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.

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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.

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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.

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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

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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.

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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