directly to patients or parents, with clear instruction to take 30 mg of prednisolone (or equivalent) at the onset of a severe attack, contacting the practitioner or clinic staff later for guidance or help if necessary. Ex-steroid-dependent patients have a warning label on their steroid cards stating, "This patient was steroid dependent for . . . years and was transferred to Becotide inhaler on . . . and may be at risk because of adrenal atrophy for at least two years." In recent years patients subject to very sudden attacks are sometimes supplied with terbutaline for subcutaneous administration by patient, parents, or doctor when obviously necessary as well as oral steroids. Immediate relief is thus available at the crucial time. We have found no problems except tremor with this self-medication and consider this unusual approach fully justified when there are problems in obtaining prompt medical attention.

We find it safer to leave the remedy in the patient's own hands as it is so common for family doctors to be unreasonably reluctant to use steroids in high doses soon enough. Recent surveys of death from asthma in hospital¹² and at home¹³ have shown that steroids were frequently under-used or not used at all and that both doctor and patient underestimated the severity of the attack. In fact, we take all the precautions suggested in your excellent leading article of just over a year ago^{1,2} plus individual monitoring and instant availability of oral corticosteroid and injected bronchodilator. If such precautions were consistently adopted such tragedies might be less likely.

H MORROW BROWN

Derby Chest Clinic, Derby

- ¹ *British Medical Journal*, 1975, **1**, 413.
- ² Brown, H M, and Storey, G, *British Medical Journal*, 1973, **3**, 161.
- ³ Brown, H M, and Storey, G, *Clinical Allergy*, 1974, **4**, 331.
- ⁴ Brown, H M, *British Medical Journal*, 1977, **1**, 376.
- ⁵ Brown, H M, and Storey, G, submitted for publication.
- ⁶ Brown, H M, and Storey, G, submitted for publication.
- ⁷ Mellis, C M, and Phelan, P D, *Thorax*, 1977, **32**, 29.
- ⁸ Grant, I W B, et al, *British Medical Journal*, 1972, **2**, 110.
- ⁹ Choo-Kang, Y F J, et al, *British Journal of Diseases of the Chest*, 1972, **66**, 101.
- ¹⁰ Brown, H M, Storey, G, and George, W H S, *British Medical Journal*, 1972, **1**, 585.
- ¹¹ Brown, H M, and Storey, G, *Postgraduate Medical Journal*, 1975, **51**, suppl 4, p 59.
- ¹² Macdonald, J B, et al, *British Medical Journal*, 1976, **2**, 721.
- ¹³ Macdonald, J B, Seaton, A, and Williams, D A, *British Medical Journal*, 1976, **1**, 1493.

SOMA

SIR,—Two publishing firms have written to you (16 April, p 1027) since my article "SOMA: new hope for medical authors" appeared (2 April, p 887). Since the article was published I have received over 100 letters from authors or prospective authors concurring with the points made in my article. The two publishers who wrote (and there are over 30 medical book publishers in the UK) have indicated ways in which their firms offer to authors some terms which are somewhat better than those offered by other publishers—could there be a more potent argument in favour of SOMA than this? One of the aims of SOMA is to direct authors to those publishers whose terms are most favourable.

Some publishers offer royalties of 15% on the retail price of copies of books sold in the UK over 2500—would it be impolite to ask Mr Per Saugman, of Blackwell's, if his

company every pays royalties of more than 12½% to authors?

The Society of Authors has drawn attention to the fact that there is no standard contract agreed between the society and the Publishers Association—it is certainly implied by some publishers that such a contract exists and many medical authors believe this to be so; we are all grateful to the Society of Authors for correcting this widely held but false impression.

I J T DAVIES

Postgraduate Medical Centre,
Raigmore Hospital,
Inverness

Pituitary-dependent Cushing's disease

SIR,—Your leading article on this subject (23 April, p 1049), is open to criticism. The concept of "pituitary dependence" is now outdated and has been modified since recent discoveries have shown that the hypothalamus regulates pituitary function. This control over the anterior pituitary is mediated via the hypothalamic hormones, and indeed the isolation of material with corticotrophin (ACTH)-releasing activity (CRF) from the median eminence was the first successful demonstration of a hypothalamic hormone.¹ As this hypothalamic-pituitary mechanism has been better understood it has been a logical step to place more emphasis on the hypothalamus as the aetiological factor in many endocrine disorders. Present opinion therefore favours an underlying hypothalamic dysfunction as the cause of Cushing's disease. This view is supported by observations that the discontinuous pattern of ACTH secretion² reflects the secretory bursts of CRF from the hypothalamus³ and that the circadian rhythm of cortisol secretion may be retained in Cushing's disease.^{4,5} Studies indicate that the synthesis of CRF in the hypothalamus is probably mediated by serotonin,⁶ and serotonin antagonists have been shown to block hypoglycaemia-induced cortisol secretion.⁷ It seems likely that Cushing's disease may be due to a disorder of brain amine metabolism involving serotonin.⁸

The article then dealt with the surgical management of Cushing's disease without reference to the possible medical treatments. Drug therapy for Cushing's disease is gaining increasing recognition. The concept of "hypothalamic-pituitary dependent" Cushing's disease has encouraged the use of drugs which have an action upon brain amine metabolism. Bromocriptine is a dopaminergic-receptor stimulant which is useful in treating such hypothalamic-pituitary disorders as acromegaly and hyperprolactinaemia. This drug has been demonstrated to lower plasma ACTH levels in patients with untreated Cushing's disease⁹ and it is also useful in the management of Nelson's syndrome,¹⁰ which may develop after bilateral total adrenalectomy for Cushing's disease. More recently cyproheptadine has been suggested as the new drug treatment for Cushing's disease.¹¹ Cyproheptadine is a potent antiserotonin, and reports claim that it can induce remission in Cushing's disease.¹¹ Further use and development of such drugs for Cushing's disease offer a safer therapeutic approach, since they may make the risks of pituitary surgery unnecessary.

S P DEACON

Pilgrim Hospital, Boston, Lincs

- ¹ Saffran, M, Schally, A V, and Benfey, B G, *Endocrinology*, 1955, **57**, 439.
- ² Hellman, L, et al, *Journal of Clinical Endocrinology and Metabolism*, In press.
- ³ Weitzman, E D, et al, *Journal of Clinical Endocrinology and Metabolism*, 1971, **33**, 14.
- ⁴ Hellman, L, et al, *Journal of Clinical Endocrinology and Metabolism*, 1970, **30**, 686.
- ⁵ Doe, R P, Vennes, J A, and Flink, E B, *Journal of Clinical Endocrinology and Metabolism*, 1960, **20**, 253.
- ⁶ *Lancet*, 1975, **2**, 1135.
- ⁷ Plonk, J W, Bivens, C H, and Feldman, J M, *Journal of Clinical Endocrinology and Metabolism*, 1974, **38**, 836.
- ⁸ Scapaginini, U, et al, *Neuroendocrinology*, 1971, **7**, 90.
- ⁹ Lamberts, S W J, and Birkenhager, J C, *Journal of Endocrinology*, 1976, **70**, 315.
- ¹⁰ Lamberts, S W J, and Birkenhager, J C, *Lancet*, 1976, **2**, 811.
- ¹¹ Krieger, D T, Amorosa, L, and Linick, F, *New England Journal of Medicine*, 1975, **293**, 893.

* * * The majority of patients with pituitary-dependent Cushing's disease have a small pituitary tumour at the time of presentation. Bromocriptine and cyproheptadine may reduce ACTH levels in some patients, but whether they influence the growth of the tumour remains to be determined. Preoperative control of cortisol overproduction was considered in the leading article and two well-tried drug regimens were mentioned: metyrapone-aminoglutethamide and metyrapone alone. Transsphenoidal hypophysectomy and interstitial irradiation are safe procedures that rapidly correct the syndrome.—Ed, *BMJ*.

A case of a twisted ankle

SIR,—As I understand it, the patient in your interesting Clinic in General Practice (14 May, p 1260) needed a little magic: an x-ray of her ankle for wholly sympathetic and proper psychosocial reasons. X-ray is shorthand for radiological consultation, especially in hard times when we are trying to make expensive radiology departments into care-effective diagnostic centres rather than photographic workshops.¹ Why was your article not a dialogue between the two doctors immediately concerned in the problem, the general practitioner and the radiologist?

THOMAS SHERWOOD

Department of Radiodiagnosis,
Royal Postgraduate Medical School,
London W12

- ¹ *Lancet*, 1976, **1**, 520.

A case of right iliac fossa pain

SIR,—We were dismayed that the article on a case of right iliac fossa pain (23 April, p 1066) was principally concerned with excluding organic disease rather than with making a positive diagnosis on which rational management could be based. None of the doctors really thinks that the patient has appendicitis, yet they are prepared to subject a young girl to numerous investigations, even appendicectomy.

The consultant psychiatrist regards "whole-person" medicine as a "seductive concept." Is he really going to "exclude organic disease" before taking a full family and personal history? The exclusion of organic disease is indeed a seductive concept and the hypochondriacal patient will always feel, and make the doctor feel, that some stone may have been left unturned.

The associated features of the symptom and its setting must be considered. Is it really an

isolated symptom? The general practitioner rightly inquires for other symptoms of organic disease, but we need also to ask whether there is any disturbance of sleep, mood, concentration, irritability, or energy. Does she suffer from headaches, palpitations, bad dreams? Is there any change in her progress at school? These are symptoms which distinguish an emotional problem from appendicitis. The GP rightly attempts to relate the pain to the phase of the menstrual cycle, but what about other situations—school, home, going out with boyfriend, arguments? A comprehensive history will show which areas are sensitive and may demonstrate a relationship in time between the pain and significant events. The patient must be seen alone and the parents interviewed separately. The doctor will then be in a position to explain to the patient and her parents that she is not suffering from appendicitis but from a common and well-recognised disorder which is the result of emotional disturbance for which he is able to offer or arrange help and that further investigations are unnecessary. A common result of this approach is that the pain may never again be mentioned, which clinches the diagnosis.

There are three important objections to performing unnecessary investigations here. They reinforce the patient's (and her relatives') belief that she is suffering from an organic disorder; they make psychological intervention less acceptable, and the cost to the NHS must be astronomical if all teenage girls with this type of pain are referred for extensive investigations and even appendectomy.¹ The chagrin of missing organic disease is mentioned, but the results of missing a psychological disorder are less often considered, particularly the cost of continued suffering and unemployment.

SAMUEL I COHEN
FRANCIS CREED

Department of Psychiatry,
The London Hospital,
London E1

¹ Lee, Z A H, *Lancet*, 1961, **1**, 815.

Clinics in General Practice

SIR,—I wish to record my disappointment in the series of articles entitled "Clinics in General Practice" which is currently appearing in your journal. My disappointment is due to the degeneration of what is basically an excellent idea into a meaningless charade.

I realise that these articles constitute a considerable advance over notes on the serum rhabarb:faecal treacle ratio in cases of Lithuanian jungle sores, but there is much room for improvement all the same. It is only natural that trainee GPs should exhibit the ingenuous enthusiasm of a Bertie Wooster, but why must the supposedly more mature GP behave like a superannuated amateur psychologist or, worse still, display all the artless sophistry of a third-rate social worker? The consultants are portrayed as rather practical, simple fellows who believe, as I do, that physical illness must be excluded before patients are patronisingly diagnosed in pseudo-psychiatric terms.

Could we have a little more along the lines of intelligent diagnosis, outpatient investigations, and sensible, timely referral to a consultant for answers to specific problems? I am sure that most readers would welcome a realignment of your approach because until

then these articles will have all the relevance of the minutes of the Flat Earth Society.

J A McSHERRY

Carruthers Clinic,
Sarnia, Ontario

Road Traffic (Seat Belts) (No 2) Bill

SIR,—The Road Traffic (Seat Belts) Bill was rejected on its second reading in the House of Lords on 26 April. On 2 May the Road Traffic (Seat Belts) (No 2) Bill "to require the wearing of seat belts in motor vehicles on motorways" was read for the first time, also in the House of Lords.

Without attempting to recapitulate the familiar arguments in favour of the wearing of seat belts on all classes of roads, the Society of British Neurological Surgeons wishes to place on record its conviction and advice that the passage of legislation requiring the wearing of seat belts would result in very considerable reductions in human suffering, deaths, and hospital expenditure. As the acknowledged authorities on the management of head injuries we consider that such legislation would be a piece of preventive medicine of even greater value than the compulsion upon riders of motor bicycles to wear crash helmets, a step that itself owed its origin largely to the advice of neurological surgeons. In no country where the wearing of seat belts has been made compulsory has there later been any reason to doubt the wisdom of the measure. The United Kingdom, Eire, and Italy are the only member countries of the EEC where seat-belt wearing is not compulsory. This society is assuring the Minister for Transport and the Secretary of State for Scotland of its wholehearted support for seat-belt legislation as it is convinced by careful monitoring of the problem that simple persuasion has been ineffective.

PATRICK CLARKE
Honorary Secretary,
Society of British Neurological Surgeons

Neurosurgical Unit,
Middlesbrough General Hospital,
Middlesbrough, Cleveland

Chasing the cause of Crohn's disease

SIR,—The genuine endeavour implied in your leading article with this title (9 April, p 929) is not in doubt, but you will not succeed in your objective by totally ignoring a determinant which has been substantiated at about 90% unanimity by investigators who over 30 years have explored the matter with sufficient expertise, at sufficient depth, and over a sufficient period of time. I refer to the consistent finding of a constellation of psychological attitudes in the sufferer and to a definitive form of emotional stress immediately antecedent to the onset of the disease and usually continuing in varying degrees throughout its course, with intensification of the stress punctuating relapses of the disease.

If research workers in the psychosomatic field were to ignore contemporary somatic research you would probably castigate them, and rightly. Yet this is what you have done in your article in reverse. I do not wish to imply that you are by any means the only sinner in this respect; indeed, your learned contemporaries have taken the same hemianopic view for years. When I have found

sufficient energy to do so I have complained about it, the last time being in 1958.¹

The psychosomatic findings in Crohn's disease may be inconvenient but will not go away by pretending that they do not exist or are invalid. Indeed, when recent systematic studies²⁻⁴ are added to earlier reports, which with the exception of those by Stewart⁵ and Grace⁶ were mainly of an observational character, then the validity of the case compares favourably with some recent enthusiasms in the purely somatic field. I have no doubt that those of us who have pursued the psychosomatic aspect of Crohn's disease over many years⁷⁻¹⁰ would be prepared to lay any odds that a hypothesis for the pathogenesis of Crohn's disease which did not incorporate in the causative chain of events the psychosomatic determinant would fail.

It is certainly right for the search to continue for an antigen, which, as you suggest, is as likely to be dietetic or chemical as viral, bacterial, or from autogenous damaged tissue, yet it is odd that research workers postulating exposure to antigens as universal in Western society as sugars, dyes, or flavours or as widespread as the opportunity for cross-infection from patients by bacteria or viruses do not then pause to ask themselves why Crohn's disease is so relatively uncommon, and do not conclude that, even if an antigen is involved, the major determinant must be elsewhere—for example, in a disordered immunological response genetically or psychosomatically determined or both.

J W PAULLEY

Ipswich

¹ Paulley, J W, *Lancet*, 1958, **2**, 959.

² Ford, C V, Guber, G A, and Castelnuevo Tedesco, P, *Journal of the American Medical Association*, 1969, **208**, 311.

³ McKegney, F P, et al, *Psychosomatic Medicine*, 1970, **32**, 53.

⁴ McMahon, A W, et al, *Psychosomatic Medicine*, 1973, **35**, 91.

⁵ Stewart, W A, *New York Journal of Medicine*, 1949, **49**, 2820.

⁶ Grace, W J, *Gastroenterology*, 1953, **23**, 542.

⁷ Gainsborough, H, *Current Medicine and Drugs*, 1961, **2**, 1.

⁸ Reinhart, J B, and Succop, R A, *Journal of the American Academy of Child Psychiatry*, 1968, **71**, 252.

⁹ Paulley, J W, *Psychotherapy and Psychosomatics*, 1971, **19**, 111.

¹⁰ Paulley, J W, *Practitioner*, 1974, **213**, 59.

Swimming goggles and eye injuries

SIR,—The Royal Life Saving Society (RLSS) was interested and alarmed to read the short report by Dr F Jónasson (2 April, p 881) in which he describes permanent eye damage occurring in two of three teenage swimmers when goggles were being cleared of steam, slipped from their fingers, and struck the globe of the right eye.

The RLSS is extremely concerned at the widespread and increasing use of swimming goggles, particularly by young people. The society has already banned the use of swimming goggles during the conduct of their practical examinations taken in the water and in initiative tests in competitions. This decision had been taken on the grounds that swimming goggles were not an item of first-aid equipment likely to be freely available to lifesavers at a drowning accident as well as because of our concern at possible injuries to the wearer. The RLSS had been aware of a number of injuries similar to those reported, affecting the globe and bony orbit but happily less severe than in Dr Jónasson's patients and in no case associated