spectively on data recorded in a prospective mode in the first instance, before the suspected relationship between the morbidity and the drug had been identified at all. The rest of the patients of the recording practices who are not suffering from the morbidity act as a source for suitable controls. The total morbidity for all patients is available as a standardised baseline. This method for retrospective control studies avoids the need for costly exercises in linking records with prescribing data from other sources.

The Birmingham Research Unit of the Royal College of General Practitioners is at present organising a programme for testing certain suspected morbid associations with commonly used drugs, but the system could be available for wider use as a component in any integrated programme for hypothesis testing of this kind.

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¹ Research Unit, *Journal of the College of General Practitioners*, 1971, 21, 609.

² Crombie, D L, *Journal of the Royal College of General Practitioners*, 1975, 25, 337.

³ Research Unit, *Journal of the College of General Practitioners*, 1959, 2, 140.

⁴ Research Unit, *Journal of the College of General Practitioners*, 1967, 13, 267.

⁵ MRC Working Group, *British Medical Journal*, 1967, 2, 355.

Cutting the drug bill

SIR,—We have recently completed a four-week project which may be of interest to our general practitioner colleagues. With the assistance of a local pharmacist we selected a group of nine commonly prescribed expensive drugs and on every FP10 issued we used only their generic names. The drugs chosen, together with their most familiar proprietary names were as follows: diazepam (Valium), frusemide (Lasix), phenylbutazone (Butazolidin), amitriptyline (Tryptizol), indomethacin (Indocid), ampicillin (Penbritin), imipramine (Tofranil), methylodopa (Aldomet), and nitrazepam (Mogadon). The list did not include other commonly prescribed products such as penicillin, oxytetracycline, antacids, etc because it has been our usual practice to use generic names in these cases. The patients were informed that we were now using the "chemical" names in their prescriptions "similar to those used by the hospital." Some patients were initially confused but soon readily accepted the new name. In no case did we have any objection on clinical or therapeutic grounds.

At the end of the four-week period we costed the alternatives and found we had saved approximately £120. This would mean a saving of approximately £1500 per year in our 4500 two-man practice. If this were repeated over the country as a whole it would save in the region of £15m to the NHS.

In times of stringent financial economy when the hospital and community services throughout the country are being asked to skimp and save we feel that it behoves our GP colleagues to scrutinise their prescribing habits. We find that this scheme had no detrimental effect on direct patient care and was a rewarding exercise in self-audit.

We would also like to see the Department of Health and Social Security take a far more active advisory role in promoting that excellent publication the *British National Formulary*.

We are besieged by drug-firm representatives competing for our custom. We are "bribed" with luncheons, dinners, gifts, samples, etc, and it is not surprising that this continual barrage of proprietary drug advertisement produces a less discriminatory approach to prescribing. We feel that the Department could arrange for GPs to be visited regularly—say, every six months or so—by well-informed, well-briefed doctors and pharmacists, who have a wealth of experience. Many retired professional colleagues would no doubt be delighted to accept part-time work on such a worthwhile project. The savings effected by this scheme would far exceed the cost.

MONTE LUBEL

A K SINHA

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Staffing in the medical laboratory service

SIR,—In responding to your leading article (2 April, p 866) entitled "The pathologist must control the laboratory" we are fully in agreement with the conclusion expressed in the title for the very excellent reasons which you give. The success of clinical pathology as we have known it (some of us for 30 years or more) has been due in large measure to the harmonious symbiotic relationship between the medical and technological staff working in it, in which each side knew the other's skills and responsibilities and respected them. This situation must continue if the peculiar art of the laboratory-based doctor is to be available to the patients of his area.

It is our opinion that certain aspects of the policy advocated by the Institute of Medical Laboratory Sciences in their evidence to the Royal Commission bring out very clearly a division between us which is beginning to appear and which carries with it a very real danger of disrupting the necessary happy relationship we have enjoyed until now. It seems to us that war may develop in the clouds of institutes, colleges, and associations above our heads, but resulting in destruction at the laboratory level of harmony which is essential for the proper maintenance of a patient service. If a technologist-versus-pathologist situation, aided by a scientist wedge between the two, is allowed to develop the good will amongst us all which sustains the service that we try to give may well suffer considerable damage. If we retain and develop a proper appreciation of each other's contribution there is no need for this to happen.

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SIR,—We would like to support the comments made by Professor L G Whitby and others (26 March, p 833) about the role of graduate scientists in the laboratory services. We too are unable to accept the Institute of Medical Laboratory Sciences policy statement¹ and their subsequent document presenting evidence to the Royal Commission² and are very concerned about the apparent total lack of insight by the IMLS into the contributions made by graduate scientists.

The role that should be made by graduate

scientists in the laboratory services is complementary to that of technical staff and we wholly endorse Professor Whitby's comments on this matter. If functions such as research and development, clinical liaison, and interpretation of data are not fulfilled laboratories will become little more than factories, perhaps efficient ones, but performing useless tests. As laboratory services inevitably become more specialised it is the responsibility of the laboratory to educate the users of the service so that the best, in terms of service to the patient, can be obtained from the apparently diminishing resources available. Many of those who advocate merging the role of the graduate scientist with that of the technician appear to be making a dangerous assumption that the present role of the graduate can be readily undertaken by the clinician, and regrettably this view is also shared by a minority of the medical profession. Consideration of the fact that many science graduates spend five or six years learning at university, quite analogous to the training of the medical graduate, and take higher qualifications such as the MCB or MRCPPath should soon dispel this idea. We believe that the team approach to providing a medical laboratory service, with medical staff, graduate scientists, and technicians each providing part of the total service, is the only way of ensuring a balanced acceptable service.

Finally, we wish to make it clear that we are not opposed to, and indeed would support, an integrated staffing structure so that all individuals can progress along a path appropriate to their qualifications, training, and experience, provided that the role of the graduate is recognised at all levels. If graduate scientists become unable to fulfill their proper role and maintain their status then they will cease to enter the NHS and as a result we predict that the laboratory service will succumb to the grey tide of mediocrity sweeping all sectors of our society, producing yet another retrograde step in patient care.

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¹ Institute of Medical Laboratory Sciences, *Future Staffing in the Medical Laboratory Service. A Policy Statement*. London, IMLS, 1976.

² Institute of Medical Laboratory Sciences, *Evidence to the Royal Commission on the National Health Service*. London, IMLS, 1977.

Experiments with computers

SIR,—We write as two individuals directly concerned with the evaluation of computer projects within the Department of Health and Social Security's experimental programme. We would like to point out that in your summary (12 February, p 404) of the Public Accounts Committee report¹ you have reproduced some of the factual errors and misleading statements. For example, the London Hospital has not dropped any stages of its bed-state system—phase I has been operating across the whole hospital since April 1973 and phase II since August 1975. The statement that Stoke has spent £1.7m saving five minutes per patient is totally misleading. The Stoke project has of course achieved far more than savings in

patient time (and in any event the number of patients is some 160 000 a year).

The objective of many of the major projects was to improve the *efficiency* of medical care—that is, they lead directly to increased quality or quantity of care or reduce the cost. This may be improved by clinical decisions being more soundly based, improved scheduling of patients, improved use of staff time, or better planning and management control. To measure these things requires new methods. These are being developed. This is the first major programme within the Health Service where an attempt has been made at evaluation. We are therefore pioneering the evaluation of health care programmes in general. The evaluation results available to date are in no sense complete and should not be taken as such. You suggest that the only thing that has been measured is the cost of the systems. Most of the projects have produced interim evaluation reports in which a large number of benefits have been highlighted.

While we would agree that there are many small projects (such as computer-aided history-taking and diagnosis) which have been inexplicably excluded from DHSS funding, we reject your opinion that “the only systems likely to pay off in the near future are very simple ones.” Our opinion is fully supported by unpublished material available to us. The main advantage of the large project is the potential to co-ordinate the key services of the hospital, enabling efficiency of medical care and scheduling and rationalisation of resources to be improved on a massive scale.

It is also important to note that the cost figures mentioned relate to the costs of prototype systems, and prototype costs are always much higher than the costs of developed systems. This statement is just as true for hospital systems as it is, for example, in the automobile industry.

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¹ Committee of Public Accounts, Sixth Report (1975-76 Session), p 483. London, HMSO, 1976.

Delusions of parasitosis

SIR,—Your leading article on this subject (26 March, p 790) does not mention the use of monoamine oxidase inhibitors in the treatment of this condition. It is unfortunate that this group of drugs is almost totally ignored by most doctors. We find that senior medical students coming to the practice have hardly heard of them, yet with careful selection of patients and with due regard to the dietary restrictions they can work near-miracles in patients with severe obsessional states and depressions.

We have a patient now aged 58 who presented with delusions of parasitosis in 1966. She complained of small bugs or worms crawling about in her gums and would bring specimens of the alleged bugs carefully wrapped in tissue paper. We were, of course, never able to see them and as she did not improve with various tranquillisers and antidepressants she was referred to a psychiatrist with a tentative diagnosis of paranoid schizophrenia.

She was given electric convulsion therapy, amitriptyline, trifluoperazine, and chlorpromazine but continued to suffer greatly for the next two years. In April 1968 we put her on Parstelin (tranylcypromine 10 mg, trifluoperazine 1 mg) one tablet four times a day. When seen one week later she was greatly improved. Her delusions disappeared completely and have never returned, though she has continued to have a number of symptoms, particularly abdominal pain which has been fully investigated without a cause being found.

Because she (and we) suffered so greatly when she had her delusions we have not dared to stop the Parstelin, but on reading carefully through her notes to write this letter it seems obvious that it is time for a cautious withdrawal of treatment and this we shall now do, but she will continue to need the support of her monthly visit to see one of us. We just hope she will not revert to coming to our house at all hours with her little packets.

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RAINE ROBERTS

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SIR,—Your leading article on this subject (26 March, p 790) gives a good description of a syndrome which, until lately, certainly had a poor prognosis for recovery, as you say. However, the situation appears to be changing and evidence is emerging that this disorder may be particularly responsive to treatment with pimozide (Orap).¹ Dr J Riding and I have described a good response to this medication in five cases of monosymptomatic hypochondriacal psychosis, two of which presented with delusions of skin infestation.¹⁻³ Reilly and Beard have reported confirmation of our findings⁴ and it would seem that patients with delusions of parasitosis form one subgroup within a larger collection of individuals who have delusional beliefs that they smell unpleasantly or have an abnormal appearance or that some other aspect of their anatomy or physiology is deranged, despite all evidence and reassurance to the contrary. A striking feature in these patients is that the personality is otherwise well preserved and there is usually little other evidence of psychosis. Psychiatrists often do not see these patients because they haunt departments of plastic surgery, otorhinolaryngology, tropical medicine, and dermatology. When they are seen in a psychiatric department psychological treatment almost invariably proves of no avail, and until recently drug therapy was equally unhelpful.

Since coming to Canada in 1975 I have treated four further cases of monosymptomatic hypochondriasis, three of them with delusions of infestation, with pimozide, all with good results to the present time. I hope to publish these cases elsewhere in the near future but in the meantime I think it important to point out that there may be a ray of hope for some of these wretchedly miserable patients, whose whole life becomes dominated by a false belief about their health and never-ending search for a cure.

The dose of pimozide required in treatment is usually modest, between 2 and 6 mg per day in most cases given in a single morning dose. At this level side effects are minimal or absent and improvement usually begins within two weeks. It is worth emphasising that pimozide does not appear to work in cases in which the symptoms are at a neurotic as opposed to a

psychotic level. Patients with dysmorphophobia or similar neurotic illnesses have a fixed belief that there is some serious abnormality of bodily structure or of health, but this belief does not reach a delusional level. It is therefore important to have a psychiatric opinion before starting treatment with pimozide to differentiate between the two types of disorder.

I would be interested to know if any other psychiatrist has had a similar experience with the treatment of cases of delusion of parasitosis. I have now started a clinical trial of pimozide and would be glad to share my experience of the drug's effects.

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¹ Riding, J, and Munro, A, *Lancet*, 1975, **1**, 400.

² Riding, J, and Munro, A, *Acta Psychiatrica Scandinavica*, 1975, **52**, 23.

³ Munro, A, *British Journal of Psychiatry*, 1976, **129**, 287.

⁴ Reilly, T M, Beard, A W, *British Journal of Psychiatry*, 1976, **129**, 191.

SIR,—Your leading article on this subject (26 March, p 790) is of interest, but it is not only doctors and health authorities who are involved: our pest control surveyors are often called upon to placate these unfortunate people. As you have mentioned, the diagnosis must be correct, so our first objective is a thorough survey of the house. If no insects or mites can be found, however, we also are faced with the problem of how to deal with the patient.

Under these circumstances our principle is to refuse politely to undertake any insecticidal treatment. A placebo or even a genuine treatment for some quite unrelated infestation is rarely successful; we simply have to make expensive call-backs. Our surveyor then suggests that where no insects can be found the patient may have developed a “skin allergy” and a visit to the doctor may help. The word “allergy” appears to be sufficiently well known to be acceptable by most people, even if they are suspicious of doctors.

It is to be hoped that general practitioners are aware of delusory parasitosis and able to identify this condition. Ebeling¹ suggests that marital problems constitute a major cause, a factor that may be worth bearing in mind when attempting to formulate a course of treatment. An added difficulty arises when the sufferer persuades her husband that he too is “parasitised”; the doctor may then find himself seeing the wrong patient.

Perhaps of interest is the American woman who forced her entire family to bath in petrol and rub with sulphur and lard every day—almost guaranteed to produce a skin reaction.

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¹ Ebeling, W, *Urban Entomology*. Berkeley, University of California Division of Agricultural Sciences, 1975.

Detection of bone metastases

SIR,—The real value of radioisotope scanning as the most effective method for detecting bone metastases appears now to be gaining general acceptance. I am sure that many radiologists