communication is unlikely to mention what information has been given to the patient. It is obviously undesirable for a general practitioner to know that the patient before him or her has cancer, yet to have no idea what the patient has been told. The effort required to improve this aspect of hospital discharge communications is very small.

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Unilateral headache

Sir,

During the last 12 months I have seen four patients with unilateral headache, three of whom also had ipsilateral tinnitus. The symptoms had lasted for three weeks or more and all the patients were women, aged 39–56 years. On enquiry, all four patients described having had cold sores of the lip or nasal area on the ipsilateral side, between three and 13 weeks before the headache appeared.

Joseph and Rose[1] have suggested a possible link between herpes simplex and cluster headache in a 42-year-old man. In their case, the headache actually preceded the cold sore by four to five weeks. Hardebo,[2] from Sweden, described a 32-year-old man who had chronic left-sided cluster headache one week after ipsilateral herpetic labial lesions. In neither case was tinnitus a feature.

Cluster headaches tend to affect men. In my cases the headache was mainly temporal, spreading over the eye and on to the maxillary area. The eye tended to water. The pain was present throughout the day, with several episodes of increased severity.

It seems possible that the herpes simplex virus can affect the trigeminal nerve. It is more difficult to explain how the virus affects the vestibular nerve. I wonder how frequently unilateral persistent headache in middle-aged females may be attributable to herpes simplex infection?

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Management of drug abuse in general practice

Sir,

I was interested to read the editorial by Dr Chang (June *Journal*, p.248) and I particularly approved of the way that she highlighted the benefits to be gained by an addict from membership of Narcotics Anonymous and of the help that families can obtain from their membership of Families Anonymous. I was also struck by her last paragraph where she mentions the benefit that doctors obtain from their contact with these patients.

However, I was disturbed that the editorial was presented as a clinical impression. It was unreferenced and statements such as 'Methadone is at present considered to be the drug of choice for detoxification' and 'Maintenance prescribing is actually counter-productive to recovery' were unsupported. The editorial also did not mention the fact that patients who misuse drugs are a heterogeneous population with only 0.03% of heroin users remaining in a phase of long-term dependent use.[1]

G.E. Vaillant of Harvard University medical school in his centennial address to the Society of Addiction in 1984 commented that the mean period of addiction for long-term heroin addicts was 10 years. This suggests that if addicts can survive and be supplied with drugs in a controlled fashion for an average of 10 years then they are likely to give up. If we accept this and also take into account the dangers of adulterants in street heroin[2-4] there is a case to be made for supplying methadone under controlled conditions for some addicted patients over a longer period than the short reduction schedules mentioned in the government guidelines.[5] The government itself has recognized that the rising incidence of the acquired immune deficiency syndrome has changed the cost-benefit equation in supplying maintenance methadone prescriptions for some long-term addicts. This is not necessarily a policy of despair and a *carte blanche* for providing drugs forever to addicted patients. However, it does involve a redefinition of one's aims in looking after these patients. In my practice our overall aim is to help addicted patients to lead a drug-free life. By supplying them, first of all, with a methadone prescription we try to give them personal space to plan for any changes in their life that are necessary to becoming drug free.[6]

One final criticism of the editorial is that the author does not produce any outcome measures for the method of management she is advocating. In my practice we have carried out an audit.[7] We have looked after 31 patients over four years and three have become drug free. One patient, who in the eight years before he was cared for by the practice had never been out of prison for more than four months at a time, has now been out of prison for four years, has stopped sleeping rough on the river banks and has his own council flat. One girl who remains addicted to a low dose of methadone has had a baby after several terminations of pregnancy. One family who had their children taken into care have got their children back and are living a relatively stable life. One man who used to drink 150 units of alcohol per week as well as taking methadone is now teetotal.

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Sir,

Dr Chang's editorial makes important points regarding the natural history of drug use and the appropriate use of the family as a therapeutic resource. It also highlights the disadvantages of prescribing by general practitioners. The answers, however, are not as simple as 'Don't take drugs; go to meetings'. While the outcome for many drug users is a natural progression to the drug-free state over a period of years (and meetings) the damage done during these years must surely be of primary concern. Short term abstinence may not be possible and many drug users continue to inject in an increasingly controlled way with the sort of support suggested by the author. It is important, however, to mention the increasing