designated the "local medical committee." As one who has had the honour of serving in various capacities on the Herts Local Medical Committee since 1948 I have felt for some time that this is to some extent an unfortunate and misleading title. After all, a "local medical committee" is a statutory committee of practitioners duly elected to represent their colleagues with, in my opinion, an important duty and responsibility to those colleagues in matters relating to their day-to-day work, and in matters concerning their relationship to hospital and local authority services.

Consultant colleagues constitute "medical advisory committees" which have a responsible position in the hospital service, and I am satisfied that, if the designation could be altered to "medical practitioners' (advisory) committee" the position of such a body would be more clearly defined to other professional and lay bodies, who would, I hope, realize and appreciate that they exist to safeguard the position of the general practitioner, and make their contribution to the National Health Service as a whole.—I am, etc.,

Bishop's Stortford,
Herts.

R. P. GAMMIE.

Mental Retardation

SIR,—May I write in support of Dr. J. Gibson's suggestion (November 9, p. 1201) that we think again about what we call subnormality?

Terminology in the field of mental disorder and deficiency has always suffered from the unhappy associations that quickly accrue to whatever terms are used, and which sooner or later make them unacceptable, however harmless they were on first adoption: e.g., "asylum," or "mental health" itself.

The terms "subnormality" and "severe subnormality" have no biological foundation, and appear to have been adopted mainly because of the parliamentary draftsmen's need for precision even at the cost of over-simplification. However, the concept of normality on which the term "subnormality" rests is far from precise. As determined by current techniques of mental measurement, normality extends over no fewer than four standard deviations from the mean (two above and two below). Thus the "normal" are defined as approximately 98% of the population, and the 1% which falls below the lower level of normality have been designated as "sub-normal."

Recent experience in the successful training and employment of the so-called severely subnormal previously thought to be unemployable has undermined the whole notion of ineducability. Dr. Gibson's alternative suggestion of "retardation" corresponds with observed fact when applied to children, will not be misleading when applied to adults, and leaves room for the hope which many of us are now beginning to feel about

helping the retarded to live fuller and more satisfactory lives. The idea of three degrees of retardation is already familiar, and is convenient to use. With the virtual disappearance of any form of certification except where social need demands it, we do not have to continue with the use of finite definitions.—I am, etc.,

London W.1.

KENNETH SODDY.

SIR,—Dr. J. Gibson (November 9, p. 1201) has characteristically brought into the open a subject causing professional controversy since the Mental Health Act introduced the terms "sub-normality" and "severe subnormality." Nothing but confusion has been caused by the regrettable tendency to use these terms to cover a multitude of other meanings. It should be clearly understood that the terms indicate that the patient has been so classified for the purposes of the Mental Health Act, and only that.

As soon as the patient presents as a medical, psychiatric, or educational problem, any administrative label is irrelevant and tends to prejudice the outcome of treatment, as witness "untrainable" and "ineducable." Clinically, therefore, the problem is to assess the individual patient's disabilities and abilities, and to design a practical therapeutic regime tailored to his unique requirements. For the purposes of administrative planning, statistics might usefully continue to be based on the well-established and more meaningful terms, "idiot," "imbecile," and "feeble-minded." These three words are well entrenched in the research literature and have no present legal implications.

Lastly, retention of the traditional "mental deficiency" to indicate the specialty seems to meet with most approval, and gives rise to no confusion. The patients as a group might then be called just "patients" with qualification as necessary, according to clinical features. "Defectives" or "retardates," I feel, is on a par with "gastrics" or "cardiacs."

Finally, it is to be hoped that as public attitudes to handicapped people improve euphemistic "lexicon" will be a game we no longer need to play.—I am, etc.,

J. T. R. BAVIN.

Leavesden Hospital,
Watford, Herts.

SIR,—Dr. J. Gibson's letter (November 9, p. 1201) regarding terminology in mental subnormality is timely. The adjectives applied to the terms sub-normality and severe subnormality are moderate. We are not dealing with any subhuman species but with unfortunate fellow humans who are not so well endowed intellectually as those who have schemed up the terms in question.

Mental retardation is surely a better term if one has to change from mental deficiency, and there is no confusion with

the word subnormality in its legal connotation. We need finer subdivisions of our patients, and the American terminology mentioned in Dr. Gibson's letter might well be adopted. We here, showing a burst of originality, classify into three groups called A, B, and C. A are those patients whom we think will be returned to the community as self-supporting members. B group are those who, though trainable, will always require a sheltered environment both for work and leisure, and the C group are those requiring full care.—I am, etc.,

GORDON DUTTON.

South Ockendon Hospital,
Romford, Essex.

SIR,—I was very interested in Dr. John Gibson's letter of November 9 (p. 1201) advocating adoption of terms "mental retardation."

The arbitrary division into "sub-normality" and "severe subnormality" is inadequate and confusing, and by using these vague and loosely interpreted terms the psychiatrists have lost their common language. I would rather be in favour of adopting the American classification of "mental retardation," since the sub-groups of severely, moderately, and slightly retarded describe the degree of trainability and therefore serve not only as a classifying entity but also as a guide to prognosis.—I am, etc.,

W. WOLLEN.

Dartford, Kent.

Wound Closure with Adhesive Tape

SIR,—That there is a good case for sutureless closure of selected wounds, and especially those in ischaemic tissues, is well brought out in the useful article by Mr. N. G. Rothnie and Professor G. W. Taylor (October 26, p. 1027). However, before surgeons embark upon a spate of wound-taping, I feel bound to comment upon certain aspects of this subject; my remarks are largely provoked by Mr. P. J. B. Murray's paper (p. 1030).

The illustration in Mr. Murray's article shows a rather prominent hernia wound on one side which has been closed by adhesive tape and, on the opposite side, another hernia wound which has been closed by suture. The latter wound has an extremely ugly appearance with irregular-stitch marks which seem needlessly wide of the edges, and give the impression of having been tied too tight and left in too long. Mr. Murray refers to the sutures in hernia wounds being left for 10 days, and those in sympathectomy wounds for 14 and 21 days (though I realize that the longer period may have been chosen for special reasons in this investigation). Fine silk sutures, carefully inserted and removed not later than the fifth day from a groin or sympathectomy wound will normally ensure a neat scar.

Mr. Rothnie and Professor Taylor refer to the difficulty of efficient taping of

groin wounds, and, where the surgeon wishes to avoid interrupted sutures, I would suggest that a subcuticular nylon stitch can effect a neater scar than is shown in Mr. Murray's taped wound. In children's wounds (excluding those simple ones which do not require administration of an anaesthetic) it will often be better to use a subcuticular stitch rather than tape. Such a suture can be taken out with the minimum of upset; indeed, in nervous children it can often be removed whilst they are asleep. Although subcuticular sutures are often satisfactory even in ischaemic tissues, I am sure that Mr. Rothnie and Professor Taylor are right in saying that adhesive tape is far the safest method of closure for such tissues. I must apologize if I seem churlish in picking on Mr. Murray's paper, but the object of my letter is to deplore the all-too-common practice of relatively crude wound closure, sometimes with unsuitable sutures which are often left in too long.—I am, etc.,

REGINALD S. MURLEY.

Radlett, Herts.

Addison's Disease in Identical Twins

SIR.—The medical memorandum by Dr. M. E. Smith and others on Addison's disease in identical twins (November 23, p. 1316) contains an observation of particular interest. The illness in each twin appears to have begun at approximately the same time. This was also true in the case of twins (probably non-identical) reported by me,¹ each of whom developed the symptoms of Addison's disease in the same month at the age of 19. There is evidence here suggesting the operation of a biological clock set by genetic pattern. The nature of biological clocks has been discussed by W. Gooddy² and by C. P. Richter.³ The purpose of this letter is to draw attention to the value in this connexion of collecting data on the times of incidence of endocrine disease in twins.—I am, etc.,

C. P. SYMONDS.

Ham, Wilts.

REFERENCES

- ¹ Symonds, C. P., *Brit. med. J.*, 1958, 1, 100.
- ² Gooddy, W., *Lancet*, 1958, 1, 1139.
- ³ Richter, C. P., *Proc. nat. Acad. Sci. (Wash.)*, 1960, 46, 1506.

Diethylpropion and Addiction

SIR.—Dr. B. E. Roebuck (October 12, p. 936) takes to task Drs. F. Oswald and V. R. Thacore (August 17, p. 427) for their conclusions on this subject. Perhaps he will be prepared to accept the fact that a warning about addiction is more than overdue when he learns that single tablets of amphetamine are obtainable by undercover sale in various places in Britain at a cost of 1s. 6d. per tablet. Single tablets of diethylpropion hydrochloride are rated lower at 1s. per tablet. He will need to remember, of course, that

in Britain persons requiring these drugs for a truly medical reason can obtain enough tablets for a month's treatment or more from their N.H.S. doctor at a total cost of 2s. If there is a "black market" for these drugs, surely the only people willing to pay this relatively steep price are addicted persons, even if at times they do not quite fall into the strict definition of "addicts." Undoubtedly habituation may lead to addiction, and if we were only sufficiently aware of this danger we could avoid addiction.

The evidence of Drs. Oswald and Thacore is very convincing and fits the facts as we in general practice are beginning to observe them. If further evidence is required, perhaps experience of patients who have recently had diethylpropion hydrochloride sent to them directly from the U.S.A. because their general practitioner was not anxious to continue to provide this same drug might shake Dr. Roebuck's confidence in his figures. When a drug becomes an item of self-medication to such an extent, surely the slippery pathway past habituation to addiction has been started.—I am, etc.,

E. V. KUENSSBERG.

Edinburgh.

Increased Libido with Chlorprothixene

SIR.—Dr. G. Sedman's letter (October 19, p. 999) is interesting, but must one conclude that the increased libido was the effect of the drug? Is it not possible that in this patient with morbid masturbation guilt the drug acted as a heaven-sent opportunity to relieve her of guilt? I have dispensed with jargon, but this sort of situation is not uncommon in the psychotherapist's consulting-room.—I am, etc.,

London W.1.

PHILIP M. BLOOM.

Monoamine-oxidase Inhibitors and Cheese

SIR.—The following case may be of interest in the light of the recent publications on the subject of side-effects, particularly severe headache, occurring in patients under treatment with a monoamine-oxidase inhibitor and the consumption of cheese.

A young man of 26 has been under treatment for depression with phenelzine ("nardil") 15 mg. and chlordiazepoxide ("librium") 5 mg. three times a day since the beginning of August, 1963. His depression has responded very well to this treatment, and when seen on October 17, 1963, he said that he felt quite well but that six days before he had suddenly developed a severe headache. He put this down to the fact that he was doing a heavy job which necessitated bending and using a vibrating machine. Three days later he had a similar attack when the headache was extremely severe, mainly in the occipital area and spreading

over the top of the head. It lasted for about half an hour, but was so bad it caused him to come to hospital, where no abnormality was found and he was sent home.

He was asked what he had had to eat on the days when these attacks had occurred. On the first occasion he had had "a dinner of cheese sandwiches" and on the second he had had a heavy meal of cheese on toast, six to eight slices. The headache occurred three hours later.

It will be noted that in this case the monoamine-oxidase inhibitor involved was phenelzine, whereas most of the previous cases recorded have been with tranlycypromine ("parlate"). It occurs to me that the reason why the symptoms are commoner and perhaps more severe with the latter drug is that it is a more potent inhibitor of monoamine-oxidase, which is suggested by the fact that it acts more quickly and a smaller dose is required.

It would appear, however, that there is now very good reason for believing that the consumption of cheese is at least one of the major factors in causing these severe headaches, and it would seem wise to advise all patients on any form of monoamine-oxidase inhibitor to avoid eating cheese while under treatment.—I am, etc.,

J. C. SAWLE THOMAS.

London W.1.

Nomenclature of Drugs

SIR.—For the last few months, as a family doctor, I have attempted to follow the instructions given to us always to prescribe the B.P. preparation as opposed to the ethical product, and this on the face of it appears an easy exercise.

However, the problem is very much more difficult, the reason being that the ethical products are the first learnt, not only in the medical literature and from the representatives of their respective firms, but also from the consultants. We are not in the fortunate position of knowing that the chemist will prescribe the B.P. preparation if the ethical one is named on the prescription. In our area, it is the common practice for the hospital pharmacies to dispense B.P. or hospital-made products for any drug prescribed by the ethical name.

May I make a plea for more uniformity in the names which are given, easier names, and greater co-operation with the trade? It is, on the whole, rare for two firms to make the same product, and therefore it might be easier to come to some agreement with the pharmaceutical industry about this whole problem of nomenclature. Fashions and usages change, and, having learnt perhaps in 1963 40 or more of the current drugs in common use by both names, by 1967 I would guess a proportion of these drugs will have gone out of use and a further lot of double nomenclature will have to be learnt—this seems a wasted effort.—I am, etc.,

C. H. D. BARTLEY.

Wimborne, Dorset.