test³ and in which there was no significant shift as a result of therapy. Like Frost-Larsen *et al*⁴ we did not include details and results of all the investigations performed in our report, which had been abbreviated at the Editor's request. Tear break-up time was estimated; Rose-Bengal staining, labial gland biopsy, and sialography were also performed. The unreliability of these in assessing lacrimal and salivary gland involvement have been discussed previously.^{5,6}

The mean unstimulated salivary flow rate in our Sjögren's patients of 0.17 ml/min or 2.55 ml/15 min (fig 1) is below our normal range of 0.27-1.88 ml/min and below the normal mean values previously established by other workers using the same method of collection.^{7,8} However, too much emphasis should not be placed on mixed salivary flow measurements compared with stimulated parotid flow rates, which are considered to be more reliable in assessing the degree of xerostomia.⁶

We note that Dr Manthorpe and his colleagues have still not cited any pharmacological mechanism whereby bromhexine could increase secretion from pure serous glands such as the lacrimal and parotid glands.

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¹ Bloch KJ, Buchanan WW, Wohl MJ, Bunim JJ. *Medicine* 1965;44:187-231.

² Mackie IA, Seal DV. *Br J Ophthalmol* 1976;60:70-4.

³ van Bijsterveld OP. *Arch Ophthalmol* 1969;82:10-4.

⁴ Frost-Larsen K, Isager H, Manthorpe R. *Br Med J* 1978;i:1579-81.

⁵ Mackie IA, Seal DV. *Br Med J* 1978;ii:638.

⁶ Chisholm DM, Mason DK. *Br Dent J* 1973;135:393-9.

⁷ Zaus EA, Fosdick LS. *J Dent Res* 1934;14:1-13.

⁸ Kerr AC. *The physiological regulation of salivary secretions in man: a study of the response of human salivary glands to reflex stimulation*. Oxford: Pergamon Press, 1961.

McIlroy—a suggestion

SIR,—McIlroy,¹ that most famous example of Munchausen's syndrome, continues his peregrinations. He was admitted to this psychiatric unit on 15 September complaining of depression. The next morning he "collapsed," simulating a cardiac infarct, and was transferred to Jervis Street General Hospital. He was subsequently returned to St Brendan's after his cardiac status was deemed satisfactory. While arrangements were being made for his readmission to the ward he departed. Over the next two days we traced him to five other Dublin hospitals, but since 18 September he has disappeared again.

The literature on McIlroy, while anecdotal and colourful, tells us little about the man himself. We are therefore writing to you with the suggestion that McIlroy, wherever he next appears, should be taken into hospital (compulsorily if necessary) for the specific purpose of a full in-depth psychiatric evaluation. Moreover, the possible side effects of the prodigious amount of investigations he

has had, such as the radiation effects of hundreds of x-rays, clearly need monitoring. In short, McIlroy in his own right now merits serious psychological and somatic study. For our part we in St Brendan's are willing to accept him for such studies should he reappear again in Eire. We suggest that a unit in the UK do likewise.

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¹ Pallis CA, Bamji AN. *Br Med J* 1979;i:973-4.

Diuretics are dangerous with lithium

SIR,—Dr R J Kerry and others (2 August, p 371) have re-emphasised the established fact that thiazide diuretics cause reduced lithium clearance leading to increased serum lithium concentration and sometimes lithium toxicity. It is not at all clear, however, that this interaction occurs with classes of diuretics other than the thiazides.¹ Although evidence is limited, available data suggest that diuretics of the osmotic, carbonic anhydrase inhibitor, and xanthine types actually increase lithium excretion. Long-term use of potassium-sparing diuretics (spironolactone, triamterene, amiloride) may lead to lithium retention, although this observation is based on a single study. When frusemide (40 mg daily) was given to five normal volunteers, there was no change in serum lithium level over a two-week period, suggesting that the interaction of loop diuretics with lithium may be quite different from the thiazides.²

Although the danger of giving lithium with diuretic drugs has been well substantiated only with the thiazides, I do agree that careful clinical and laboratory monitoring is indicated when lithium and any diuretic are combined in a medically ill patient.

Finally, it should be noted that thiazide diuretics have proved to be quite effective in the treatment of lithium-induced nephrogenic diabetes insipidus. In such situations it is generally necessary to lower the lithium dose to compensate for drug-induced lithium retention.³

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¹ Jefferson JW, Greist JH. In: Davis JM, Greenblatt D, eds. *Psychopharmacology update: new and neglected areas*. New York: Grune and Stratton, 1980: 81-104.

² Jefferson JW, Kalin NH. *JAMA* 1979;241:1134-6.

³ Himmelhoch JM, *et al.* *Clin Pharmacol Ther* 1977;22: 225-7.

Treatment of sciatica

SIR,—I am writing to raise a few points about your reply in "Any Questions?" (30 August, p 606) about the treatment of classical sciatica. This question is clearly rather too difficult to answer in the short space available and perhaps the attempt should not have been made, but since it was may I make the following comments?

(1) Myelography has largely been replaced by radiculography for defining root lesions. (2) I doubt if the consensus is that a definite disc protrusion is an indication for surgery. (3) It is untrue that a negative myelogram excludes a reasonable chance of improving sciatica by

surgery unless a comment is made about age. A young patient with definite sciatic and clinical findings of root compression may have bony compression in the absence of disc protrusion. (4) Analgesics alone should rarely be used anyway; an anti-inflammatory drug gives consistently better results in patients with early acute sciatica and may give better results in the older patient with degenerative arthritis. Indeed, pathology, investigation, prognosis, and management are really very different at different ages. (5) A fenestration procedure would probably be considered preferable to laminectomy. (6) Finally, I have never seen "classical sciatica" improved by specific psychiatric treatment.

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* * (1) Radiculography is used in relatively few centres for defining root lesions and myelography appears to be the most widely used technique in Britain. (2) In a patient with a definite disc protrusion failure to respond to conservative treatment is in most people's opinion the prime indication for surgery. (3) A negative myelogram was not said to exclude a reasonable chance of improving sciatica by surgery; it simply reduces the chance of cure. (4) Although anti-inflammatory agents may give better results analgesics are more widely used. (5) Fenestration is admittedly a more accurate term for the standard operation but laminectomy remains the more commonly used term. (6) There are patients with apparent classical sciatica, usually of the chronic variety, in whom secondary depression is an aggravating factor requiring treatment.—Ed, *BMJ*.

Private versus public health care systems

SIR,—In a review in this journal (14 June, p 1428) Lord Taylor of Harlow has some very uncomplimentary things to say about my book *The Health Care Business*.¹ While there is nothing I can do about the fact that he does not agree with my conclusions, I would like to correct some gross inaccuracies in his representation of the book's contents.

(1) Nowhere in the book do I state or imply that the NHS is "very inefficient" (nor that "Sweden has the most efficient health care in the world"). I attribute the low cost of health services in the UK, relative to Canada and the US, to a number of factors, such as an efficient system of GP services (p 138) and substitution of less expensive paramedical personnel (such as home nurses) for physician manpower (p 131). I also claim, however, that one reason for the relatively low cost in the UK is the fact that some categories of patients who would be given specialist or hospital treatment (or both) in North America are given simple and less expensive treatment (or no treatment at all) in the UK. The aspects of the UK health care system which Lord Taylor cites as evidence of my ignorance ("We would seldom admit a patient with an upper respiratory infection"; "Thanks to our good GP service and excellent home nurses . . . we treat a great deal of terminal illness at home"; "In Britain, the GP is a powerful barrier to any unnecessary admission") seem to me to support these explanations, not to contradict them. As I conclude in the book, the North American health care systems might have some lessons to learn from the NHS in these areas, but not from the "long waiting lists for cold surgery," which I do take to represent an undesirable feature of the UK health care system.