than an objectively demonstrable entity. Research has been rightly directed to demonstrating the variables which influence the relapse of acute schizophrenia with productive symptoms. What is also needed is an objective assessment of the variables which may influence the development or resolution of schizophrenic defect. Have changes in institutional management changed the development of defect or merely where a schizophrenic lives? Do long-term phenothiazines influence the postacute course or merely productive symptoms? Is defect inevitably associated with an organic brain lesion?

G J LODGE

Department of Psychiatry,
Withington Hospital,
Manchester

¹ Cheadle, A J, Freeman, H L, and Korer, J R, *British Journal of Psychiatry*, 1978, **132**, 221.

² Kraepelin, E, *Dementia Praecox*. Edinburgh, Livingstone, 1919.

³ Huber, G, *Fortschritte der Neurologie, Psychiatrie und ihrer Grenzgebiete*, 1966, **34**, 409.

⁴ Johnstone, E C, et al, *Acta Psychiatrica Scandinavica*, 1978, **57**, 305.

⁵ Mellor, C, *British Journal of Psychiatry*, 1970, **117**, 15.

⁶ Spitzer, R L, Endicott, J, and Robins, E, *Research Diagnostic Criteria*. New York, New York State Department of Mental Hygiene, New York State Psychiatric Institute, Biometrics Research, 1975.

⁷ Bleuler, E, *Dementia Praecox or the Group of Schizophrenias*. New York, International University Press, 1950.

Patients' responses to barium x-ray studies

SIR,—Maureen Reynolds's first-rate paper about communication in hospital (24 June, p 1673) explored ground similar to the paper by Dr Jenifer Wilson-Barnett on patients' responses to barium x-ray studies published a few weeks earlier (20 May, p 1324). I have been astonished that this earlier paper did not provoke a flood of correspondence.

This trial showed that patients who received explanation and information about a barium meal or enema were less anxious than those who did not. Why on earth was such a trial necessary? Can there really be anyone anywhere who is surprised that explanation reduced anxiety? For those who cannot believe their common sense without a scientific paper to quote in their support there are already the equally unnecessary papers quoted in the introduction to the later paper.

However, what is most disturbing is the use of a control group. Can it be ethically and humanly acceptable to give procedures like barium studies to a group of patients and deliberately withhold explanation? Perhaps the simple and cheap innovation of subjecting each doctor to the common investigations that he or she uses would make us kinder and more humane doctors.

D HASLAM

Huntingdon, Cambs

* * * We sent a copy of this letter to Dr Wilson-Barnett, whose reply is printed below.—ED, BMJ.

SIR,—Far from there being a flood of criticism over this short research report the correspondence, both personal and published (24 June, p 1699), has been wholly complimentary.

This experimental study assessed the degree of anxiety evoked by barium x-rays and examined the effect of giving patients a

full explanation of the procedures and sensations involved well before screening. The fact that this explanation would alleviate anxiety was not accepted as common sense by staff, many feeling that explanation might have an adverse effect on patients.

The suggestion by Dr Haslam that information was deliberately withheld from control subjects was not the case. Control patients were subject to the routine and normal preparation for barium x-rays by staff. However, in other studies,¹ including that praised by Dr Haslam, patients were found to receive very little information about what to expect during investigations. Many staff members excuse themselves by saying, "Patients would rather not know." It may well be that they also do not have detailed knowledge about the ever-increasing number of diagnostic tests. Is there a better way to convince them that patients benefit from such explanation than to produce objective evidence?

If, as seems to be the case, information-giving to patients is neither common sense nor common practice in hospital, and if Dr Haslam believes that withholding information is unethical and unacceptable, is he suggesting that much of what goes on in hospital care is therefore unethical and unacceptable?

JENIFER WILSON-BARNETT

Department of Nursing Studies,
Chelsea College,
London SW3

¹ Wilson-Barnett, J, and Carrigy, A, *Journal of Advanced Nursing*, 1978, **3**, 221.

Economising on drugs

SIR,—Your leading article "Freedom to prescribe—in ignorance" (17 June, p 1573) comments on the various activities of hospital therapeutic committees.

It is not only in hospitals that the attempt to produce a basic list of drugs has been made. I am one of a group of six dispensing doctors and the need for ever-increasing economy in maintaining our drug stock led us to review the drugs we use with the aim of producing a basic stock list. This does take relatively as much time as you describe in hospital, and what started as an exercise to achieve financial savings has become a valuable educational exercise. Justifying a particular drug choice to one's colleagues, including trainees, concentrates the mind wonderfully, and we have even managed to produce a practice policy for the use of some categories of drug.

I am sure other people are working along similar lines and I would be interested to hear of any conclusions as an aid to our own efforts.

I R WALLACE

Newmarket, Suffolk

SIR,—In attempting to deal with this problem (leading article, 17 June, p 1573), I hope that both doctors and the Department of Health and Social Security will attempt to limit our ignorance and not our freedom. In an attempt to control prescribing habits Australia has four categories of drug. The result is more paperwork for everyone and the need to get special permission from the Department of Health to prescribe a drug such as flucloxacillin; and at the same time the prescribing

in some practices is as haphazard and irrational as any I have heard of in Britain. No amount of regulation will guarantee good prescribing.

By all means update the *British National Formulary*. By all means persuade the Association of the British Pharmaceutical industry to put page numbers in the index of approved names in their *Data Sheet Compendium*, which, despite its limitations and your doubts (3 June, p 1435), is a most useful handbook. By all means bombard us with advice in the *Prescribers' Journal* and the *Drug and Therapeutics Bulletin*. But let us resist the apparently simple solution of regulations and restrictions.

CHARLES A WEST

Church Stretton, Salop

Surgical approaches and drug treatment in the carcinoid syndrome

SIR,—Your leading article (17 June, p 1572) on the treatment of the carcinoid syndrome suggested that before hepatic artery ligation a course of cytotoxic drugs should be given. This would cause some release of vasoactive substances from the tumour and prevent a "carcinoid crisis" occurring with the more major necrosis that would follow ligation of the artery.

We have recently studied the 24-h urinary excretion of 5-hydroxyindole acetic acid in a patient with carcinoid syndrome and liver metastases (reported to the Royal Society of Medicine, Section of Endocrinology, Cambridge, May 1978) and found that after a bolus injection of cytotoxic drugs (cyclophosphamide, methotrexate, and doxorubicin (Adriamycin)) the excretion increased at least 25-fold. This presumably reflects a similar (or greater) release of pharmacological mediators from the tumour into the circulation, with the possibility of precipitating a crisis. Before any medical or surgical interference with a carcinoid tumour it is safer to try to inhibit the synthesis and effect of these substances by the administration of agents such as *p*-chlorophenylalanine and cyproheptadine.

The latter drug was very useful in controlling this patient's severe skin symptoms and it is surprising that no mention is made of its use in your article, as it appears to be relatively non-toxic and effective.

PAUL SIKLOS

Addenbrooke's Hospital,
Cambridge

Replacement therapy in Turner's syndrome

SIR,—The report by Drs J L Margo and K E Hawton of the association of anorexia nervosa with Turner's syndrome (1 July, p 15) highlights what is, in my view, regrettable but common practice. Here a girl was diagnosed as having Turner's syndrome when she was a child, but it was not until the age of 18 that she began treatment with oestrogens to induce female secondary sex characteristics. I do not suggest that this delay precipitated her anorexia nervosa, but it must have provoked considerable and avoidable anxiety.

There is no evidence that the time of starting oestrogen replacement therapy affects the final height of these patients.¹ Accordingly