the drone of aircraft or the sounds of farm tractors, chainsaws, and accelerating motorcycles. The "normal" background noise is such that some people who have returned from holidays in truly isolated areas may remark that the silence there was "frightening."

I feel that excess sound is not only annoying, as discussed in the article, but intimidating to certain individuals. After all, in nature small birds call loudly when mobbing a roosting owl; again, song birds maintain their territories in spring by their song output, which serves to deter rivals. Among humans, intimidation by noise has long been recognised and war whoops and battle cries have accompanied fighting throughout the ages. Without doubt, the psychological effect of noise on people of all ages has been too little considered or investigated.

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Do housemen take an adequate drinking history?

SIR,—I have waited in vain for someone to spring to the defence of Dr I G Barrison and his colleagues (18 October, p 1040) against the carping criticisms of Dr D S Rampton and Dr Michael Dixon (8 November, p 1284). Some doctors still don't appreciate the frequency of alcoholism—20-30% of hospital medical and surgical problems are alcohol-related^{1,2}—and this is largely due to failures in training. Anything that can be done to educate medical staff—and there are ways of obtaining a reasonably accurate account of alcohol intake—should be welcomed in the light of the current epidemic of alcoholism; the negative attitude of your correspondents is unhelpful.

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¹ Jarman CMB, Kellett JM. *Br Med J* 1979;ii:469-72.
² Holt S, Stewart IC, Dixon JM, Elton RA, Taylor TV, Little K. *Br Med J* 1980;281:638-40.

Controlled trial of cromoglycate and slow-release aminophylline in childhood asthma

SIR,—In your issue of 27 September, (p 842) a brief report was published on a trial comparing cromoglycate and aminophylline in childhood asthma. While the trial itself was straightforward, with reasonable parameters for assessment, it is the interpretation of these results and the comment that are questionable.

The authors seem to have gone out of their way to select out features of theophylline therapy that apparently were beneficial when compared with cromoglycate. For example, "All doses were taken on significantly more days" than cromoglycate would appear somewhat irrelevant against the fact that cromoglycate was significantly more effective on symptom card scores. Similarly, the answer to the question "Which preparation would be preferred?" was asked in conjunction with the proviso "assuming they are equally effective"—they are not. The fact that slow-release aminophylline required regular blood level estimations is forgotten, and the price differential between the two treatments is emphasised.

The practising physician requires to know which treatment is most likely to help the

asthmatic patient. The interpretation of comparative trials of two active agents is fraught with pitfalls and open to bias. One can only hope that in future your editorial and referee system will scrutinise carefully any such interpretations.

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*We sent this letter to the authors, and Drs Edmunds and Carswell reply below.—ED, *BMJ*.

SIR,—We firmly deny that our analysis was biased in favour of either treatment in the assessment of the results of our trial. We do not have a financial or professional interest in either active drug.

Although the symptom scores were significantly lower during treatment with cromoglycate, the difference was not supported by a difference in the mean morning or evening peak flow rates. Nor did other indices of well being, such as salbutamol doses used, number of symptom-free days, or proportion of days with peak flow less than 50% of that predicted, show supporting significant differences. "Symptom score" is a subjective assessment made by the patient or parent, and the finding of an unsupported difference between the two treatment periods must be interpreted with care.

The question of the patient's preference may not have been the one Dr Edwards would have asked, but it gives a patient-oriented assessment of the form of treatment which would be preferred independently of therapeutic efficacy. The question was posed before the treatment code was revealed to the patient.

The measurement of plasma theophylline concentration ensures that maximally effective dosage is used. It is a helpful adjunct but not a necessity in theophylline treatment. Commonly in clinical practice, with a careful choice of initial theophylline dosage, only one blood sample is required to demonstrate that the dosage is maximal. Salivary concentrations may be used in routine clinic monitoring.¹

We agree that the interpretation of such comparative trials is commonly difficult, but suggest that the appropriate objective assessment is most likely to arise from professionally independent investigators such as ourselves.

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¹ Boobis S, Trembath PW, Chambers RE, Edmunds AT, Caswell F. *Ther Drug Mon* 1979;1:485-93.

Listening and talking to patients

SIR,—While we share Professor Charles Fletcher's concern for the deficiency of interviewing skills in doctors we do not think that "inadequate teaching is probably the main reason why many doctors never become good at interviewing" (4 October, p 932). As a matter of fact many medical schools include some sessions on interviewing techniques in their syllabus. We do not believe that more teaching, in itself, will improve the interviewing skills of medical graduates, unless this is accompanied by the following major changes in attitudes.

(1) Medical education is still very much examination oriented. No wonder that students develop those skills which they see as relevant to exams. So long as medical students can pass the final examination, even though their patients may have left the room in tears, and so long as they almost certainly fail if they miss the diagnosis, medical schools will continue to produce good diagnosticians but bad interviewers.

(2) Asking students in their final examination to diagnose "spot cases" and examine "short cases" is, in fact, testing the student's ability to make a diagnosis with little or no communication with the patient.

(3) This is reinforced even more by the attitude of some teaching consultants, who may ask students to examine "this lump," observe "that gait," or listen to "this heart," but seldom ask them how much "this person" is worried about his lump, how this gait has influenced this person's life, or how much adjustment that person needs to make because of his heart condition.

(4) The attitudes adopted by the examination system and by medical teachers are likely to produce doctors who can compete very favourably with those professionals whose success depends on arriving at a quick diagnosis in the minimal possible time, such as motor mechanics. The problem is that the human engine, unlike the motor vehicle, is one with an emotional component. Any diagnosis of a fault in that engine, without due regard to its vast emotional component, is not only incomplete but also incorrect.

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Antibiotics in surgical treatment of acute abscesses

SIR,—Mr R H Grace (15 November, p 1353) has dissected the results of our published work on the treatment of anorectal abscesses to show that there is a recurrence rate of 20-22%. He then implies that because of this there is no place for primary suture in the treatment of an anorectal abscess.

Unfortunately he is unable to quote any other study showing a lower incidence of recurrence. The discerning surgeon will probably conclude that, until some other treatment has been shown to give better results, it would be advisable to follow a method which has been tried and tested over 25 years, even though its protagonists accept that it achieves a permanent cure for only about 80% of patients.

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Comparison of various treatments for irritable bowel syndrome

SIR,—The recent paper (15 November, p 1317) by Drs J A Ritchie and S C Truelove raises many interesting points on the irritable bowel syndrome.

Thompson and Heaton¹ have recently demonstrated that 13.6% of otherwise normal people living in the Bristol area can be shown to have the symptoms associated with irritable

bowel syndrome. This raises the question as to what induces these normal people to become irritable bowel syndrome patients. Patients with irritable bowel syndrome take up a considerable proportion of a gastrointestinal clinic's attention (25% in one study²) but this is still substantially less than the potential number. It has been proposed that irritable bowel syndrome is a result of a deficiency of dietary fibre. The paper by Drs Ritchie and Truelove suggests that this is not the case. The complex therapeutic regimen that they have found necessary suggests a less obvious aetiology.

This is further suggested by a survey that we made of 60 patients who had received bran as the sole treatment for irritable bowel syndrome. These patients were characterised as having lower abdominal pain (78%), diarrhoea (51%), flatulence (18%), urgency of defecation (22%), and passage of mucus (12%). An important feature of the diagnosis was relief of symptoms after defecation and normal findings from sigmoidoscopic examination, rectal biopsy, and barium enema. The patients were instructed to take 20-40 g of wheat bran each day according to their weight. Two to four years later they were contacted and 85% replied to a questionnaire. Of these, 78% were still taking bran; 65% felt better and 35% showed no improvement. Bowel habit was regarded as normal in 61%. However, 88% of the subjects still experienced lower abdominal pain after two years of treatment and 64% after four years. The frequency of diarrhoea had fallen to 27% after two years and 12% after four years. Flatulence had increased so that 40% now had this complaint. The frequency of urgency, distension, and passage of mucus was unchanged.

Bran may treat symptomatically a disease state characterised by colon spasm but not remove the cause. While a primary muscle or emotional factor is attractive, we are attracted to the possibility that a spasmogen is present in the contents of the lumen. The spasmogen may be dietary, bacterial, or endogenous in origin. Bran could alleviate symptoms by expanding the faecal bulk by virtue of water binding³ and hence diluting the concentration of the spasmogen.

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¹ Thompson WG, Heaton KW. *Gastroenterology* 1980; 79:283-8.

² Ferguson A, Sircus W, Eastwood MA. *Lancet* 1977; i:1062.

³ Findlay JM, Smith AN, Mitchell WD, Anderson AJB, Eastwood MA. *Lancet* 1974; ii:146-9.

SIR,—The recent paper (15 November, p 1317) by Drs J A Ritchie and S C Truelove would seem to indicate that the proprietary drug combination Motival has a special place in the treatment of irritable bowel syndrome. Their recent work shows this compound to be slightly superior to lorazepam when either is given in combination with a smooth muscle relaxant and an intestinal bulking agent. Their choice of Motival is entirely empirical and in my opinion a questionable one.

Motival is a combination of low doses of fluphenazine, a phenothiazine major tranquiliser, and nortriptyline, a tricyclic antidepressant drug. No attempt is made by the authors to discuss the possible contribution of either drug alone in irritable bowel syndrome

or to examine the efficacy of either drug alone or together individually with the muscle relaxant and bulk agents.

Both constituents are potentially dangerous drugs. Fluphenazine, in common with other neuroleptic drugs, may cause tardive dyskinesia, which may be reversible or irreversible. Taken over a sustained period, surprisingly small doses have been known to cause this serious condition. Nortriptyline is a potent tricyclic drug, dangerous alone in overdose or in combination with fluphenazine. Since irritable bowel syndrome is a chronic disorder, one may expect that drug therapy may be given for very long periods and dispensed in large boluses as the interval between consultations with the doctor decreases over time.

The benzodiazepines are remarkably safe and relatively inexpensive drugs. Lorazepam is one of the shortest-acting of this class and therefore less likely to be effective when given twice daily than fluphenazine and nortriptyline with their longer half lives. My clinical hunch is that diazepam, with its known muscle-relaxant properties and longer half life of active metabolites, would be as efficacious as Motival, or more so, in a similar trial.

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Generalised allergy to porcine and bovine monocomponent insulin

SIR,—The letter by Drs J M Goldman and Hilary C Brynildsen (29 November, p 1494) contained an unfortunate error in terminology by suggesting that Lilly's Iletin II insulins were of monocomponent quality. This is not so and the case reported should therefore have omitted any reference to the use of monocomponent insulins.

I should emphasise that the term "monocomponent" or "MC" was chosen by Novo to represent a unique level of purity characterised by exclusive radioimmunochemical specifications—that is, specifications for this insulin material must not allow other substances in quantities sufficient for induction of undesirable biological reaction in patients.¹ Thus the Lilly Iletin II preparations, which can be classified as "purified," with a proinsulin impurity content not greater than 10 ppm, should not be confused with the Novo "monocomponent" or "MC" insulins, which contain no more than 1 ppm of these impurities by weight of the dry insulin.

Furthermore, although Novo insulins of monocomponent quality are now available in the United States, the use of the term "monocomponent" or "MC" is not at present permitted by Food and Drug Administration legislation. In Britain, however, all Novo insulins are of MC quality and are marketed as such.

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¹ Schlichtkrull J. *IDF Bulletin* 1979;24:7.

Endometriosis—a time for reappraisal

SIR,—We are prompted by your recent leading article on endometriosis (4 October, p 889) to suggest that the time has come to challenge some of the previously widely accepted and

"well-defined" features of this fascinating condition.

Our experience in the West of Scotland accords with that of Professor M Elstein and Dr C I Filho (22 November, p 1427) in that a high index of suspicion has led us to identify pelvic endometriosis in a much younger age group than suggested previously. The majority of our patients are below the age of 35—indeed, many are teenagers—and, in addition, we have not seen the increased frequency identified by others in the higher social classes.¹ The proposal that women who delay their first pregnancy are more likely to develop endometriosis we believe is inherently wrong. A significant number of our patients presented not with pain but with infertility, and it seems much more likely that it is endometriosis which causes the pregnancy delay and not vice versa.

We share the optimism felt widely over the introduction of danazol and to date have treated over 200 patients with this agent. Our impression is that reservations in terms of cost effectiveness are unfounded, when one considers that the cost of one day in a teaching hospital bed costs approximately £100 whereas the cost of one month on danazol is approximately half of this sum.

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¹ Venter PF. *S Afr Med J* 1980;57:895-9.

The anaesthetist and the pain clinic: dextromoramide analgesia

SIR,—As the people responsible for the views on the use of dextromoramide in the control of terminal pain expressed in the Leeds AHA's *Drug Information Bulletin* on care of the dying patient, we feel we must reply to comments made by Dr A J Grace (8 November, p 1285).

Dextromoramide is an effective analgesic in some cases but our concern is the lack of consistency and uncertain duration of this effect in the control of terminal pain. The studies of Swerdlow¹ and Bauer² are not relevant in this context as they do not concern this aspect of dextromoramide use. In the other papers quoted by Dr Grace (Kolodny,³ Flavell-Matts,⁴ Calesnick⁵) the results show considerable intersubject variation and are not consistently detailed or relevant to the point at issue. In one of these studies⁴ only seven of 16 cancer patients had complete pain relief with dextromoramide and the author states, "in my experience the use of morphine will always provide pain relief."

Caddy's⁶ results are based on the oral administration of a single 5-mg dose to only one subject. His study concerned assay techniques rather than pharmacokinetics in a clinical context, and he found a biphasic plasma half life for dextromoramide of approximately seven hours for the first phase and over 60 hours for the second phase. These results certainly do not give sufficient information to enable generalised conclusions to be drawn regarding plasma half life in the therapeutic situation, and even if they did it would not be of prime importance. It is after all the analgesic effect in the patient which is important and not the plasma drug concentration per se.

Dr Grace also states that dextromoramide was recently recommended by the *Drug and*