occur more frequently in children of lower intelligence," as suggested in this article.—I am, etc.,

Winchester, Hants.

E. B. MCDOWALL.

Diagnosis of Hysteria

SIR,—I read with great interest Dr. W. V. A. Erskine's letter (August 21, p. 478) on the above subject. I agree most fully with Dr. Erskine's emphasis of the importance of "clear definition" in our conception of hysteria and allied conditions. The lack of this is responsible for enormous frustration both to psychiatrists and general practitioners.

Dealing with Dr. Erskine's queries *seriatim*, in my opinion anxiety which is not the outcome of depression, or an undiagnosed physical ailment, is *always* produced by suggestion and hence is always hysterical in origin and should respond immediately to counter-suggestion. I do not therefore believe in the existence of an "anxiety state" as a separate entity. Also, in my opinion, a diagnosis of "anxiety hysteria" should carry with it no derogatory implications whatever.

In my experience the "nature" of the "anxiety" may tell us very little about the crucial question as to whether or not *actual* depression is present. Many other things, sleep, tearfulness, sociability, history of onset, etc., must be taken into account. As Dr. Erskine points out, "a primary anxiety state with secondary depression" presents a difficult problem. If a primary anxiety state is allowed to continue for months without relief, the long-sustained tension will eventually induce a secondary depression and it will be necessary to remove this by E.C.T. or other means before tackling the primary anxiety state by suggestion.

Dr. Erskine thinks that attacks of agitation (by which I assume he means the agitation of acute depression) and acute anxiety are distinguishable. Yes, I agree, but only when many other considerations are taken into account. Viewed from a distance, they may be absolutely identical. Apart from operating theatres, outbreaks of hysterical fainting not uncommonly occur in church choirs and other groups. Unless nipped in the bud, one patient can set off a "chain reaction" similar to the suggestion of mass hypnosis. In "hysterical hemiplegia," acute anxiety symptoms may be present in addition to the "paralysis" or grossly ataxic gait, but when the latter symptoms are removed by suggestion all anxiety symptoms vanish.

Finally, in my experience, anxiety symptoms alone, unlike depression, do not mean any "breakdown," and on their removal the patient can immediately resume all his former responsibilities.—I am, etc.,

Pinner, Middlesex.

ROBERT THOMPSON.

Significance of a Flat Small-intestinal Mucosa

SIR,—I was most interested to read the two excellent papers of Drs. W. Hindle and B. Creamer (August 21, p. 455) on small intestinal mucosa. The authors referred to our work on the state of the small intestine in ulcerative colitis patients.¹ I would like to

comment on their statement, "The degree of abnormality was related to the severity of ulcerative colitis, but as repeat biopsies were not performed it is uncertain whether the changes in the mucosa improved during remissions in the ulcerative colitis."

In fact Dr. S. C. Truelove and I have extended our study on the subject to include 60 patients with ulcerative colitis and 55 controls.² Repeat biopsies were performed on 10 ulcerative colitis patients after a lapse of time varying between 2 and 14 months.

In addition to the peroral biopsy examination small intestinal function tests were also employed, including D-xylose absorption test and faecal-fat excretion test. There was close correlation between the degree of the abnormalities of the small intestinal mucosa and the abnormal results of the absorption tests. Moreover, the correlation was rather closer between the histological appearances of the biopsy specimens and the severity of clinical state of the colitis patients. Two patients, who had a severe attack of ulcerative colitis, had biopsy specimens showing flat mucosa and highly abnormal faecal fat excretion. One of them had liver cirrhosis but the other's liver function tests revealed normal values. Twelve patients with a moderate or severe attack of ulcerative colitis showed markedly abnormal jejunal biopsy specimens classified as partial villous atrophy.

Repeat jejunal biopsy examination and absorption-function tests were carried out on 10 patients with severe colitis. Of these 10, seven, who were first examined while they were suffering from an acute attack, had marked abnormalities of the jejunal mucosa, of which one was completely flat. They were re-examined while in absolute remission of the disease, and the histological appearances of the biopsy specimens returned to normal in three and showed significant improvement in four (including the one with the flat mucosa). Correspondingly the mal-absorption state manifested by high faecal fat excretion and impaired D-xylose absorption became normal on re-examination during remission. By contrast, two patients whose ulcerative colitis was more severe at the time of re-examination than originally showed increased villous abnormalities in the small intestine. We concluded that the small intestinal mucosa is in a highly plastic state in ulcerative colitis and swings from normality to villous abnormality in parallel with the inflammatory changes in the colon.

I emphatically endorse the conclusion drawn by Drs. Hindle and Creamer that the finding of a flat jejunal mucosa on biopsy can no longer be regarded as diagnostic of idiopathic steatorrhoea.—I am, etc.,

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Laevadosin in Muscular Dystrophy

SIR,—In the *B.M.J.* (28 August, p. 533) the short communication on "Laevadosin in Muscular Dystrophy" must surely disappoint those who expected a more explicit account of the long-term trial promised earlier.¹ Its brevity does not, however, prevent the emergence of matters requiring comment.

It is unfortunate that Dr. J. N. Walton and his colleagues should persist in pressing unimportant priorities on Robert Beckmann by

quoting his 1959 publication² on the value of whole-meal wheaten groats in feeding healthy infants. Even if one's German is unsafe there is still a summary in English. Several years were to elapse, in fact, before the publication of detailed and systematic investigations into the effects of this nucleoside/nucleotide mixture in the experimental therapy of muscular dystrophy.^{3,4}

This present account, however, recapitulates the attempted Newcastle assessment of October 1964,¹ which was severely and comprehensively criticized, without contradiction, as being biochemically, statistically, and clinically unsound.⁵ In this continuing context it is hardly surprising, therefore, to read that the abnormal elevations of serum creatine kinase in muscular dystrophy decrease more in treated than in untreated patients, but only if one retains in the treated group those patients in whom the elevations decrease; nor to learn that, though dramatic results were not obtained, the precise effects of attempted therapy still remain undetermined. What is surprising is that recommendations of any kind should be thought to be expected, or even possible.

The problem of muscular dystrophy will be solved only by the submission of every slightest clue to patient, scrupulous investigation, accurately recorded and thoughtfully interpreted⁶; in such a disease no other approach is admissible.—I am, etc.,

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Petechiae from Vests

SIR,—Dr. M. A. Kibel (28 August, p. 521) is quite correct in saying that this type of eruption is very common in children and completely harmless. For years I have been pointing out these petechiae to residents and to postgraduate students; the invariable response has been to assume that they were indicative of serious disease and my assurances of their innocence have sometimes been accepted with polite scepticism. I would hazard that all British paediatricians recognize them and have taught their residents about them. They are far commoner than all the serious forms of purpura in childhood put together.

I have never known the parents to have noticed them, nor have they ever been mentioned in a family doctor's letter, probably because the doctors also realized that they were insignificant. The lesions almost always show the definite geometrical pattern of the cellular vest and occur in small patches, seldom more than one inch (2.5 cm.) square, at sites where the vest is likely to be pressed against the skin—where the shoulder strap is tight under the anterior axillary fold, on the back where the child leans against the chair, etc.