thought and planning. I suggest a system based on insurance clinics is a feasible and worth-while goal—to improve general practice conditions. It would save the G.P.'s time and save the Government money—a combination, I feel, which makes for a fair chance of accomplishment.—I am, etc.,

J. DOWNES.

Burnley, Lancs.

Vaccination against Measles

SIR,—I would like to say how much I welcome your leader on measles vaccination (September 28, p. 759) which asked us to consider carefully whether or not general vaccination would be of value in this country. It marks a step forward from a previous less critical leader (November 11, 1961, p. 1274) which stated, when considering the disease in England and Wales, that "a single and safe method of abolishing it would therefore be an immense boon," and it will be particularly welcome to such as myself working in public health, who might have found that our lack of enthusiasm for it would have put us in a difficult position either in carrying out the work or in advising local authorities on its value.

Leaving aside those schemes we already have, may we now hope for reconsideration of the desirability in general of extending our vaccination programmes. As your leader indicates, we may be playing with fire, and yet we tend to make our decisions on the basis of immediate benefit with insufficient consideration of long-term effects. Indiscriminate indulgence in vaccination is little more justifiable than the indiscriminate contamination of our environment by pesticides and the like. Least of all is it justifiable to advocate such procedures to avoid some inconvenience or for small (and nebulous) economic gain, and yet, to consider only one, there is no doubt that 'flu vaccine is in many instances being recommended on just these most dubious grounds.—I am, etc.,

J. H. E. BAINES.

Weeping Cross,
Stafford.

Drugs for Depression

SIR,—The panel discussion on "Drugs for Depression" (September 28, p. 799) raises several interesting points.

Dr. C. A. H. Watts suggests that depression is a complicated subject and says that "if we are to get it across to general practitioners it must be kept as simple as possible." With his first statement no one will disagree, but his aspersion on the general practitioner's ability to comprehend is a little suggestive of dog eating dog.

Dr. Watts is undoubtedly correct when he says that severe classical depressions are only a small proportion of the patients one sees in general practice; indeed only a very small proportion of the depressed patients one sees in general

practice manifest these symptoms. For instance, feelings of guilt are very rarely found in this practice.

This suggests that it would be useful to have a definition of the milder depressions which are so common in general practice. The typical depressed patient's leading symptom, the one which brings her to her doctor, is usually fatigue; this is a persistent and unreasonable fatigue which is not improved by sleep. There may be some delay in falling asleep, but sleep is in fact often described as being long and heavy, and the patient remarks that she is just as tired in the morning as when she went to bed—her sleep never refreshes her. She may say it takes her half the morning to get herself pulled together; she may say she has no energy and that she has to force herself to do her work. She may say she thinks she is anaemic or she may ask for a tonic. Only rarely does she admit to being depressed unless she is asked more or less directly in a question such as: "How are your spirits?" Occasionally this question will bring tears to the patient's eyes immediately; sometimes she will simply say that she is always depressed, that things "get her down" more than they should, that she frequently weeps about nothing at all, and that she is unreasonably irritable and difficult to live with. Occasionally she will complain of loss of appetite. Often she will say that she has everything to make her happy and yet she feels miserable.

This form of depression, which might be called "minor depression syndrome," is one of the commonest in general practice. Its constituent symptoms may be stated briefly as follows: (a) depressed mood (feeling of misery, or tears at interview, or tears reported); (b) retardation (morning tiredness, a constant lack of energy, or inability to concentrate); (c) irritability (lack of patience, or bad temper, or moodiness).

In its simplest terms the syndrome can be said to consist of depression, tiredness, and irritability, and its importance in the context of this letter is that it is this syndrome which responds so effectively to modern psychotropic drugs.

The effect of the doctor's personality on his treatment is mentioned in the discussion, and there seems to be agreement that it is of importance. In my view "personality" is becoming of much less importance with the advent of more specific treatment with a biochemical basis. What is surely of greater importance is to discourage this magic effect of personality because of the obvious danger of causing undesirable dependence on the physician.

I think general practitioners would agree that a very true picture of the worth of any treatment can be drawn by the family doctor dealing in his own accustomed manner with patients whom he is treating in their own environment.

This brings me to my final point, which is an appeal for the controlled use of the term "placebo": it is now used indiscriminately for the true placebo and for

dummy treatment. An example will make the difference plain. A patient says he is unduly tired and asks for a tonic; the doctor realizes that the cause is a domestic disturbance, but nevertheless he prescribes an inherently useless "tonic." The patient expects a bottle of medicine and he gets one: this is a "placebo" (placebo, I will please). On the other hand, a patient says he feels unduly tired and asks for a tonic; the doctor realizes the patient is anaemic and requires iron; if, despite this, he prescribes, say, lactose tablets, then he is prescribing a "dummy."

Nevertheless it was a most interesting discussion.—I am, etc.,

J. J. HOBBS.

Ashington, Northumberland.

Rabies in Tibet

SIR,—Following on your recent leading article on the subject of rabies it might be of interest to you and your readers to know how this disease is—or was—treated in Tibet.

I lived on the Tibetan border for eight years, but my husband lived and travelled in the hinterland of Tibet for three years, from 1947 to 1950. Rabies is fairly common in Tibet because of the large number of dogs, many of them pariahs, and wolves. When any Tibetan is bitten by a rabid dog or wolf every person who can be mobilized is called on to round up the animal, no matter how difficult this may be. If the animal is caught within a reasonable time it is killed, its brain and saliva are mixed together, and the concoction is given to the person or other animal bitten. It is claimed that this is invariably effective as a cure.

A similar claim is made for their treatment of smallpox. When someone is found to be infected, the fluid from the vesicle is taken and either mixed with snuff or mixed with milk. All the members of the community then either sniff or drink the mixture, according to choice, and again, apparently, it is completely effective if taken quickly.—I am, etc.,

MARGARET A. PATTERSON.

London S.W.17.

Steroids and Disseminated Sclerosis

SIR,—Your leading article (August 31, p. 513) refers to the benefit obtainable from the treatment of disseminated sclerosis with high-dosage long-term A.C.T.H. therapy. Its mode of action is still debatable and may not be entirely due to adrenocortical stimulation, as long-term steroid therapy has not been shown to benefit patients suffering from this disorder.¹

Further advances in the treatment of this condition may lie in the use of the newer drugs that have been shown to depress immunological mechanisms both in cases of renal transplantation² and auto-immune disease.³ In this latter instance, a patient with thrombocytopenia and auto-immune haemolytic anaemia

never responded to steroids at any stage of her illness, but a remission was eventually achieved by the use of imuran and actinomycin C.

Therefore, since steroids do not sometimes benefit even diseases with a well-established auto-immune pathology that respond to the newer antimitotic and anti-metabolite drugs, these may also be of value in the treatment of disseminated sclerosis in so far as the immunological response of the patient is contributing to the maintenance of the disease process. The basic aetiology of disseminated sclerosis has not been finally established, but a case has been made out for its close relation to post-infectious encephalomyelitis⁴ and experimental allergic encephalomyelitis.⁵

Furthermore, although steroids have enabled a number of other neurological complaints to be successfully treated, such as post-infectious polyneuritis and polymyositis, not every case responds; here, too, the use of other drugs that depress immunological activity may prove effective.—I am, etc.,

F. J. LICHTIGFELD.

London S.E.23.

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Post-cardiotomy Syndrome

SIR,—In their interesting paper (September 21, p. 706) on "Immunological Studies in the Postcardiotomy Syndrome" (P.C.S.) Dr. J. F. Robinson and Dr. Wallace Brigden state that this condition is an uncommon complication of heart surgery. Yet they found it in five of 36 patients, an incidence of 14%. In reported series the incidence has varied between 10 and 40%.¹

In 1961² we pointed out that whereas in the early days of cardiac surgery this well-recognized syndrome occurred in about 5% of our cases³ the condition had become rare. Now in more than 500 consecutive patients with rheumatic heart disease treated surgically in the past seven years and reported in this *Journal*⁴ there has not been a single instance.

Mild fever may be present for a week or two following any cardiotomy, and a raised E.S.R. for a longer period, but the P.C.S. is readily distinguished as an entity characterized by the unexpected development, a few weeks or months after operation, of fever with pleural or pericardial pain, often with arthralgia and sometimes followed by relapses.

Drs. Robinson and Brigden consider that the apparent drop in frequency, to which we referred in the discussion which followed their paper to the British Cardiac Society last April, is due to an

earlier tendency to include too many patients whose symptoms were due to a direct effect of the operation and to a generally shortened duration of stay in hospital so that delayed reactions may be missed. These factors have not been operative in our series. All patients are kept in the thoracic surgical unit for 8–10 days after operation, returned to the same medical unit in which all have been previously assessed, and then transferred to the same convalescent hospital for 14 days. They are then seen again by the physician and thereafter followed at regular intervals, first after three months, then six months, and then annually. All are questioned and examined at central or peripheral clinics. Very few indeed have moved away within two years and even then we usually manage to keep in touch by letter. It is therefore probable that few if any instances of the syndrome are missed.

As in Dr. Robinson's and Dr. Brigden's series, almost all the patients in these seven years have undergone operation by the transventricular route.⁵ It has seemed probable to us that the virtual disappearance of the syndrome may be best explained by more careful attention to the toilet of the pleural and pericardial sacs. This appears to be supported by the fact that no instance has occurred in more than 100 patients undergoing a second valvotomy⁶ where the pleural and pericardial sacs are adherent, and by the occurrence of a similar syndrome in patients investigated by left ventricular puncture in the early days when a relatively large bore needle was used. In these cases leakage of blood into the pericardial sac seems the most likely explanation.

These facts do not, of course, affect the conclusion that there is strong evidence for the view that the P.C.S. is due to hypersensitivity in the immunological sense.—We are, etc.,

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Clergy-Doctor Relations

SIR,—In April, 1962, a conference of doctors and clergymen met at Lambeth Palace at the invitation of the Archbishop of Canterbury to consider questions involved in co-operation between the medical profession and the clergy. As a result, a small working party was set up to go further into some of the practical problems, and its report on clergy-doctor co-operation has now been published by

the Church Information Office. The Working Party has recommended the establishment of an Institute of Religion and Medicine with the major objectives of bringing together and providing a means of communication between some 50 or 60 clergy-doctor groups that are meeting more or less regularly in different parts of the country, to add to the number of these groups, and to promote all aspects of co-operation between members of the two professions in local areas. Other objectives are to improve training in matters of common concern both in theological colleges and in medical schools, to study the occupational strains on members of both professions, and to foster interprofessional co-operation in dealing with emotional problems of sick people and those who are psychologically ill. Questions of general hospital and mental hospital chaplaincy will also be considered.

Some 120 doctors and clergy, in about equal proportions, attended a meeting at the College of General Practitioners on October 10, 1963, to consider the report of the Archbishop's Working Party. The proposal to form an Institute of Religion and Medicine was unanimously adopted by the meeting, which also endorsed the objectives of the Institute but laid additional emphasis on some of the more theoretical aspects of co-operation at a conceptual level. The meeting also unanimously adopted a resolution to establish a provisional executive committee with the objective of formulating a constitution for the Institute, suggesting a programme for consideration by the first general meeting to be held not later than June 30, 1964, and of laying the foundations of an administrative structure.

Membership of the Institute will be open to doctors and ministers of religion of all denominations. It is proposed that the basis of organization should be a series of working parties to study and report on selected subjects to the annual conferences of the Institute. Working parties will, in the main, be organized locally, but in some instances regionally or nationally when there is a topic of wider interest to be considered. It is anticipated that all members will take an active part in one or more working parties.

There must be a great number of doctors interested in hearing more about these proposals who did not receive an invitation to attend the meeting on October 10. These invitations were sent out on a personal basis to people known to members of the working party to be interested, and we apologize to all those not included. May I invite all who are interested in doctor-clergy co-operation and who would like to hear more about these plans as they are formulated during the next few months to write to me personally at 58a Wimpole Street, London W.1.—I am, etc.,

KENNETH SODDY,
Chairman,
Archbishop's Working Party.