Perianal abscess: "Have I excluded leukaemia?"

Sir,—Dr David N Slater’s Lesson of the Week on leukaemia presenting with perianal abscess (15 December, p 1682) concluded that all patients presenting with a perianal abscess should have a full blood count and differential white cell count performed preoperatively to exclude leukaemia.

Although perianal abscesses is clearly a common surgical emergency, it is an uncommon presenting feature of leukaemia. In a health service which at present does not run mass screening programmes for the commoner causes of death from cancer it is unjustified to recommend these investigations routinely for all patients as a preoperative screen for leukaemia. This takes into account the expense of performing many of the investigations out of normal laboratory hours and the fact that the blood count for a perianal abscess is likely to be very low. The conclusion reached from these two interesting but uncommon cases is invalid when the subject is taken in a broader context.

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Mental Health Act

Sir,—Recent correspondence concerning the Mental Health Act 1983 (1 December, p 1542; 15 December, p 1694) has not yet highlighted a problem which troubled many psychiatrists working under the old (1959) Act and which unfortunately has not been resolved under the 1983 Act. Urgent discussion of this issue may be required, since the new body set up by the Act, the Mental Health Act Commission, may rule that a practice followed under the old Act and, of necessity, under the new Act should be regarded as illegal. The problem can be illustrated by the following case.

This man was diagnosed in 1971 as suffering from parasitic hallucinations. Experience has shown that while he takes injectible psychotropic drugs he remains almost symptom free; when he does not he relapses. Experience has shown that neighbours and workmates are plotting against him, that his house is bugged, and that messages are being conveyed to him by newreaders on television. At such times he has carried a knife and has terrorised his family, to whom on occasion he has been physically violent. Three times in the last 13 years. Each occasion has been for one reason or another been stopped and he has relapsed soon afterwards. He has now relapsed while taking medication.

He has never himself accepted the need for regular medication, though it has been possible to maintain him well on low doses—for example, fluphenazine 12.5 mg fortnightly.

In these circumstances and to ensure that he continued to take medication he was detained under section 26 of the Mental Health Act 1959, though almost all the time he was out of hospital on leave, working, and living with his family. He was seen regularly by the GP and by nursing staff but, in addition, had been recalled from leave to stay overnight in hospital once every six months, to that he demonstrated. The length of this procedure seemed to the responsible medical officer to be undesirable (since it used a provision of the Act in a manner which was not intended) but unavoidable if relapse and danger were to be prevented.

Unfortunately no better procedure is available under the new Act. Indeed, it appears that the commission may issue guidelines to say that this practice is improper.

Inquiry among our colleagues suggests that it is common for a consultant psychiatrist to be looking after one or two patients who previously, under this type of problem, the importance of the issue goes beyond the small numbers affected. On the one hand, if untreated, such patients represent some of the most dangerous of the mentally ill, who, should they relapse on their delusions, may require a place in a special hospital. On the other, if treatment in the community cannot be enforced then the alternative must be to keep these patients resident in hospital permanently. This is contrary to good patient care, national policies for the mentally ill, and common sense.

We understand that when the present Act was being framed the possibility of including a community treatment order was considered. Is it not time for such a proposal to be revived and enacted?

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The faults reported in the GP’s letter do indicate that the senior social worker was wrong not to send out an approved social worker to make an assessment when the GP requested it. The social worker is the person who makes an application for admission and in this case it is up to him or she to decide whether or not a section 2 admission should be considered. If, however, he or she could decide that such section, if any, was appropriate without seeing the potential patient. On the other hand, the inability of the doctor to get a speedy response to his request for a domiciliary visit, and, therefore, of the medical recommended as required for a section 2 admission is an example of a more widespread problem. Any person who is going to be deprived of his or her liberty, even when there is good reason, is entitled to a full and competent assessment, and the Act, save in emergencies, defines this as meaning the involvement of two doctors. Social workers are correctly trained to understand that one of their roles is to ensure that this happens and one of the hindrances they have to cope with is the unwillingness in many areas of health authorities and hospital doctors to develop procedures to enable this good practice to be possible.

Obviously the social worker’s failure to bring the correct forms was inefficient. Before GPs cast too many stones, however, they should perhaps consider putting their own house in order. Unlike social workers, most GPs have not received training in the Mental Health Act despite the fact that they often play a crucial part in its implementation.

Many of the problems of the type referred to in the GP’s letter could be circumvented if all those concerned in implementing the legislation actually talked to each other more and developed codes of practice that offered the opportunity to resolve the conflicts that necessarily arise from the different professional ideologies of those concerned in implementing the Act—and which are one of the major safe guards offered for the protection of the patient.

William Withering and digitals

Sir,—Unless my memory is at fault there is an account in Tacitus of a king of Parthia at death’s door with bodily swelling and shortness of breath. His son, covetous of the throne, determined to expel his father’s demise. He had him poisoned with foxglove. To his intense chagrin the father recovered from his illness and, while not in rude health, showed every sign of living on.

Public rejoycing was brief. The son had him strangled.

This must be the first account of (involuntary) digitals therapy. Finally, I can only lament that Withering’s (5 January, p 7) did not publish his findings 12 months earlier. Digitals might have given Dr Johnson a few more years of life (he died in December 1784).

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Patient leaflet might become confused when reading an "imported" leaflet and at least temporarily lose much of the benefit to which he or she is accustomed. The Allen and Hanburys UK instructions for Ventolin and Becotide are virtually identical and are in the process of being endorsed by the Asthma Society and Friends of the Asthma Research Council for introduction progressively across the range of aerosol preparations.

Finally, the instructions quoted for UK Becotide are from an up-superceded leaflet and the current instructions are consistent with those quoted by Drs Pozniak and Johnson from the "Italian Becotide leaflet." These quotations are in fact from a leaflet intended for the Middle and Far East and it would appear that the instruction leaflet has been placed into an Italian aerosol package by an agent outside the Glaxo group and hence beyond our control. This of course emphasises my third point.

Examples such as these serve to emphasise some of the important drawbacks associated with the parallel importing of ethical products.

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3 Parliamentary Committee on admission to mental hospitals. Chichester: John Wiley and Sons, 1980:69.