³ Magarian GJ. Hyperventilation syndromes: infrequently recognised common expressions of anxiety and stress. *Medicine (Baltimore)* 1982;**61**: 219-36.

⁴ Roth M. The phobic anxiety-depersonalisation syndrome. *Proc R Soc Med* 1959;**52**:587-95.

⁵ Sheehan DV. Panic attacks and phobias. *N Engl J Med* 1982;**307**:156-8.

SIR,—Dr Philip Snaith's leading article on panic disorder (30 April, p 1376) argues for the recognition of this condition as a separate form of anxiety and its treatment with antidepressants. Recognition of panic as a separate entity is argued for on the grounds of its status in the *American Diagnostic and Statistical Manual of Mental Disorders* and on the alleged evidence which shows it to be a "biogenic form" of anxiety disorder—which, one presumes, anxiety disorder in general is not. It is important for his case that panic is considered a separate disorder. If it were not recognised as a distinct entity the plea for treatment with antidepressants cannot be made without as much as a comment on the comparative efficacy of anxiolytic drugs or psychotherapeutic methods in the treatment of anxiety.

The case for this new category is not strong. Even the *Diagnostic and Statistical Manual of Mental Disorders* begins its description of panic disorder as follows: "The essential features are recurrent pain (anxiety) attacks." The symptoms they list are those of anxiety. The *Diagnostic and Statistical Manual of Mental Disorders* accepts for inclusion not only what Dr Snaith reports as "the sudden, dramatic onset of an overwhelming sensation of terror and imminent collapse" but also the more prosaic "discrete periods of apprehension." So, panic disorder is no more than recurrent anxiety. It would seem that neurotic Americans will have panic while for the rest of us anxiety will do.

It is difficult to see how panic disorder is separated from anxiety on the basis of its response to antidepressants when two of the reports that Dr Snaith himself cites^{1,2} show the effectiveness of antidepressants on anxiety—with no reference to panic. Dr Snaith considers responsiveness to antidepressants adequate grounds for separating a biogenic or "endogenous" form of anxiety. If the fact that some subjects with a given problem find relief with drugs is used to justify the recognition of an aetiologically distinct subgroup among them, we must also recognise "endogenous social phobia," "endogenous grief," and even "endogenous marital problems."

A reference of crucial importance for Dr Snaith's case is the study by Sheehan *et al.*³ This is poor evidence for the specific effect of antidepressants on panic disorder per se, as Sheehan's patients showed significant improvement in their depression scores also. In assessing response the panic elements were not even reported on separately. Even worse, Sheehan's subjects suffered not only from "spontaneous panic attacks, multiple autonomic symptoms and overwhelming fear," as Snaith quotes, but also, as Sheehan went on to state in the same sentence, from "a flight response and polyphobic behaviour." The "endogenous anxiety" which Sheehan's patients suffered from was not panic disorder, as Dr Snaith's selective excerpt might have led us to believe, but, in fact, agoraphobia. This fact must have been difficult to miss as Sheehan parenthetically equates his "endogenous anxiety" to "agoraphobia with panic attacks" in the very first line of his abstract.

Whether or not it is agoraphobia we are

talking about, current evidence does not support the claim that "psychotherapeutic methods . . . will be ineffective until panic attacks stop."^{4,5} His suggestion that it is untreated panic which leads later to secondary phobias invokes the conditioning theory of fear acquisition.⁶ Unfortunately, more recent views suggest that things may not be so simple.⁷ What we are left with is only Dr Snaith's guess that drugs prescribed early in the course of the "disorder" will obviate the need for psychotherapy. This can and should be tested before making it the basis for promoting new therapeutic practices. But even this guess seems wild in the face of reports that discontinuing antidepressants, where found helpful in the treatment of similar disorders, leads to relapse.^{8,9}

Unfortunately, when a leading article in the *BMJ* is used to promote a new fad, it is bound to find some takers—irrespective of whether the case for it has been made.

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- ¹ Ravaris CL, Robinson DS, Ives JO, Nies A, Bartlett D. Phenelzine and amitriptyline in the treatment of depression. A comparison of present and past studies. *Arch Gen Psychiatry* 1980;**37**:1075-80.
- ² Rowan PR, Paykel ES, Parker RR. Phenelzine and amitriptyline: Effects on symptoms of neurotic depression. *Br J Psychiatry* 1982;**140**:475-83.
- ³ Sheehan DV, Ballenger J, Jacobson G. Treatment of endogenous anxiety with phobic hysterical and hypochondriacal symptoms. *Arch Gen Psychiatry* 1980;**37**:51-9.
- ⁴ Marks IM. *Cure and cause of neurosis*. New York: John Wiley and Sons, 1981.
- ⁵ Emmelkamp PMG, Wessells H. Flooding in Imagination vs flooding in vivo: A Comparison with agoraphobias. *Behaviour Research and Therapy* 1975;**13**:7-15.
- ⁶ Rachman S, Costello C. The aetiology and treatment of children's phobias. *Am J Psychiatry* 1961;**118**:97-105.
- ⁷ Rachman S. The conditioning theory of fear acquisition: A critical examination. *Behaviour Research and Therapy* 1977;**15**:375-87.
- ⁸ Tyrer P, Steinberg D. Symptomatic treatment of agoraphobia and social phobias: A follow up study. *Br J Psychiatry* 1975;**127**:163-8.
- ⁹ Lipsedge MS, Hajioff J, Huggins P, Napier L, Pearce J, Pike DJ, Rich M. The Management of severe agoraphobia: A Comparison of iproniazid and systematic desensitisation. *Psychopharmacologia* 1973;**32**:67-80.

Missed jaundice in black infants

SIR,—As doctors who are practising in an African country—Nigeria—and who have been treating hundreds of icteric black neonates every year for many years, we would like to comment on the hypothesis by Dr W O Tarno-Mordi and Dr D Pickering (5 February, p 463) that severe neonatal jaundice may be missed in black infants because of their dark skin at birth. The truth is that the degree of pigmentation of the black infant's skin during the first one to two weeks of life, when neonatal jaundice is normally a problem, does not mask jaundice.

Ballowitz and Avery¹ and Post *et al.*² have shown that at this age the skin reflectance (and hence the colour) of newborn blacks resembles that of white neonates. The ease with which anybody detects jaundice in newborn infants depends on his experience and level of awareness. In our population we can usually spot cutaneous jaundice before the serum bilirubin concentration reaches 170 $\mu\text{mol/l}$ (10 mg/100 ml) in any infant. It is surprising that the mother of case 1 detected the jaundice in her son on the third day of life whereas the doctors and nurses did not notice it until the eighth day.

Finally, a means for an objective assessment

of the effect of the black newborn's colour on visual estimation of dermal icterus has now been provided by the recently available transcutaneous jaundice meter (Minolta Camera Co, Japan). Brown *et al.*³ Schreiner *et al.*⁴ and others have shown that at any given concentration of serum bilirubin the device gives comparable indices and similar correlation coefficients for total bilirubin versus meter reading for both black and white infants. Our own experience (unpublished data) with the jaundice meter on Nigerian infants supports these reports. Furthermore, in the original report of Yamanouchi *et al.*⁵ the authors do not describe the jaundice meter as "unreliable" in black infants. They in fact state that "to date, the device has been tested exclusively upon newborns of Japanese heritage."

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- ¹ Ballowitz L, Avery ME. Spectral reflectance of the skin. Studies on infant and adult humans, wistar and guinea rats. *Biol Neonat* 1970;**15**:348-60.
- ² Post W, Kranss AN, Waldman S, *et al.* Skin reflectance of newborn infants from 25 to 44 weeks gestational age. *Hum Biol* 1976;**48**:541-57.
- ³ Brown AK, Kin MH, Nuchpuckdel P, *et al.* Transcutaneous bilirubinometry in infants: influence of race and phototherapy. *Pediatr Res* 1981;**15**:653.
- ⁴ Schreiner RL, DeWitt DP, Norris SA, *et al.* Evaluation of the Minolta bilirubin meter as a screening device in white and black infants. *Pediatrics* 1982;**69**:107-9.
- ⁵ Yamanouchi I, Yamauchi Y, Igarashi I. Transcutaneous bilirubinometry. Preliminary studies of non-invasive transcutaneous bilirubin meter in the Okayama National Hospital. *Pediatrics* 1980;**65**:195-202.

Caring for the young disabled

SIR,—We support Ms Daphne Gloag's implication of the necessity for more facts about the numbers of people with severe disabilities and their use of support services (30 April, p 1376). It is difficult to supply these services appropriately unless the requirements are known and evaluated. There is a lack of continuing, accurate, statistical information on the needs of, and available resources for, disabled people in the United Kingdom, both in the community and in residential or hospital care.

With regard to the use of resources we would particularly like to draw attention to the value of day hospital care with a full remedial therapy support service for people with severe physical disabilities. At this hospital we have made available 10 places for day hospital care for several years now, and we have found its value well recognised. This scheme has been so successful that we are building a 20 place day hospital and inpatient unit to open in 1984-85 for remedial therapy on both a day and an inpatient basis.

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SIR,—Ms Daphne Gloag (30 April, p 1376) suggests that many of the younger disabled may not be in touch with all the "right" agencies. There may well be differences of opinion among carers as to which agencies are appropriate, but where is the best source of advice?