to inflict unnecessary treatment on those who are destined to die of some other cause as it is not to withhold valuable treatment from those who need it.

DAVID KIRK

Urological Department,
Royal Infirmary,
Glasgow G3 7ER

Treatment without consent: emergency

SIR,—I was interested to read the recent article by your legal correspondent regarding treatment without consent in emergencies (18 May, p 1505). In the care of people with mental handicap informed consent to treatment can be a problem. Because the mentally handicapped person's ability to understand and communicate is less than the norm extra efforts must be made to ensure that the individual has expressed adequately his needs and has understood as well as is possible any procedures offered to him. The greater the handicap, the more difficult it is to fulfil these ideals.

In the case of a severely handicapped adult who cannot communicate consent it may be necessary to proceed on the inference that it has been given, as no one else can give this consent for him. This places his carers in the unsatisfactory position of

acting in his assumed "best interests." If their actions impinge on his rights the medical staff treating him may be technically in breach of the law.

Such a situation could arise, for example, in the case of a mentally handicapped person admitted to hospital for surgical treatment. In such circumstances members of our psychiatric staff have occasionally been asked to obtain consent for a procedure from the relatives or, failing this, to give consent on behalf of the patient. We have had to point out that in law this cannot be done. Our recent practice has been to give a written agreement to any necessary surgical or other invasive treatment; this, while not a consent, has at least the effect of constituting a second opinion. It is at best a compromise and does not satisfactorily address the need for adequate and legally recognised representation of those unable to put their own case. The medical staff treating them rely on the application of common law for acting in what they have seen as the best interests of the patient, but there is, as pointed out in the article, little in the way of case law to give reassurance on this point.

As the situation currently stands, many mentally handicapped people are in the position of relying on such morally defensible but legally problem ridden decisions. The advent of the 1983 Mental Health Act and the increasing movement towards self advocacy for the mentally handicapped have served further to highlight these problems.

We have discussed the matter with the mental health commissioners and would be very interested to hear of the views and experiences of others in this difficult area.

A KEARNS

Harperbury Hospital,
Shenley, Herts WD7 9HQ

Alternatives to the digitalis glycosides for heart failure

SIR,—I feel I must reply to the comments made by Dr Peter Wilmshurst (18 May, p 1515) which related to my leading article (16 March, p 803). Whatever the reasons, Dr Wilmshurst deliberately misrepresented my views and used phrases from the article out of context to imply that I consider amrinone to be a useful and safe inotropic agent. At no time did I suggest that amrinone should be used as an alternative to the digitalis glycosides, and I clearly stated that "the incidence of adverse effects (was) unacceptably high."

The main message of the leader was that at present there is no effective oral inotropic agent available and there is a real worry that many of these agents (especially the β_1 agonists) may do more harm than good. I feel that the selection of milrinone as the most promising agent is still justified but this has more to do with the ineffectiveness of other inotropic agents than with the outstanding efficacy of milrinone. Most authorities consider that this drug has some, albeit small, inotropic activity¹ because, unlike most pure vasodilators, it is rarely associated with hypotension and increases in cardiac contractility have been described at low doses when there is little or no vasodilator activity.²

I agree that recent evidence suggests that the bipyridine derivatives do inhibit phosphodiesterase, at least in animal models. Whether this activity is important in patients with congestive heart failure at standard dosage has yet to be shown. The haemodynamic effects are not comparable to those of theophylline, there is a dissociation between effect and the changes in cyclic adenosine monophosphate,³ increases in plasma catecholamines have not been shown by other groups,⁴ and the differences between the dose response curves for

inotropic and vasodilator activity⁵ are not in keeping with pure phosphodiesterase inhibition. Indeed, if Dr Wilmshurst's thesis is correct that amrinone is a pure vasodilator devoid of any inotropic activity, it is hard to reconcile this with the action of a phosphodiesterase inhibitor. On this point, it is unjustifiable to state that because amrinone has similar haemodynamic effects to nitroprusside, a drug with venodilating and arteriolar dilating properties, amrinone has no inotropic activity. Additional benefits have been described when amrinone is combined with the selective arteriolar dilator hydralazine.⁶

Finally, a leading article is not and cannot be a comprehensive review of the published reports and the number of references must be limited. Some inotropic drugs and several references have therefore been omitted. Some references—for example, on prenalterol (Drs C G Wathen and A L Muir, 4 May, p 1352)—would have been included if they had been published at the time when the article was written. Incidentally, contrary to the inferences made by Dr Wilmshurst, I am not an employee of the Winthrop Pharmaceutical Company nor am I a member of the group who believe that the digitalis glycosides have no place in the management of heart failure in patients who are in sinus rhythm.

DENNIS JOHNSTON

Department of Therapeutics and Pharmacology,
Queen's University of Belfast,
Belfast BT9 7BL

- 1 Sonnenblick EH, Mancini DM, Le Jemtel TH. New positive inotropic drugs for the treatment of congestive heart failure. *Am J Cardiol* 1985;55:41A-4A.
- 2 Grose RM, Strain JE, Bergman MJ, McGinnis J, Greenberg MA, Le Jemtel TH. Milrinone vs Dobutamine: a comparative study. *Circulation* 1984;70:11.
- 3 Maskin CS, Sinoway L, Chadwick B, Sonnenblick EH, Le Jemtel TH. Sustained hemodynamic and clinical effects of a new cardiotonic agent, WIN 47203, in patients with severe congestive heart failure. *Circulation* 1983;67:1065-70.
- 4 Saborowski F, Griebenow R, Sirinyan G, Hense K. Metabolische und hemodynamische Befunde nach Gabe von Amrinone bei Patienten mit koronarer Herzkrankheit. *Z Kardiol* 1983;72 (suppl 1):81.
- 5 Siegel LA, Keung E, Siskind SJ, et al. Beneficial effects of amrinone-hydralazine combination on resting hemodynamics and exercise capacity in patients with severe congestive heart failure. *Circulation* 1981;63:838-44.

Community care: planning mental health services

SIR,—I was interested to read the leading article by Dr Greg Wilkinson (11 May, p 1371) and should like to point out one further community resource which is badly needed: support and assessment for mentally ill parents of babies and young children. Life outside mental hospital is likely to increase the pregnancy rate of the mentally ill and disabled, both for ordinary reasons and because they are a group vulnerable to unprotected intercourse. The birth of a child may have unpredictable effects: sometimes a parent who is barely managing to look after himself or herself will find the demands of a baby intolerable; sometimes a baby seems to act as a stabilising focus, helping the parents to function better—but this is not necessarily ideal for the child. There is much evidence to suggest that to be born to mentally ill parents is the most serious (certainly in numerical terms) risk that a child can run.¹

At the moment support for, and management of, this group is diffused among the general practitioner and child health and social services. Day nursery staff often find themselves "containing" parents despite minimal, if any, training in this work. Above all, the health visitors bear the brunt of the problem. Although a health visitor's training and practice is broadly based and includes considerable counselling expertise it is not training

in adult mental health. It can be particularly worrying when a parent refuses access to the health visitor; although she has responsibility for the children in her area, the health visitor has no legal right of entry. There is bound to be delay while the health visitor becomes sufficiently worried to contact the social services and the social services become sufficiently worried to approach the courts.

There are, then, three main needs: firstly, residential and day care facilities for assessment of mother and baby and guidance and facilitation of parenting skills when these are lacking; secondly, extra community support over the time that the parent-child relationship is developing, provided by either specially trained health visitors or social workers; and, thirdly, simpler and earlier access to the court to allow the health visitor to carry out her usual function and to protect the child. Ideally, preventive action would be taken before birth to avoid the punitive overtones inherent in going to court later. Although provision for these needs does exist it is in short supply and unevenly distributed over the country.

EVELYN ADEY

Queens Park Health Centre,
London W10 4LD

1 Mills M, Puckering C, Pound A, Cox A. What is it about depressed mothers that influences their children functioning? In: Stevenson JE, ed. *Recent research in developmental psychology*. Book supplement No 4, *Journal of Child Psychology and Psychiatry*. Oxford: Pergamon Press, 1985:11-17.

SIR,—Dr Greg Wilkinson's leading article nicely demonstrates the paucity of knowledge on this subject by the preponderance of unanswered questions it poses.

To determine the possible impact of mentally handicapped patients discharged from long stay hospitals into the "community," I compared the number of visits made to our surgery by the 14 mentally handicapped inmates of a small hostel we look after with those made by age and sex matched controls from the practice age/sex register for the year April 1984-March 1985.

I called each contact at the surgery for any new illness an "episode of illness" and divided the type of illness into "essential," when treatment, diagnosis, or medical follow up was necessary, and "non-essential," when the illness was trivial and self limiting.

The results clearly show that we provide considerably more attention to our mentally handicapped patients (table). As one might expect, "essential" episodes of illness required more visits—for example, for follow up of hypertension. Visits for episodes of non-essential illness were more frequent in the mentally handicapped, despite the presence of a psychiatric nurse in the hostel during the day.

Sixty seven of the visits for "essential" episodes of illness were for injections of cloxipol, which our practice nurse carried out and which would otherwise have fallen to the hard pressed district nurse. Only three of the mentally handicapped men did not attend at all in the study period, compared with six controls.

There are numerous explanations for the differences shown in this study; eight of the 14 mentally handicapped men smoked compared with only three controls, the diet in the hostel is high in fat and energy, and the men take little exercise.

Episodes of illness in mentally handicapped men and controls

	Handicapped		Controls	
	Non-Essential	Essential	Non-Essential	Essential
No of episodes of illness	14	20	9	8
No of visits	87	21	17	9

Although visiting frequently with "non-essential" illness, more important illness was neglected. For example, one man had a total hip replacement but failed to exercise properly and developed gross quadriceps wasting in the affected leg.

In the Portsmouth and South East Hants district there is a population of half a million. The district plan involves discharging about 700 mentally and psychiatrically handicapped inmates into the community, an average of three per GP. Because the patients will be clustered in hostels or homes, some GPs will assume responsibility for far more handicapped patients than others. It is clear from this study that this may have a substantial effect on the workload of these GPs.

T J GOULDER

Portsmouth PO7 6NN

Two different mechanisms in patients with venous thrombosis and defective fibrinolysis

SIR,—I was interested to read the article by Professor Inga Marie Nilsson and colleagues (18 May, p 1453) concerning an increased concentration of plasminogen activator inhibitor in some patients with venous thrombosis.

Most patients (73 out of 100) were said to be taking vitamin K antagonists "at the time of investigations . . ." yet the results show all patients had normal one stage prothrombin times, factor V concentrations, and protein C concentrations.

It would seem important to resolve this paradox as the influence of vitamin K antagonists on the concentration of plasminogen activator inhibitor is, to the best of my knowledge, unknown.

MARTIN J AUGER

Royal Liverpool Hospital,
Liverpool L7 8XP

** Professor Nilsson replies below.—ED, *BMJ*.

SIR,—In response to Dr Auger's query I should like to offer the following additional details by way of explanation.

Although 73 of the 100 consecutive patients with recurrent deep vein thrombosis were taking vitamin K antagonists when referred to our laboratory for coagulation investigation, we instructed them to stop taking them three to four days before their first scheduled visit. This is because a vein biopsy specimen is usually taken at the first visit to determine the plasminogen activator content in superficial veins and explains the normal or near normal values for the one stage prothrombin time.

As mentioned in the paper, the plasminogen activator inhibitor was checked in most patients at least twice and was consistently high; since vitamin K antagonists were not withdrawn in conjunction with such checks, clearly they appear to have no effect on the concentration of plasminogen activator inhibitor.

INGA MARIE NILSSON

Department for Coagulation Disorders,
Allmänna Sjukhuset,
S-21401 Malmö, Sweden

Training in dental anaesthesia

SIR,—The news that the government is to fund more house officer training posts in dental anaesthesia (18 May, p 1519) is ironic in view of the remarkable decline in numbers of outpatient dental anaesthetics. Since 1975 the number of general anaesthetics funded by the Dental Estimates Board has gone down from 1.1 million to under 0.5 million in 1983, and there is no reason to suppose that this decrease will not continue.

The number of general anaesthetics carried out at the Charles Clifford Dental Hospital was over 6000 a year in 1957 but reduced to 964 in 1984. Statistical extrapolation using these and the intermediate years' figures predicts zero in 1992-3—an unlikely occurrence but one suggesting that the traditional dental gas will become a historical relic. There will still be a small reservoir of patients requiring general anaesthesia for dental extractions: the very young, patients with an abscess, and the mentally handicapped. These patients could be accommodated within an efficient day stay unit in a district general hospital or specialist dental hospital, where endotracheal anaesthesia with full monitoring facilities and postoperative care can be provided.

If this is the future trend then there will be no future for dentists with a year's training at senior house officer level in the hospital service. There will be no opportunities for them in general dental practice and they would not find a place in the anaesthetic service of a district general hospital.

ADRIAN PADFIELD

Charles Clifford Dental Hospital,
Sheffield S10 2SZ

Treating drug misuse

SIR,—We were interested to read Dr Anne MacDonald's letter (11 May, p 1431) on the treatment of drug misuse. One of the difficulties of this problem is the paucity of good research into the relative values of different forms of treatment. Guidelines are needed where scientific evidence of efficacy is lacking, and it is for this reason we welcome *Good Clinical Practice in the Treatment of Drug Abuse*.

We were surprised to learn that most psychiatrists in Glasgow are prescribing benzodiazepines to opioid users undergoing withdrawal. There is only one paper in the more recent published reports on opioid detoxification mentioning benzodiazepines and this was a single case study in a general practice setting, where the main agent used was clonidine.¹ Psychiatrists seeing large numbers of drug users are in a better position than GPs to publish reliable data on which future treatment regimens can be based. We would urge the psychiatrists in Glasgow to collaborate and show how useful their treatment really is.

We presume that Dr MacDonald's method is restricted to inpatient use. To prescribe high doses of benzodiazepines on an outpatient basis would in our view, and that of many others of experience, be fraught with difficulties. Benzodiazepines may be relatively safe in overdose but they are certainly not safe from a standpoint of dependence or when combined with other, possibly illicit, drugs. They are commonly abused in their own right and may be sold to obtain other drugs.

Anxiolytic drugs will not, of course, specifically counter the opioid withdrawal syndrome. If it is felt that the correct approach is merely to reduce anxiety when someone is going through "cold turkey" would it not be better to do this by non chemical means?

So far as general practitioners are concerned drug addiction is a subject on which many will admit both inexperience and apprehension. These days more of us are beginning to meet such patients and are likely to do so even more in future. Diabetes and hypertension, which Dr MacDonald quotes in comparison, are, unlike addiction, thoroughly taught in medical school, and policies are based on long term statistical research.

Among postgraduate studies the one subject which is conspicuously absent from psychiatric study courses and pharmaceutical seminars is drug