sensory deficit of varying degree in the trigeminal territory. The denser the anaesthesia, the lower the recurrence rate, whichever the technique used. Henderson's results after alcohol injection are a perhaps unique exception in this respect.

Microsurgical techniques are mostly aimed at reducing the morbidity from facial sensory loss either by fractional rhizotomy, dividing only the "portio major," or by relieving presumed arterial compression. It will be surprising if in the long run these procedures find any more general acceptance than Taarnhøj's decompression.¹ Surgical treatment is unlikely to reduce the recurrence rates unless it produces complete anaesthesia at least in the affected division of the trigeminal nerve and should, therefore, be confined to those patients willing to accept the sensory loss in return for a more or less permanent cure.

We feel that on most occasions percutaneous radiofrequency thermocoagulation has more to offer than any other form of therapy because sensory deficit can be controlled and confined to the distribution of the pain. As the aim of this technique is to obtain selective loss of pain sensation only in the affected area, with minimal injury to the nerve, the chance of delayed recurrence is relatively high in comparison with any other method of surgical treatment. This recurrence, however, can be treated by repeating the technique more swiftly and simply than by intracranial surgery. The treatment is tolerated best and the incidence of facial dysaesthesiae lowest if as with other procedures under basal sedation thermocoagulation is carried out when the pain is at its height, and not during a remission.

R M KALBAG
R P SENGUPTA

Regional Neurological Centre,
Newcastle General Hospital,
Newcastle upon Tyne

¹ Taarnhøj, P, *Journal of Neurosurgery*, 1954, **11**, 299.

The urethral syndrome

SIR,—We read with interest the recent leading article on "The urethral syndrome" (3 September, p 593), in which our recent paper on the treatment of this condition by the Richardson urethroplasty was criticised. In answering these criticisms we would like to emphasise the points which we made, because it would appear that they have been missed by your leading article. That we failed to distinguish between bacteriuric and abacteriuric patients is not correct. All cases were examined for evidence of infection and in only eight out of 38 cases was this detected, the point being that infection in this series was an uncommon aetiological factor.

Perhaps it was the simplicity of the urodynamic data which we used to diagnose the bladder outlet obstruction—namely, flow rate, residual urine, if it was present, and trabeculation—which caused you to opine that our urodynamic data were inadequate. We must point out that we used these data not only to detect bladder outlet obstruction—we also used the flow rate and residual urine measurements to test the success of the operation. In that context we contend that our urodynamic data were adequate.

In your leading article you state in the second paragraph, "Two prospective trials of treatment of proved urinary tract infection in

this age group have failed to show any benefit from either urethral dilatation or internal urethrotomy." You then state in your last paragraph, "When all else fails (use of anticholinergic drugs, a course of local or systemic oestrogens, elimination of vaginal infection, voiding after intercourse, cessation of bubble baths, etc) urethral dilatation or urethrotomy may succeed in relieving symptoms in both bacteriuric and abacteriuric patients." We think that most readers would have shared our surprise at these inconsistencies.

Nevertheless, we emphasise that the patients who were referred to one of us (AJS) were referred because all other forms of management had failed. As an aetiological factor, we offered the positive findings of fibroelastosis in contradistinction to the nebulous one of "the possibility of reversible muscle spasm" as the result of a "local irritative urethral or bladder lesion." We think that non-compliance of the urethra as the result of fibroelastosis can cause, in the initial stages of compensatory detrusor hypertrophy, strong but ineffective and uncoordinated detrusor contraction, which might result in muscle spasm at the vesicourethral junction.

Although we do not agree with your concepts on the aetiology and management of the urethral syndrome, we would like to congratulate you on the thought given to this problem, which causes so much unnecessary suffering in women, and, because it is not life threatening, receives scant attention from many urologists.

A J SPLATT
D WEEDON

Royal Brisbane Hospital,
Brisbane,
Australia

Soft contact lenses

SIR,—In your excellent leading article (10 September, p 655) on the relative merits of soft contact lenses you omitted to mention the special cases of uniocular aphakia. When a patient has a cataract removed from one eye and is still able to see reasonably well with the other, spectacle lenses will produce double vision, whereas a contact lens (either hard or soft) will avoid this unpleasant complication.

F J CURTIS

Reigate,
Surrey

Patients referred to community psychiatric nurses

SIR,—The variation in the number of patients referred by different practices in a health centre to an attached community psychiatric nurse described by Dr C M Corser and Mr S W Ryce (8 October, p 936) is of great interest and may be compared with the results of an experimental attachment of community psychiatric nurses to two health centres in Salford in 1975. The length of the experimental attachment was three months and during this period, and indeed for long afterwards, a psychiatrist attended each health centre on one

afternoon each week providing consultant support for the psychiatric nurses. There were 15 general practitioners in the two health centres and they referred a total of 56 patients to the psychiatric nurses. Three doctors made no referrals and one referred 12 patients, the remainder occupying intermediate positions in the table.

B E MARKS

Department of General Practice,
University of Manchester

Doctors and the global population crisis

SIR,—It was precisely because of the deviation of some doctors from the traditional code of ethics and the abdication from responsibility of the GMC following the 1967 Abortion Act that led to the setting up of the British section of the World Federation of Doctors Who Respect Human Life. Our members are a witness to the Declaration of Geneva 1948, article 8, which states: "I will maintain the utmost respect for life from the moment of conception . . ."

PEGGY NORRIS
Honorary Secretary,
British Section,
World Federation of Doctors
Who Respect Human Life

Huyton,
Merseyside

Pruritus as a presentation of myelomatosis

SIR,—I read with interest the report by Dr J G Erskine and others on pruritus as a presentation of myelomatosis (12 March, p 687). I would like to comment on the reference to our communication.¹ The three cases described by us were initially diagnosed as benign monoclonal gammopathy (as mentioned in the report). I should like to emphasise that in the same communication we emphasised the point that one of the three patients subsequently developed a typical clinical picture of Waldenström's macroglobulinaemia. Thus macroglobulinaemia as well as myelomatosis should be considered in the differential diagnosis of generalised pruritus.

Z ZELICOVICI
M LAHAV
P CAHANE

Department of Allergy, Serology,
and Hematology,
Kupat Holim, Zamenhoff,
Tel-Aviv

¹ Zelicovici, Z, *et al*, *Israeli Journal of Medical Sciences*, 1969, **5**, 1079.

Estimating bowel frequency

SIR,—A report by Dr A P Manning and co-workers (24 July 1976, p 213) revealed that patients who had estimated their bowel frequency to be six motions or less a week had a consistent tendency to underestimate their frequency. However, only 13 of 81 patients were wrong in their predictions by as much as three motions a week. We asked 120 healthy

Doctor No:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
No of patients referred . . .	1	7	7	0	2	0	0	1	6	4	5	12	1	2	8

Stated bowel frequency in relation to average actual frequency.

men to tell us their usual number of bowel movements per day and then collected their stool specimens for five consecutive days.¹ The accompanying figure shows that those who stated they usually had one motion or less a day had a tendency to underestimate their frequency, while subjects who said they had two movements a day overestimated their bowel frequency. Based on these data, it would be more desirable to ask subjects how many movements they usually have per week, rather than their usual frequency per day as we have done. As stated by Manning *et al*, recordings of bowel movements should be done whenever possible instead of interviews, especially in epidemiological studies.

A NOMURA

Kuakini Medical Center,
Honolulu,
Hawaii

¹ Glover, G A, *et al*, *Lancet*, 1977, 2, 110.

Ban on dental anaesthetics

SIR,—Following the announcement in the *BMA News Review* (August 1977, p 248), the council of the Association of Anaesthetists duly recommended to its members, on the advice of the anaesthetic subcommittee of the CCHMS, that they should no longer administer anaesthetics for dental extractions under the terms of the NHS except in cases of special hardship. This recommendation was made at the annual general meeting in late September, as a result of the DHSS's refusal even to discuss the introduction of an attendance fee which would allow the present fee of £2 gross (including travelling, drugs, and all other expenses) to be raised to a rate which would at least cover expenses, and might even compare with that currently charged by an artisan attending one's home to look at, but not treat, a domestic appliance. Within days of this recommendation, and on an independent issue, the British Dental Association was forced to adopt a policy unique in its negotiating history—namely, it has had to recognise the decision of many of its members to withhold certain items of dental treatment under the terms of the NHS.

It is always abhorrent to any responsible medical or dental body to have to advise its members to limit the care available to patients

under the terms of the NHS; but, so far as the dental services in general, and dental anaesthesia in particular, are concerned, the responsibility for this limitation of service must lie fairly and squarely on the shoulders of the Secretary of State and his advisers, and the public should be made aware of the intolerable intransigence exhibited by the DHSS following years of patient negotiation by the professions. It would seem that it is this Government's intention to preside over the systematic destruction of the State dental services as we have known them.

MICHAEL P COPLANS

Association of Anaesthetists of
Great Britain and Ireland,
London WC1

Ulcerative colitis and amyloidosis

SIR,—I found the clinicopathological conference (1 October, p 871) very interesting. I have published a review¹ of the literature on the association of amyloidosis with inflammatory bowel disease. Relevant case reports were scarce, but there was no clear-cut evidence that amyloidosis ever complicated true idiopathic ulcerative colitis. The association with Crohn's disease was more definite. Although this case report appears to be the most convincing example of amyloidosis complicating ulcerative colitis, I would like to make the following observations: (1) Granulomas are seen in about 70% of cases of Crohn's disease of the colon, but their absence certainly does not exclude such a diagnosis. (2) At necropsy there was only evidence of chronic inflammation of the colon, with no sign of acute colitis. Can one really distinguish the two forms of inflammatory bowel disease on this evidence? (3) As stated by Professor Wright, both the perianal suppuration and the long-standing diarrhoea with mucus but no blood are more in favour of Crohn's disease. (4) The possibility this was a "primary" amyloidosis (or indeed secondary to occult myeloma) is surely not excluded, especially as amyloidosis can produce both radiological and clinical features of inflammatory bowel disease. Moreover, one cannot rely on the distribution of amyloid to distinguish primary from secondary amyloidosis.

I only make these points to suggest that there must still be at least some doubt whether amyloidosis is a real complication of ulcerative colitis.

PHILIP SHORVON

Wembley Hospital,
Middx

¹ Shorvon, P J, *American Journal Of Digestive Diseases*, 1977, 22, 209.

Poisoning with tricyclic antidepressants

SIR,—Drs P J Dally and Joan R Gomez (3 September, p 638) have misrepresented me and have themselves made some questionable claims, as well as showing a rather cavalier attitude to controlled drug trials. I did not suggest that all antidepressants are equal; but, given the marginal superiority of tricyclics over placebo in many general practice trials, there is not much to be lost—as Dr G Edwards (8 October, p 954) implicitly agrees—by starting with a relatively safe drug for the minor upsets that constitute the majority of cases, especially as compliance with treatment is generally poor. Many psychiatrists, inci-

dentally, would dispute their suggestion that iproniazid is especially effective in severe depression.

They write that no one would, or should, give tricyclics to patients "whose depression stems from a disordered personality or who are prone to suicidal gestures" without special precautions. That would surely apply to the majority of depressed patients, and it is precisely because so many are given tricyclics for the wrong reasons, in large quantities and without supervision, that the problem exists. Indeed, they evidently accept that this is so because they ask why I do not criticise unnecessary or unthinking prescribing. If they had read the references I provided (and I could have given several more) they would see that I have been doing my best; and I can assure Dr Clive Stubbings (3 September, p 639) that I have not limited my criticism to GPs.

Although after some 10 years flupenthixol is hardly new, I do agree with Dr Edwards that new drugs should be used with great caution, and that is my usual practice and teaching. In this context, however, it is the short-term toxicity that is important, and that is fairly easily established. If we wait for the dawn of selectivity in prescribing habits, as Dr Edwards suggests, I fear we shall wait long and probably in vain, and many people will die as a result. At least everyone now seems to accept that the toxicity of tricyclics is an important and largely avoidable factor in the success of suicide attempts. Unfortunately, there is little evidence that they have prevented any suicides to set against the toll of tricyclic deaths, which has been increasing steadily by over 20% each year since 1969.

COLIN BREWER

London W1

Vaccine against gonorrhoea

SIR,—Your leading article (8 October, p 917) "A vaccine against gonorrhoea?" is particularly timely since Brinton¹ has recently announced a trial of a vaccine prepared from gonococcal pili. The danger you suggest of partial immunity resulting in symptomless infection deserves closer examination. The risk would not be to the vaccinated individuals but to their sexual partners. The particular advantage of the proposed pili vaccine, however, is that antibody to pili should prevent adhesion of gonococci to the mucous membrane and so reduce carriage. Only future observations will tell. Analogies are dangerous, but when diphtheria toxoid was first introduced on a large scale it was feared that many carriers would result. In the event *Corynebacterium diphtheriae* almost disappeared.

It is possible to argue in the opposite sense and suggest that the high frequency of asymptomatic infections already found is due, in part, to a poor immune response and that immunisation could increase the likelihood of symptoms, perhaps via the development of immune complexes or similar mechanisms.

What is certain is that as many as 68% of infected men may be asymptomatic,² while the number of women with symptoms and undetected infection is greater than generally supposed.³

Epidemiological control by selective vaccination of high-risk groups or by diagnosis and treatment requires effective screening. At present screening is done entirely by cultural methods and is hindered by the problems of