thereby providing the whole panoply of medical, psychological, social, and educational services for these children. When confronted with the choice between providing a children's ward within a regional (adult) centre organised on a specialty basis and "providing regional children's centres which bring together the various specialties and deal solely with children," the Court Committee¹ strongly favoured the latter, "because these children... need to have the overall paediatric oversight associated with a comprehensive children's department."

The officers of the North-west RHA and some adult oncologists feel quite differently and have planned to remove an excellent paediatric oncology unit from a children's hospital and place it in a large oncologically based hospital. It has been necessary for the Minister of State for Health to set up an inquiry team to advise independently on the situation. Obviously, such a team cannot be involved each time a controversial decision is taken by an RHA.

This issue therefore raises two important questions. (1) Do the DHSS and the RHAs accept the general direction of development of regional children's units within comprehensive children's departments? (2) Who should professionally advise an RHA on matters pertaining to child health? The views of the paediatric sub-committee (of the Regional Medical Committee) have been disregarded in this instance. Should we make an exception in the case of child health and have a travelling team of troubleshooters continually adjudicating for the DHSS? There must be a place for a regional health authority committee, a mixture of professional and informed lay members, to ensure that the officers of the authority accept honest and sound advice from the appropriate source. The lesson has been learnt at district level in the North-west Region at a tragic cost.² Do we have to repeat the lesson at regional level?

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¹ Committee on Child Health Services, *Fit for the Future*, 1978, vol I, p 193. London, HMSO, 1978. (Court Report.)

² Tribunal of Enquiry into the Death of Andrew Philip Brown at Rochdale Infirmary. Report of North-west Regional Health Authority and Rochdale Area Health Authority, 1975.

Choice of treatment in operable lung cancer

SIR,—We feel that your leading article on the choice of treatment in operable lung cancer (14 April, p 970) was misleading. The operative mortality for resection is now around 5%, the five-year survival rate is 27%, and the 10-year rate is almost 18%¹; postoperative morbidity is not a serious problem. No results which remotely compare with these can be offered by radiotherapy.

While it is true that radiotherapy carries no immediate mortality, your leading article made no reference to the late mortality, by no means negligible, from such causes as tracheo-oesophageal fistulas. Nor did it refer to the unpleasantness of the treatment itself, which has led many patients who have had both radiotherapy and surgery to say that they preferred the latter. To suggest that there is a "near

certainty" of an increase in the life span of two to three years after treatment with radiotherapy seems unduly optimistic.

The statement that "many of those hesitant or unwilling to take the risk may survive just as long without operation" is based on virtually no evidence, and is quite contrary to our experience of the fate of the patients who have not accepted our advice to have an operation. Surgery alone still offers the only real hope of prolonged survival. Radiotherapy, although invaluable in the palliation of symptoms, can offer no results which compare with it, and, on the available evidence, patients should not be told that they may do just as well if nothing is done.

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¹ Belcher, J R, and Rehahn, M, *British Journal of Diseases of the Chest*, 1979, 73, 18.

Hypnosis

SIR,—Dr H G Kinnell (17 March, p 751) argues that the case for the "specific usefulness of hypnosis" is not proved, and your leading article on hypnosis in the NHS (7 October, p 978) suggests that its hospital use is limited to psychiatrists and to a few specially trained psychologists working under the clinical responsibility of a consultant psychiatrist. I hope that these are not the last words because there are good reasons for supporting the cardiological uses of hypnosis.

Many patients are disabled because the pulse rate rises excessively in response to physical and emotional changes and the blood pressure climbs too high for too long in response to common-or-garden stimuli. Relatively small amounts of exercise produce the symptoms and signs usually associated with severe effort, and the subjects commonly are "played-out by continuous work, disturbed sleep and continuous strain"¹ or "exhausted by constant strain day and night... affected by sleeplessness... unable to go away and leave their posts."² Today it is recognised that profound abnormalities of the blood lipids, sugar, uric acid, and coagulation can also occur when exhaustion follows high and prolonged arousal.³

It is not known how exhaustion and hyperarousal produce this condition of sympathoadrenal hyperactivity and instability, where homeostasis has such a weak grasp; but the processes must be reversed before good health can be recovered in the majority of cases of severe arrhythmia, angina pectoris, acute coronary insufficiency, myocardial infarction, and hypertension. If we fail to reverse them we may be tempted to adopt symptomatic remedies such as long-term beta-blockade or even open heart surgery if arteriography happens to show inviting coronary arterial narrowings.

The major obstacle to reversing the processes and the major problem of cardiac rehabilitation is to persuade the patients "who would rather die than submit to enforced quietude"⁴ to rest and be still for long enough to get well. In this department of cardiology many of these warriors are dealt with expertly, and greatly to the relief of the rest of us, by a general practitioner who teaches autohypnosis and employs group hypnosis to provide an adequate degree of control over behaviour, and the enjoyment of escape from tachycardia, cardiac pain, and excessive hypertensive responses to life events.

I have not proved whether this colleague has "specific usefulness" but I do know that the staff and patients would not like to be without his strong and beneficent influence.

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¹ Lewis, T, *The Soldier's Heart and the Effort Syndrome*. London, Shaw and Sons, 1918.

² Mackenzie, J, *Diseases of the Heart*. London, Oxford University Press, 1908.

³ Nixon, P G F, *Practitioner*, 1976, 217, 765 and 935.

⁴ Dunbar, F, *Psychosomatic Diagnosis*. London, Johnson Reprint Co Ltd, 1968.

SIR,—Having benefited from instruction in the theory and application of hypnosis, I feel that Dr H G Kinnell's letter (17 March, p 751) merits some comment. As a GP I cannot speak about any possible use for hypnosis in the field of psychiatric medicine but now, after some nine years of practical experience, I can hardly imagine my own work without this valuable aid in therapy.

In what may just be described as tension states, be they physical, mental, or emotional, many of the "difficult" problems of general practice can be greatly helped, if not cured—these same problems having failed to respond to more conventional measures. The list could go on and on but includes dysmenorrhoea, migraine, nocturnal enuresis, the smoking habit, phobias, persistent warts, and many aspects of pain, including that of terminal malignancy.

I would like to answer some specific points in Dr Kinnell's letter. Is hypnosis of scientific value? The patient who is helped knows he is better able to control his problem and the question becomes academic. Lack of awareness of doctors and dentists surely stems from the failure of so many medical and dental colleges to implement the recommendation of the BMA subcommittee appointed some 25 years ago, to inform undergraduates and arrange training for postgraduate students in hypnosis.¹ This function is certainly fulfilled by the courses arranged by the British Society of Medical and Dental Hypnosis, to the benefit of many practitioners.

There are dangers in hypnotherapy, which is why Waxman insists that doctors and dentists, with their specialised knowledge and ethical code, are the people best qualified to assume full clinical and legal responsibility.² Patients' co-operation most certainly develops but degeneration of this to dependence on the therapist is surely the fault of the therapist, who should act only as a teacher, enabling the patient to realise that his tension is controllable and encouraging what Hartland refers to as ego strengthening.³

Clinical anecdotal tales abound, of course, and are of great importance to those actually involved. Can one dare to suggest that even in the biggest double-blind crossover trials all patients are still individuals on some doctor's list and therefore "anecdotal," whether they benefit from the therapy or drop out because of some toxic side effect. Hypnotherapy in properly selected cases is free from toxic side effects. It is economical, except for the investment of a certain amount of time in the patient. Quick induction techniques allow virtually all such time to be treatment time and often much can be achieved within a few minutes. Techniques depend on the experience of the therapist and waking hypnosis or regression, phantom or not, can all be of value in helping the patient to acquire some control

of his problem and its distressing symptoms.

Failures do occur, as in every other kind of therapy, but any success in this "difficult" group is surely worthwhile, when hypno-therapy does turn out to have been the treatment of choice.

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¹ *British Medical Journal*, 1978, 2, 978.

² Waxman, W, *British Medical Journal*, 1978, 2, 571.

³ Hartland, J H, *Medical and Dental Hypnosis and its Clinical Applications*. London, Baillière Tindall, 1977.

Teratomas of the ovary

SIR,—We think there are several important points that were not included in your leading article (21 April, p 1034) on teratomas of the ovary. Although rare, malignant teratomas of the ovary have many features in common with their testicular counterpart. In testicular teratomas the prognosis has improved considerably for three main reasons. Firstly, the majority of malignant teratomas are now known to produce either or both of the tumour markers human chorionic gonadotrophin (HCG) and α -fetoprotein (AFP), which provide the most sensitive monitor of disease progression or regression. Secondly, new highly active cytotoxic drugs have been introduced, which are now used in combination. Thirdly, it has been recognised that bulky tumour deposits (greater than 5 cm diameter) may require surgical removal in order to obtain a complete clinical remission.

In our recent experience at Charing Cross Hospital we have treated eight ovarian teratomas with a cycling regimen of chemotherapy including platinum diamminochloride and etoposide (VP16-213), which is due to be reported shortly. The results were as follows. One patient died from malignant teratoma and one is still on treatment. Of the remaining six patients, five are off treatment (range 5-16 months), and one patient is well with a stable tumour, which has been biopsied on two occasions and both times showed differentiated teratoma. We would regard malignant ovarian teratomas as potentially curable tumours. The value of HCG and AFP in monitoring the treatment was confirmed and only one of the eight patients produced neither of these markers. Whole-body computerised tomography has also introduced a greater sensitivity in confirming complete clinical remissions.

Malignant ovarian tumours are rare and in order to combine the various treatment and diagnostic methods to get the optimum results these patients should be managed in a limited number of centres with a special interest in this tumour.

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Anaesthetic deaths and caesarean section

SIR,—I regret that use of the head-down lateral position as advocated by Dr B H Goodrich (21 April, p 1079) would not have prevented all the acid-aspiration syndromes that I have been asked to treat.

In two cases aspiration occurred during

recovery from anaesthesia and in one case this was undoubtedly preventable. This patient drank water about 1 hour before operation and after a straightforward D and C was returned to the recovery room unconscious lying on her back. The recovery nurses receiving her found the mouth full of clear fluid, which was being aspirated and subsequently induced a life-threatening aspiration syndrome.

I teach that all patients should be turned on their side and be in possession of protective reflexes before extubation. I also use a "therapeutic thump" to the lateral chest wall following extubation to clear any secretions, etc, from the upper airway where patients have had tonsillectomies, for instance.

Assuredly the hasty anaesthetist who extubates a half-paralysed patient while the houseman is still putting skin stitches in will find his enthusiasm tempered in the draughty corridors of the Queen's Bench.

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Treatment of onchocerciasis

SIR,—Your expert answering a query about the treatment of onchocerciasis in your Any Questions? column (31 March, p 877) advised trying metrifonate as an alternative to diethylcarbamazine in an attempt to reduce the severity of the reaction caused by treatment.

The "reaction" is due to the release of antigens from the dead microfilariae, and recent controlled trials in the Onchocerciasis Chemotherapy Research Centre in Tamale, Ghana, have shown no advantage of metrifonate over diethylcarbamazine. Furthermore, the dosage advocated in the answer by your expert is not sufficient to remove microfilariae from the skin: it is only because it is less effective that this dose has slightly fewer side reactions.

The only rational management avoiding the use of suramin is to give an initial intensive course of treatment with diethylcarbamazine to rid the patient of the microfilariae from the skin, followed by weekly doses. The initial course almost invariably causes a reaction, and there is no way in which it can be avoided. It is wise to start with a small dose such as 50 mg on the first day, 100 mg on the second day, 200 mg on the third day, 200 mg twice daily on the fourth day, then the full dose of 200 mg three times a day for three days. This regimen will kill almost all the microfilariae, and preliminary results suggest that an even shorter course may be equally effective. It is best to have the patient in hospital during this period because occasionally the reactions are severe, with fever, postural hypotension, and adenitis. Symptomatic relief can be obtained by using antihistamines, and the very severe reactions will occasionally require corticosteroids. If iritis develops, topical steroid drops should be used as well.

After ridding the patient of the microfilariae, the adult worms will remain alive, and if nothing further is done the skin will eventually be repopulated with microfilariae. In order to keep the microfilarial density in the skin low, without the need to give the potentially toxic drug suramin, diethylcarbamazine is given weekly. This drug is entirely without toxic effects and with such frequent administration the microfilariae never become sufficiently numerous to cause further reactions when the drug is taken. The initial cutaneous reaction to the dead microfilariae often takes

the form of a chronic papular dermatosis, which may take three to four months to subside. The patient should be reassured about this, and the continuation of weekly dosage will ensure that the patient escapes further skin irritation and that the eyes do not become involved. Normally, a weekly dose of 200 mg is quite sufficient; it should be continued for 10 years.

Incidentally, *Simulium*, the vector of onchocerciasis, is a black fly not a mosquito.

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Enuresis and tricyclic antidepressants

SIR,—Recent correspondence (7 April, p 951) on the subject of the use of tricyclic drugs in the treatment of enuresis illuminates one of the difficulties encountered by consultants and researchers when giving the benefit of their experiences to general practitioners—who are, in the main, the ones who have to contend with patients in their natural environment. I mean, of course, the difficulty of visualising the home conditions of the patient. At times the picture presented by some of your correspondents is idealised to the point of naivety.

In our group practice, which covers every type of family and home, the possession of adequate quantities of "easy care" linen and comprehensive laundry facilities is the exception: the family financial priorities put them rather low in the scale. Nor is the ability to produce hot water early in the morning for the necessary bathing all that common. The enuretic child may well share a bed; there may be siblings still at the napkin stage; there are often other enuretics in the family; and both parents may have to leave home early for work. The unfortunate child therefore goes to school with the faint but tell-tale smell around him and has to miss any social activities such as camps and visiting friends which entail spending a night away from home. Little wonder that there is great pressure for "something to be done" and that the practitioner, faced with waiting lists and bureaucracy when trying to arrange for a buzzer, prescribes the tricyclics that do help very many of the children.

The most splendid example of the unreality of our expectations lies in the advocacy of "childproof" containers, which are so difficult to open (except by children) that in most homes they are either left open or their contents decanted into another jar to form a marvellous pot-pourri of poisons.

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Poisoning with tricyclic antidepressants

SIR,—The report by Dr A J Cronin and others (17 March, p 722) rightly emphasises the danger of overdose, but some of its premises are debatable. It may be true that "tricyclic antidepressants are now the commonest cause of fatal poisoning in children under the age of 5 years," but the figures they quote for the UK as a whole show a gross increase in such deaths from 3.2 annually in 1962-71 to 3.4 annually in 1972-6—hardly a significant change. I agree that the buzzer "properly used" is