Developmental screening of preschool children

SIR,—I was intrigued by the article by Dr D J G Bain on "Methods used by general practitioners in developmental screening of preschool children" (6 August, p 363) in its revelation of such free-for-all methodology. "Examination forms," "visual charts," "alternative screening forms"—you think of it, the examining doctors choose it. Why are they all left to do as they like in assessing their clinical facts and recording them?

Again, "Tests for hearing, vision, and speech were omitted in 25-75% of cases." Can this really be true? It also seems incredible that a so-called screening process in a group aged 7 months to 4½ years should have no evidence related to metabolism, especially in relation to urine screening for mental deficiency.

If Dr Bain's aim was to call attention to negligence he certainly has succeeded, ever so gently.

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Nomenclature of chronic hepatitis

SIR,—Your recent informative leader on chronic hepatitis (5 November 1977) brings out a semantic difficulty which has troubled me for some time. I refer to the expression "active chronic hepatitis." Every medical student knows that the suffix "-itis" refers to an inflammatory condition and if it is not active then surely it is not inflammation. Thus the expression "active chronic hepatitis" must be a tautology. One might logically ask if there is such a thing as inactive chronic hepatitis.

An expression seems to be needed to cover the idea of both chronic aggressive hepatitis and chronic persistent hepatitis (note that the adjectives have slipped back into their accustomed positions), so clearly the correct name for these two entities should be chronic hepatitis, as indeed is used in the heading of your article. The time has come when the leaders of thought in liver disease should take a stand and throw out this misleading and illogical phrase. Incidentally, I note that the words "chronic" or "acute" are gradually undergoing a change of usage, but this is another story.

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Use of depot tranquillisers in psychiatric disorders

SIR,—Drs M S Perinpanayagam and R A Haigh (26 March, p 835) express an interest in hearing from other doctors who have used intramuscular depot preparations of tranquillisers in psychiatric patients. While of course the use of these drugs is now accepted in schizophrenia, it is apparent from their letter and subsequent letters that they may find a use in other psychiatric disorders. I should like briefly to comment on the first five non-schizophrenic patients I have treated with fluspirilene (Redeptin) injections, the results of which have been impressive.

Briefly, all five of these patients either had psychiatric disorders which were not responding to conventional oral medications or had long-standing psychiatric disorders that

had failed to respond to other treatments. Two patients had long-standing anxiety neurosis, and the third an anxiety state of acute onset; all three had totally failed to respond to oral benzodiazepines or phenothiazines. Their anxiety state was such that admission to hospital was considered necessary for two of them, and all were socially incapacitated. Within two to six weeks of beginning weekly intramuscular injections of fluspirilene their anxiety symptoms disappeared completely. A fourth patient had anorexia nervosa. She had not only received inpatient treatments of the kind usually employed in the condition but had also been seen by myself as an outpatient for several months, receiving phenothiazines and antidepressants orally. Again following the introduction of fluspirilene not only did the patient feel very much better, but her general practitioner commented that she had lost her obsessions about food. More importantly, within a few weeks of starting the drug she had increased her weight by 19 lb (8.6 kg). The fifth patient had a chronic depressive disorder and multiple hospital admissions over many years. More recently he had failed to achieve any reduction of his symptoms by conventional oral antidepressants, electric convulsion therapy, and several months as an inpatient. Within three weeks of starting on intramuscular phenothiazines his condition improved considerably. Not only did he feel better but he was discharged from hospital.

These patients with chronic psychiatric disorders of the sort that most psychiatrists have on their lists all responded quickly to fluspirilene. I would suggest that such drugs could achieve wider use in psychiatry than they do at present. If, as my observations suggest, they could be useful in the management of anorexia nervosa the need for carefully controlled trials in such conditions is mandatory.

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Beta-blocking drugs in diabetes

SIR,—We cannot agree with Dr S P Deacon and his colleagues (12 November, p 1255) that their findings support the hypothesis that β -adrenoreceptor blocking drugs which are highly β_1 -specific and devoid of membrane-stabilising activity should be safer than non-selective drugs when used in diabetic patients at risk of hypoglycaemia. While it is difficult to compare directly the relative efficacy of different β -adrenoreceptor blocking drugs when each is given at but a single dose level, we would point out the following.

In their study the tachycardia induced by hypoglycaemia was modest, as indeed was the level of exercise-induced tachycardia attained. These heart rates at or below 100/min are below the levels at which β -adrenoreceptor blocking activity is generally assessed¹ as vagal influences are very important at such low heart rates. Within the experimental design described, however, it appears that propranolol was used in a more effective dose than the other β -blockers, as evidenced by the more marked effect on pulse rate both at rest and throughout hypoglycaemia. Moreover, we are not clearly shown that the pulse rate did in fact fall during propranolol-modified hypoglycaemia. The mechanism of such a fall, if documented, would be of considerable interest.

We would ask the authors to substantiate more effectively than in their paper that doses of β -adrenoreceptor blocking drugs equivalent in one measure of pharmacological efficacy differ in modifying the metabolic responses to hypoglycaemia.

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¹ McDevitt, D G, *British Journal of Clinical Pharmacology*, 1977, 4, 413.

Borderline substances

SIR,—The letter from Dr A J Cooper on the problems of treating patients in spite of increasing advisory committees (19 November, p 1358) shows how dangerous the use of apparently well-qualified opinion can be in a clinical situation. The addition of powdered chocolate to L-tryptophan logically makes it a food even though patients will take this in preference to the new smaller tablets of Optimax. So the patients do not get their antidepressant in its most palatable form and doctors lose out also by having to use more toxic drugs.

In the *Scientific American* for July 1973 (p 51) there appeared a comment headed "The brain feeds itself" in which it was reported that at the Massachusetts Institute of Technology Fernstrom and Wurtman¹ had shown that rats' brain cells synthesise serotonin from tryptophan at a rate that depends on the ratio of tryptophan to five other neutral amino-acids, this ratio depending on the composition of recently ingested food. Consumption of carbohydrate increased the brain levels of tryptophan (as insulin secretion reduced the concentration of competing amino-acids). This suggests that powdered Optimax would be more effective because of the chocolate that is not working as a food but as an important chemical in the formulation.

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¹ Fernstrom, J D, and Wurtman, R J, *Science*, 1972, 178, 414.

Surgeons and money

SIR,—Your leading article on this subject (12 November, p 1244) does not point out the most important disincentive to doing large numbers of operations under the item-of-service contract. This is, of course, the present income tax structure.

After doing a relatively small number of operations the fee that one would be allowed to retain after income tax is so small that the extra work would not be rewarded. In view of this it is very unlikely that surgeons would operate for frivolous reasons. This is especially true in a majority of peripheral hospitals where the waiting list of patients genuinely needing operations is very long. It is the pressing need of these patients that is, and will continue to be, the incentive, not money.

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