BALINT GROUPS IN GENERAL PRACTICE

Sir,

The Education Committee of Council has set up a small working party to report on the future use of Balint groups in vocational training and in continuing education. As convener, I should be very pleased to hear from any of your readers with first-hand experience in starting and running of such groups, especially outside London. We should like to know how large the groups are, how often they meet, for how long, the venue, who leads them, their life expectation, and whether they are recognised for Section 63 purposes.

We are particularly interested in the source of the initiative, and in learning about official encouragement, or otherwise, which organisers may have experienced. We are hoping to make some measurement of unsatisfied demand outside London because there is a prospect of the Balint Society co-operating with the College and providing suitably trained leaders, but for the purpose of this study we should like to know about any continuing group composed predominantly of general practitioners, with or without a leader, where case discussion forms the basis of the meeting, and whether or not psychological problems are the focus of attention.

In other words we are interested not only in Balint groups of the classical form but also in those with perhaps a research or topic orientation, just so long as they employ the Balint process and are based on the current professional experience of their members, subjected to the critical scrutiny of colleagues.

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MEDICAL AUDIT

Sir,

I found the articles on medical audit in your September *Journal* both interesting and stimulating. In discussing motivation to audit I welcome Dr Curtis's inclusion of the less intellectual but realistic motive that we, as practitioners, develop evaluation rather than await a government sponsored system of quality control.

It seems almost axiomatic to state that audit will be impossible without an improvement in general-practice medical records. The ease with which methods of evaluation can be tested in the presence of good medical records is well demonstrated by the 'delay pattern analysis' of Keith Hodgkin. However, the low velocity move towards A4 folders is such that one would think that our contractor does not appreciate this.

In our new administrative structure, with the emphasis on future planning, accurate and comprehensive morbidity, demographic data is of importance to more areas than general practice itself. This, in addition to the spiralling costs of medical records and the increasingly sophisticated technology of data handling, suggests that urgent consideration be given to the whole question of financial responsibility for general-practice medical records.

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REFERENCE
Hodgkin, G. K. (1973). *Journal of the Royal College of General Practitioners*, **23**, 759.

TREATMENT OF MULTIPLE SCLEROSIS

Sir,

Following the preliminary report by Dr Schapira in the June *Journal* of the treatment of two of his patients with multiple sclerosis with the antiviral agent amantadine, I feel that it is worth reporting the following case history.

J. M., aged 47 years, first seen in July, 1970 complaining of discomfort in his left eye. His visual acuity was 6/6, 6/6 and there were no signs of disease. By December, 1970 he had developed amblyopia with visual acuity reduced in the left eye to 6/12 and a scotoma was present. The provisional diagnosis then was optic neuritis.

In September, 1971 vision in the left eye had fallen to finger counting at three feet and the scotoma had extended to more than 10°. The left disc had become atrophic, the right eye was normal and he had become used to monocular vision. By December, 1971 his right eye was becoming affected, and the following month he was admitted to Maida Vale Hospital for neurological investigation. These were not conclusive but the diagnosis lay between multiple sclerosis or a glioma infiltrating the region of the optic chiasma.

At this stage, I became aware of the possibility of treating multiple sclerosis with amantadine (J. G. Hunter—personal communication) and, with little to lose, the patient agreed to start amantadine in the dose of 100 mg. b.d. on 11 February 1972.

In September, 1972 he was re-admitted to Maida Vale Hospital for reassessment. The vision with his right (good) eye was still affected but variable, being worse in bright sunlight, after meals and after exercise. A craniotomy was performed and the appearances were still inconclusive, but favoured demyelination rather than an optic nerve glioma. He was then started on prednisolone 5 mg t.d.s., in addition to the amantadine. The vision in the right eye recovered and has remained good since.

After a year of prednisolone 5 mg t.d.s., he developed some 'moonface' and, in November