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Which treatments work for drinking problems?

SIR,—Professor Griffith Edwards's leader (2 January, p 4) summarises in a concise way current views on the effectiveness of treatment of drinking problems. Some of the statements in this review, however, are apt to be misinterpreted by cost conscious managers and others, who could come to the conclusion that they should leave the responsibility for treating this group of people to the voluntary and primary care agencies and decide not only to deprive mental health units of necessary funding to establish alcohol and drug services but also to consider closing these where they exist—a course of action contemplated in this district some time ago.

As has been pointed out,¹ primary care workers do not, by and large, possess the necessary skills, nor have they the time or the willingness, to treat problem drinkers. Moreover, if they were to acquire these skills it would inevitably increase the number of patients detected with higher degrees of disabilities who perhaps require specialist help.

Case register data from the Worcester Health District, where a substance abuse service has operated for some years, have indicated that the annual prevalence of substance abuse problems was 118 per 100 000 population in 1984 (105 alcohol and 13 drugs) and 151 per 100 000 in 1985 (112 alcohol and 39 drugs)² whereas the corresponding rates per 100 000 population in 1984 were 133 for schizophrenia and 147 for affective psychosis. Thus patients with alcohol and drug problems constitute a sizable and still growing proportion of the total psychiatric case load in a semirural district.

Furthermore, these patients have considerable medical, social, and legal problems, which had been previously attended to by a variety of professionals, who in turn often had not recognised that these were related to alcohol.

Many districts still do not provide specialist treatment services for this large group of patients with considerable handicaps. Capital outlay to set up a comprehensive community substance abuse service needs to be minimal. The revenue costs in the Worcester Health District are in the region of £100 000. This forms a small part of the total budget of the mental health unit, which at the moment is £7m a year.

A team of this type, integrating the voluntary and statutory sectors into one continuum of care, can effectively respond to a variety of client or patient needs, give training and support to primary care workers, and stimulate and coordinate local alcohol and drug abuse prevention strategies. I would suggest that it is also a good buy.

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The future of medical microbiology

SIR,—From representations being made to me by consultant microbiologists from all over Britain it is apparent that many are deeply concerned that some recent events could undermine not only the service that they provide but also the future of medical microbiology in Britain.

Firstly, the role of medical microbiologists in infection control is being questioned. For over 30 years they have been responsible for developing and implementing policies and procedures for controlling infection in hospitals, and they have not been unsuccessful. Hospital infection control is now an integral part of the practice of medical microbiology, and Britain leads the world in this subject. Consultant microbiologists have built up a body of knowledge and experience, which is being passed on to doctors in training, who must face questions on the subject in their examinations for membership of the Royal College of Pathologists. Unfortunately, at a time when microbiologists should be directing their undivided attention to solving such serious problems as those presented by the spread of multiple antibiotic resistant organisms and the acquired immune deficiency syndrome they are being diverted from the task.

Since the introduction of Griffiths management some district medical officers have shown a desire to assume an increased responsibility for hospital infection control. Unfortunately, although they may have statutory obligations and duties, few have the knowledge, training, and experience necessary for anything other than a managerial role. Yet microbiologists can find their authority eroded, their effectiveness reduced, and their time consumed by the new administrative arrangements.

The second area of concern results from a growing tendency to regard clinical pathology, including microbiology, as a purely technical service with laboratories looked on as mere processing units which, like slot machines, will issue results if they are fed with specimens. In this scenario the professional role of medical microbiologists working at the interface of clinical and laboratory medicine is disregarded, either because it is not appreciated or because the sort of bucket shop service which could be provided without them looks cheap. The concept of a medical microbiology service without doctors should be as unacceptable as a surgical service without surgeons. Medical microbiologists know that most of their clinical colleagues recognise the importance of the service provided. I hope that they will help us to defend it.

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Response to deoxycoformycin in T cell leukaemias

SIR,—Dr A D Ho (5 December, p 1483) comments on our results on the treatment of mature T cell leukaemias with deoxycoformycin (10 October, p 873). His experience does not appear to confirm a correlation between the membrane phenotype of the neoplastic T cells and the response to deoxycoformycin. We have now extended our results to 28 patients treated by deoxycoformycin (table) and these show even more clearly than before that no meaningful responses were observed in cases with a phenotype other than CD4+, CD8—.

One possible explanation for the differences observed is that the largest group of our patients,

Response to deoxycoformycin in post-thymic T cell leukaemias

Phenotype	No	Responders*	No remission
CD4+, CD8—	15	10 (67%)	5
CD4+, CD8—	8	0	8
CD4—, CD8+	5	0	5
All cases	28	10 (36%)	18

*Partial and complete remission.

11, had T polymorphocytic leukaemia,¹ a disease represented by one case in Dr Ho's study. Possibly the type of T cell disease may be just as important in relation to the effect of deoxycoformycin as the cell phenotype. For example, eight of the T polymorphocytic cases were CD4+, CD8— and six (75%) experienced a good response. In contrast only one out of six patients with adult T cell leukaemia/lymphoma (four were CD4+, CD8—) experienced a remission. We do not agree with Dr Ho that different definitions of remission could account for our results as some of our complete responders had prolonged periods (more than 20 months) free of disease without requiring further treatment.

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1 Matutes E, Talavera JG, O'Brien M, Catovsky D. The morphological spectrum of T-polymorphocytic leukaemia. *Br J Haematol* 1986;64:111-24.

Gonadotrophin hormone releasing analogues open new doors in cancer treatment

SIR,—In reply to my leading article (31 October, p 1084) Messrs A J Arnold and A D Desmond (12 December, p 1565) advocate the use of subcapsular orchidectomy for patients with prostatic cancer and suggest that "patient acceptability in elderly men is high."

At present three monthly depot injections of gonadotrophin releasing hormone analogues are under clinical investigation and have been shown to suppress testosterone over this period. If the patient is given a choice by his clinician of an injection once every three months or an operation I suggest that in almost every case he will prefer injection treatment. The cost at present is relatively high but no more expensive than that of cyproterone acetate treatment. Most drugs when introduced are expensive. This reflects development costs, and after an initial period the cost inevitably comes down.

Messrs Arnold and Desmond are advocating the use of a primitive and mutilating procedure and ignoring a clinical advance of advantage to the patient, who has enough, dealing with the idea of cancer, without having to experience surgical orchidectomy as well.

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Obstetricians on the labour ward

SIR,—Mr J S Samra and others (12 December, p 1566) express surprise at the findings of Ms Coupland and others (24 October, p 1077) and highlight directly and by implication the fears of many hospital doctors over two tier working. As a consultant obstetrician who elected to move from three tier to two tier working, may I seek to allay some of these fears.