pressure placed upon services for drug users by the human immunodeficiency virus. Although the debate about substitute prescribing is something which needs to be increased rather than swept under the carpet where it has been for 20 years, we cannot ignore the threat of the acquired immune deficiency syndrome. The first priority now for many doctors is to keep drug users uninfected for long enough to allow recovery or progress to controlled use.

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Dr Robertson makes an important point. It was my decision to omit any consideration of AIDS in the editorial by Dr Chang because we intend to publish a further editorial on this subject in the near future. Ed.

Sir,

Dr Chang is right to highlight the plight of families of opiate addicts and to suggest that their suffering is underrecognized. However, she goes beyond the available evidence when she states that 'getting involved with the family is of far greater benefit than counselling the addict or prescribing or indeed any other form of therapy'. Her explanation for this statement is the fact that families 'enable' their addicted relative to escape the consequences of their addiction.

Having experience of the management of opiate addiction in both general practice and as a member of a specialist drug dependency clinic I consider that such 'enabling' plays a very small part in the perpetuation of addiction. The most impressive thing about established opiate dependency is the sheer resistance to change in most cases despite disintegration of marriages and families, debt, imprisonment, disease, and indeed despite all interventions be they medical, penal or social. This, sadly, is the realistic starting point for planning management for many addicts.

Dr Chang does not mention referral to specialist drug dependency services. There is a good case for referring 'hard-core' addicts as such individuals are usually time consuming to deal with and may be awkward and aggressive. With their multidisciplinary input, specialist clinics can offer inpatient detoxification, counselling about pregnancy and about human immunodeficiency virus infection and can monitor their patients more closely with urinalysis. I think there is a place for maintenance prescribing in such clinics to try to keep confirmed addicts stable until they enter that mysterious process of maturation out of their addiction. The existence of specialist services leaves no excuse for those general practitioners who refuse to accept suspected or known addicts onto their list.

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Managing the difficult patient

Sir,

Towards the end of an excellent article on 'Managing the difficult patient' (August *Journal,* p.349), I encountered a paragraph beginning 'Sharing the burden...'. I thought this would be an elegant summary of the role of the doctor with these difficult patients, in helping them focus on and discuss their various social problems, along the lines of a problem shared being a problem halved.

Sadly, the paragraph actually suggested sharing the care of difficult patients with one's partners, which, while undoubtedly superficially attractive, really amounts to running away from the problem and seems contrary to the tone of the rest of the article. In fact, in an earlier paragraph a similar ploy of referral to specialists 'primarily to allow the doctor to escape from contact with the patient' was described as unnecessary.

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Pathogenesis of urethral syndrome

Sir,

The author of a book is entitled to expect that a reviewer for a serious journal should give potential readers an idea of the book's purpose and content.

In the August *Journal* six of the seven book reviews published did just that. The seventh, that of my book *Urinary tract infection in clinical and laboratory practice,* made no such attempt. The reviewer chose rather to highlight two small and one rather larger aspect with which he apparently disagrees, and to dismiss the whole book in somewhat personal terms.

In my view, the argument over the pathogenesis of urethral syndrome is a scientific one which must be resolved on the basis of scientific evidence. Unlike the microbiologists at the Royal Free Hospital I have never wished to conduct the debate in a personal way and I am content for my case to rest on the evidence.[1] The decisive rebuttal by careful research mentioned by your reviewer consists of one paper.[2] Patients with symptoms were investigated on one occasion only; the isolation rate of lactobacilli and the presence of pyuria were similar to the figures obtained in our laboratory. The authors' dismissal of the significance of these organisms rested upon their observation that lactobacilli were also isolated from controls. Their controls, however, were either pregnant women (from whom there is a large body of published evidence that fastidious organisms are frequently isolated) or women who were subject to urinary tract infection and had been treated for it. If my hypothesis is correct, that the cause of urethral syndrome is an imbalance of urethral commensal flora, analogous to *Candida vaginitis,* patients who have recently received antibiotics are also inappropriate as controls. It is well documented that many women who suffer from bacterial cystitis are also subject to urethral syndrome.[3] I have suggested that the latter is fuelled by antibacterial treatment given for the former. In our two-year prospective study[4] — the only one in which patients have been investigated on more than one occasion — the controls were selected appropriately as having had no urinary symptoms for one year and no antibiotics in the previous three months. The isolation rate of lactobacilli differed significantly between patients and controls. This finding was confirmed more recently by other authors who also used appropriately selected controls.[5]

We continue to amass further scientific data on the role of fastidious organisms in the urinary tract of the very large number of patients (including those with interstitial cystitis, prostatitis, and irritable bladder) who complain of urinary symptoms for which conventional microbiology finds no explanation. I am averse, as your reviewer says, to attributing psychological causes to conditions for which there is objective evidence (clinical, microscopic, histological and occasionally radiological) of disease. Despite your reviewer's view that I am 'out of touch with the clinical world' — unlikely when one is married to a general practitioner — I continue to look after a large number of such patients in a urinary infection clinic. Many of them have not been helped by the conventional management that they have received from their general practitioners or from various specialists. I have no doubt, from the clinical and microbiological evidence, that the great majority suffer from organic conditions.

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Alternative medicine

Sir,

The letter from Dr Grogono (July *Journal,* p.326) has stimulated me to give an account of my own experience of complementary medicine. I am a founder member of the College, and retired to Italy after nearly 30 years in National Health Service general practice in London. I am now nearly 76 years old and still work as a part-time consultant in primary health care in the Italian health service.

In January 1987 an ultrasound scan revealed a mass in the region of the pancreas following some years of chronic diarrhoea. Subsequent laparotomy at the Whittington Hospital in London confirmed the presence of a tumour in the head of the pancreas — 'the size of a cricket ball' — which on section proved to be an adenocarcinoma. A double by-pass was done to reduce the risk of obstruction but no attempt was made to resect the tumour. My hospital specialist advised no chemotherapy or radiotherapy, although they gave me tamoxifen on the basis of some favourable reports of its use in cancer. They also gave me pancreatic enzymes but could offer no further orthodox medical care.

By chance I heard of macrobiotics, the revival of Japanese traditional medicine, based in Boston, USA. I read anecdotal reports that patients with inoperable cancer believed they had been helped by the macrobiotic diet and way of life. After a consultation with Michio Kushi, the director of the Kushi Institute in Boston, I decided to follow his advice on diet, exercise and positive thinking.

Now, some 17 months after my operation, I feel extremely fit, with more energy than I have had for years. Fortunately my hospital consultants are open-minded and accept my decision to try complementary medicine since they had nothing else to offer. I still see them regularly when I go to London, and still continue to take the pancreatic supplement and tamoxifen. Periodic blood examinations have revealed no abnormality and subsequent ultrasound scans suggest that the tumour is shrinking and may be liquifying in the centre.

I do not know why I appear to have joined the scanty ranks of those with 'spontaneous regressions' of pancreatic carcinoma. I can offer no scientific evidence that this is due to macrobiotics. Nor am I equipped to analyse the theories and practice of traditional Japanese medicine. I have not abandoned 'scientific medicine' which clearly has many dramatic achievements to its credit. However, accounts of recent research, in particular in physics and neuropsychology, suggest that some of the Cartesian mechanistic science I was taught at medical school may need to be modified.

Meanwhile I make a plea for further research and cooperation with our colleagues in complementary medicine. I am sure that some of them are helping some of our patients with problems we have not yet solved. Attitudes such as Dr Grogono's can only rob our patients of such help or drive them to reject orthodox Western medicine completely.

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Sir,

Dr Grogono reproaches us for failing to criticize an article on homoeopathic medicine (March *Journal,* p.119) and goes on to attack various forms of alternative medicine, voicing a point of view which is less strongly held now than it formerly was. In regard to chiropractic and acupuncture, Dr Grogono should first have considered the British Medical Association's report on alternative therapy,[1] which states in regard to manipulation, osteopathy and chiropractic 'Subject to this [ordinary precautions] properly trained and registered lay practitioners can provide a safe and helpful service' and in regard to acupuncture 'There is a scientific basis for claims that acupuncture is effective as an analgesic'.

I have no personal experience of acupuncture, but following instruction in dowsing by the late Dr R.J.F.H. Pinsent, I can now use dowsing[2] without instruments to locate acupuncture points and acupuncture meridia. The method I use could have been available to the ancient Chinese originators of acupuncture.

It appears to me that many of the apparently bizarre forms of alternative medicine may have an acceptable scientific basis in biophysics, in contrast to our familiar medicine which is largely biochemistry based.

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Trimethoprim for urinary tract infection

Sir,

Trimethoprim in a single dose of 100 mg for urinary tract infections (July *Journal,* p.320) sounds an excellent idea. As the authors say 'why give more?' However, I wonder what my patients would feel about £2.60 for one tablet (basic National Health Service cost 3p)?

I would be interested to hear of any comments on this question.

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Mobility and attendance allowance

Sir,

Two errors in the article on mobility and attendance allowance in the *Members' reference book 1987*[1] have already been pointed out by Anne Grafton.[2] There is a further error which I should like to correct.

Car parking priorities are obtainable by those in receipt of mobility allowance, but this is dependent upon receiving the orange badge issued by the local authority social services department.

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