great success in these difficult cases is to transilluminate the tissues with a powerful cold-light source such as the long flexible fiberoptic light used for cystoscopy, bronchoscopy, etc, which is usually readily available from theatres or intensive therapy units. By placing the light source in the palm of the patient's hand vessels on the dorsum can be clearly seen, where none have been previously visible, by inspecting the skin surface. A similar technique can be used for the foot. The wrist can also be transilluminated allowing easy access to the radial artery for cannulation and removing arterial blood to measure blood gases.

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Intravenous urography

SIR,—Drs Benvon Cramer and Gerald de Lacey (6 September, p 661) discuss special circumstances in which the standard procedure for intravenous urography should be altered. One important modification that they do not stress is the value of taking delayed films up to 24 hours after the administration of contrast medium, if there is delay to the excretion of contrast by one, or both kidneys. This may give useful anatomical information as to the level of obstruction and may indicate the cause of that obstruction. It is particularly helpful in the management of renal and ureteric colic, and in cases of renal failure thought to be due to ureteric obstruction.

The delay in excretion gives a crude estimate of the degree of obstruction, but I would agree this is more accurately and better assessed by radioisotope methods. Intravenous urography, however, is readily available 24 hours a day in most hospitals and continues to be the first-line investigation for patients presenting as emergencies with obstruction to the upper urinary tract.

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Dietary fibre and calcium excretion in diabetes

SIR,—We read with interest the report by Mr P J R Shah and others (9 August, p 426) on the beneficial effect of bran in hypercalciuria. Our experience of the use of guar gum in maturity-onset diabetes supports their findings and suggests that a similar effect on calcium excretion may be achieved with various components of dietary fibre.

We studied the long-term effects of dietary supplementation with guar gum (21 g a day) taken in three divided doses at the main meals, in a double-blind cross-over comparison with placebo in nine insulin-independent diabetics. The main interest was in the effects on glucose and lipid metabolism, and the results will be published elsewhere. The serum and urinary calcium levels were monitored during the experiment, and it was found that after three months of guar gum supplementation the urinary excretion of calcium was significantly less (2.64 ± 0.67 mmol/24 h (106 ± 27 mg/24 h), mean $\pm$ SE) than during the control period (3.80 ± 0.74 mmol/24 h (152 ± 30 mg/24 h), $p < 0.025$). No difference was observed in mean serum calcium concentration between

the two periods. There was a concomitant reduction in mean glucosuria by about 50% during the guar gum period.

The observed reduction in calcium excretion is partially, but probably not entirely, explained by the reduced degree of glucosuria, because a positive correlation has been found between glucosuria and calcium excretion in diabetes.¹ The rather marked reduction in calcium excretion, however, which was evident in eight out of the nine diabetics studied, probably also reflects a reduction in calcium absorption due to the administration of guar gum. The possible mechanism by which guar gum could reduce calcium absorption is obscure, since in contrast to the phytate- and uronic acid-containing components of fibre, guar gum does not bind calcium *in vitro*.²

The study should be repeated and the results confirmed in non-diabetics before any general conclusions on the effects of guar gum on calcium excretion can be drawn. Our findings—although inconclusive—are in support, however of the results of Shah and co-workers and, in addition, suggest that different analogues of dietary fibre may be of practical importance in absorptive hypercalciuria.

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¹ McNair P, Madsbad S, Christensen MS, et al. *Acta Endocrinol (Copenh)* 1979;90:463-72.

² James WPT, Branch WJ, Southgate DAT. *Lancet* 1978;i:638-9.

Managing extrapyramidal disorders

SIR,—The issue of 6 September, (p 655 and p 690) contains references to the management of two extrapyramidal disorders, but the advice proffered in each case requires clarification.

Minerva quotes* a study from Boston¹ in which drug holidays were employed in patients with Parkinson's disease in an attempt to restore therapeutic benefit. While the success of this manoeuvre is open to question, the effect of stopping levodopa treatment can be quite dramatic. Next day the patient will have reverted to his usual Parkinsonian state, and a few days later he may deteriorate to become more immobile than ever before. Such patients may become mute, bedridden, and unable to swallow. Clearly this procedure is not to be undertaken lightly and is best carried out under supervision in hospital.

In response to a question concerning tests that might predict whether a child of a patient with Huntington's disease will develop the illness, your anonymous expert states that: "in descendants of families who have not yet developed the choreiform movements the use of levodopa at about 3 g a day will produce chorea in those who are at the moment asymptomatic." Certainly this is true in about a third of those at risk, but it is not yet known for certain whether such individuals will inevitably go on to develop Huntington's disease. In any case, the wisdom of undertaking such a predictive test is very questionable. There is no guarantee that the disease may not be precipitated earlier by doing so, and the psychological impact of provoking chorea in such an individual at risk can be disastrous; it is like passing a death sentence, a

burden many cannot carry. Until effective treatment for this disease is available, I, and many others concerned in the management of this disease, would proscribe the routine use of predictive tests. Elsewhere² I have argued that in the present state of therapeutic impotence it is reasonable to ask those at risk who are lucky enough not to carry the gene for the disease to share the burden of uncertainty with those who have inherited it, so as to provide the latter with some hope.

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¹ Direnfeld LK, Feldman RG, Alexander MP, Kelly-Hayes M. *Neurology* 1980;30:785-8.

² Barette J, Marsden CD. *Psychol Med* 1979;9:327-36.

*.*We regret the page number quoted by Minerva was wrong.—Ed, *BMJ*.

Acupuncture and postherpetic neuralgia

SIR,—I was interested to read of the experience of Dr G T Lewith and Dr Jennifer Field (30 August, p 622) in the use of acupuncture for postherpetic neuralgia.

I use acupuncture in the pain relief clinic at Ipswich but have not found it very helpful in postherpetic neuralgia. It does seem logical to try to prevent this distressing complication, and there is some evidence that sympathetic nerve block given as early as possible in the acute attack of herpes zoster may diminish the incidence of neuralgia.¹ I have begun to use sympathetic or somatic nerve block in the acute phase, and I find that the pain is decreased and the attack seems to be reduced in length. In the few cases treated none have progressed to postherpetic neuralgia, but further experience is needed to evaluate this approach.

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¹ Colding A. *Der Anaesthesist* 1967;16:172-4.

Percutaneous central venous cannulation

SIR,—The hazards of subclavian cannulation have again been rightly emphasised by Mr J L Peters and others (30 August, p 618). The suggested use of ultrasound to identify the subclavian artery and vein may be worthy of trial although we doubt if it will, in practice, reduce the incidence of pneumothorax. This is the major hazard of subclavian puncture particularly in inexperienced hands. A simpler alternative may be puncture of the internal jugular vein at the level of the cricoid. If the Vygon silicone catheter with detachable hub is used it is a simple matter to make a skin tunnel from the site of puncture down to the chest wall below the clavicle using the introducing cannula. This was originally described by Dr Powell-Tuck for the subclavian vein.¹ Puncture of the internal jugular vein is virtually free of the risk of pneumothorax and the use of the skin tunnel should prevent the problem of infection in patients' necklines. The major hazard is puncture of the carotid artery, but we suspect that this is less dangerous for the patient than tension pneumothorax occurring in the intensive therapy unit or on the operating table following subclavian puncture. We have now used this technique in a small number of patients—usually those on

ventilators—and would be interested to hear the views of others.

We agree wholeheartedly with Mr Peters's final point that through-needle catheters are dangerous and should be regarded as obsolete.

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¹ Powell-Tuck J. *Br Med J* 1978;ii:625.

Familial hypercholesterolaemia and coronary disease in South Africa

SIR,—White South Africans may hold the world record for the prevalence of familial hypercholesterolaemia and also for coronary heart disease mortality but the former surely cannot in any way explain the latter (6 September, p 633). The prevalence of homozygotes is given as 1 in 30 000 and of heterozygotes in the population as possibly 1 in 100, whereas in a highly susceptible population coronary heart disease will kill one person in three, leaving 97% of cases unexplained. The authors report this genetic disorder as occurring characteristically in Afrikaners whereas a report from Johannesburg in the 1960s attributed the highest coronary mortality to the Jewish population.¹

If coronary disease were largely caused by familial hypercholesterolaemia it would be a rare disease. The situation is exactly analogous to that of malignant hypertension, a deadly, dramatic, and rare condition compared with commonplace, boring, and undramatic mild hypertension, which none the less kills a thousandfold more victims. Common diseases are caused by common risk factors. The white South Africans should look to their present way of life rather than their distant ancestors to explain their coronary epidemic.

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¹ Walker ARP. *Am Heart J* 1963;66:293-5.

Mental Health Review Tribunals

SIR,—I have not yet read the MIND publication, *Representing the Mentally Ill and Handicapped: a guide to Mental Health Review Tribunals*. I have, however, read with considerable dismay the review of the book (30 August, p 610), and I hope I may have the opportunity of correcting the grave misrepresentations it contains.

The Mental Health Act, 1959, is in intent the most humane charter yet devised to protect the rights of the mentally disordered in this or any other country. To compare those compulsorily admitted to psychiatric hospitals, as is done by your reviewer, with prisoners is an insult to the patients themselves, to their doctors, and to the spirit of the Act. Patients do not receive sentences: they are committed to hospital in the interests of their own health or safety or the safety of others. Again, those committed under Sections of either Part IV or Part V of the Act (with the exception of

Section 65, a restriction order, which accounts for about only 150 patients annually) are committed not for indeterminate periods as your reviewer states but for determinate periods; the maximum being for one year under Section 26, or Section 60, in the first instance. About 90% of compulsory admissions, however, are under "short" orders—for example, for periods of up to 72 hours (Section 29) or up to 28 days (Section 25).

Your reviewer further states that less than 10% of those compulsorily admitted, that is those under "long" orders, have a statutory right of appeal to a Mental Health Review Tribunal. This is so; but it is difficult to conceive of an administrative machine that would allow for patients on "short" orders to be brought before a tribunal. Furthermore, the determinate periods of all compulsory orders are maximal, and there is nothing that prevents the responsible medical officer from discharging a patient completely (with the exception of those admitted under Section 60/65) before his order expires, or from re-admitting him as an informal patient. A further method of discharge, not infrequently employed in these days of the ever-open-door-hospital, is for the patient to discharge himself by the simple expedient of walking out of the door.

Your reviewer also alleges that patients may be treated without their consent. This certainly does occur, but I believe only in situations of dire necessity when life itself may well be in danger. Comparable situations arise in all departments of medicine. What is puzzling to me is why psychiatrists are singled out for censure because they behave like other doctors.

These things having been said, I hasten to add that I am personally in favour of patients being represented at tribunals if only to preserve the time-honoured principle of justice being seen to be done. I venture to suggest, however, that it is doubtful if as a result of such representations the number of discharges will, in the event, rise substantially if at all. I base this view on my own experience as a medical member of Mental Health Review Tribunals since their inception in 1960. I can personally vouch for the care, time, and effort taken in the preparation of the tribunals, and for the long and serious deliberations that take place among members before a decision is arrived at.

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Prostatic biopsy

SIR,—I would like to offer a few comments concerning the article by Mr J R Rhind (13 September, p 722) on prostatic biopsy. The description of the technique, which is presumably designed for surgeons in training, would seem to require amplification of a few points.

The practice in this unit is to perform transperineal needle biopsy in preference to transrectal biopsy. Recent articles have stressed the significant risks of bacteraemia during the latter procedure and it should now be considered mandatory to cover transrectal biopsy with an aminoglycoside and metronidazole given with the premedication. It is our experience that the transrectal route is less accurate than the transperineal route in biopsying T1 and T2 lesions. Although

transperineal biopsy is more difficult to learn it has a very low instance of infection and significant haemorrhage is rarely a problem.

Perineal shaving is not required but the help of an assistant is necessary to press on the lower abdomen so that the bladder and prostate are held steady for the surgeon. Perineal tumour implantation is a rare complication and usually occurs when more than one attempt at biopsy has been performed. This risk can be lessened by immersing the trocar in the preservative fluid when the biopsy core is released from the trocar.

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Two jubilees in psychotherapy

SIR,—Dr D S Macphail, in a letter (6 September, p 681) refers to the omission of your leading article (26 July, p 681) to recognise the part played by Dr Crichton-Millar, the first medical director of the Tavistock, in the development of psychotherapy in this country.

Another omission is that of the name of Dr J R Rees, the medical director of the clinic in 1933-47, and the wartime director of Army psychiatry. I believe that many of us now coming to the end of our professional career will hold that Dr Rees gave as much to contemporary psychiatry as most men. An interest in psychiatry was born in a large cohort of young men struggling to understand and treat the emotional problems of soldiers separated perhaps by years and certainly by thousands of miles from their homes, and in some cases facing an enemy much feared because little understood and in quite appalling terrain. Rees arrived in India in 1944 and set us alight with his deep but common-sense and even jovial understanding of our problems and those of our patients and by his application of psychodynamic principles to them. He showed us that the contemporary medical image of the analyst was wrong: he was not a detached exponent of improbable theories but in his own person he was an example to educate and sustain us in a professional lifetime of contact with humanity in distress.

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Women in hospital medicine

SIR,—All involved in training in hospital medicine will welcome your leading article (13 September, p 693) on this subject and the analysis of the problems presented by Dr A J Swerdlow and others (13 September, p 754). We are also very grateful for the positive help which Dr Rue, one of the authors, has given for many years to women who wish to remain in hospital medicine.

During the last few years, possibly as a result of new investigative techniques, dermatology has been attracting many very able young doctors and inevitably, with the increasing proportion of women entering medicine, many are hoping to become dermatologists. It may also be that the particular conditions of professional work in dermatology have added attractions for women. In the report on training which I presented to the annual general meeting of the British