illustrates the limitations of spontaneous ADR reporting and the possibilities of exploiting the National Health Service with computer-based record-linkage schemes to provide a data base of many millions of patients and good interpretable data on which to base rational decisions. Perhaps only then will the alarms generated by the present spontaneous reporting schemes become a thing of the past.

Peter J Keen
Editorial Representative, Library (Scientific Research) Section

(Accepted 31 October 1989)

Letters to the Editor

Preference is given to letters commenting on contributions published recently in the JRSM. *They should not exceed 400 words and should by typed double-spaced.*

Transsexuality

The views of Mrs Somerset in her letter (August 1989, *JRSM*, p 509) challenge those of us who recommend gender reassignment for some transsexual patients. The views require reply. The belief that transsexualism is a coping device to absolve guilt over homosexual inclination is not supported by the considerable literature on the subject. Certainly the outcome of gender reassignment may be poor, especially if doctors are prevailed upon to undertake these proceedings without full observation and allowance of time to assess the patient's ability to live in, and be accepted in, the gender role to which they aspire. However there is a proportion of applicants for gender change who can do so and for these people their quality of life will be improved by gender reassignment. I wrote[1] that assessemnt of outcome be undertaken independently of the clinical team and I now report an outcome study undertaken by Mr A Butler, Senior Lecturer in Mental Health Social Work at the University of Leeds. Mr Butler fulfilled the criteria for independence and lack of bias for or against gender reassignment. He reported on the first five consecutive male to female patients who had proceeded through all stages of reassignment including vaginoplasty, since the establishment of the Gender Identity Clinic at Leeds. His assessment was made at the patients' homes about a year following operation. The essential findings are: (1) all patients expressed satisfaction with the procedures including the surgical result; (2) no patient showed evidence of emotional instability; (3) four of the five had improved in social relationships and self-confidence; two of the five had broken off relationship with their family prior to referral to the Clinic but, for those who remained in contact, all stated an improvement in the quality of their relationship. This report of our interventions gave us confidence to continue with the difficult procedures of reassignment; to fail to provide such facilities for suitable patients is a failure to relieve remediable distress.

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To the discussion on transsexuality between Dr Armstrong (February 1989 *JRSM*, p 103) and Mrs Somerset (August 1989 *JRSM*, p 508), I wish to contribute a very old legal point of view which is to be found in para 19-23 of *General Commmon Law for the Prussian States* new edn 1806; Berlin: G C Nauck, namely:

para 19. If transsexuals are born the parents choose which sex the children will have during their education.
para 20. That person will be at liberty after completing their 18th year to select which sex he/she will hold in future.
para 21. After this decision his/her rights will be judged accordingly in future.
para 22. If the rights of a third party are involved by the transsexual's sex decision, this third party can insist on an investigation by an expert.
para 23. The expert's finding is made independently of the transsexual's or the parents decision.

I think this regulation per legem has been very wise as well as intelligent.

H-J MAURER
Bodolz-Enzisweiler, FRG

Pioneer Health Service, Peckham

Thank you for reminding us about Pioneer Health Service, Peckham (October 1989 *JRSM*, p 577) and the fact that 86% of males and 96% of females had disorder(s) 40 or 50 years ago.

Having served the NHS since its foundation, and having made small contributions here and there to the technological achievements of our organization, it makes me proud to read about the improvements we have produced since that primitive era. It is surely a matter for congratulation that BUPA can examine 10 400 workers aged 25-44 years (*Daily Mail*, 29 October 1988) and report that only 83% of males and 75% of women are unfit; no more than 30% of all employees have dangerously high cholesterol levels; and that blood pressure, alcohol problems and lack of exercise are rated no higher than rife today.

What on earth would have been our condition without the NHS?

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Medical student selection

It was depressing to read the complacent reply to Roberts and Porter's paper (May 1989 *JRSM*, p 288) by Roath (September 1989 *JRSM*, p 574).

He recognizes imperfection in the system of medical student selection but thinks it difficult to improve upon. He states that women now have better opportunities, that racial discrimination balances out (two wrongs make a right) and finally he regards interviewing as next to useless. These are his opinions but where is his evidence?

Roberts and Porter argue that selection should be based upon psychometric tests rather than 'scientific' achievement in A level. This is ill conceived. Modern medical practice requires an understanding of science combined with humanistic skills. To emphasize only one would be a serious error. Furthermore, how would these tests be used? If you score low, are you rejected? What criteria does one use to choose a doctor who may become a psychotherapist or molecular endocrinologist? The whole process becomes impractical since the endpoint is impossible to define.

The interview is indispensable. It is clear that interviewing gives a broader picture of the individual and allows less reliance to be placed on pure academic ability[1]. Moreover, educational achievement and personal development depend upon opportunities in the community and school and cannot be assessed in an abstract way.

The present system can be improved by increased awareness of interviewing faults and bias. The change in the selection process should not be dramatic but should emphasize the subtleties of candidates' potential value as doctors. Selecting medical students demands experience and perhaps training. Further tests and assessments will not help. What is needed is an audit of all selection in all medical schools organized, reviewed and acted upon by the General Medical Council. Only this will provide firm evidence for appropriate feedback and is infinitely better than relying upon a range of unsubstantiated opinions[2].

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Importance of early diagnosis of acute spinal extradural abscess

The paper by Statham and Gentleman (October 1989 *JRSM*, p 584) is timely in more ways than one. I would like to lend my experience to stress the important diagnostic factors which they mention because an extradural abscess is lethal and there is no time to wait for or seek magnetic resonance imaging and I believe that even myelography is contraindicated as the introduction of fluid into the epidural space could burst the abscess.

I have been asked to see six such patients in my career whose major complaint was acute back pain. The clinical features which lead to the diagnosis are restlessness, sweating and high fever and the patient looks sick and apprehensive. There is well localized acute tenderness on *gentle* percussion over the spine at the level of the abscess and, in my cases, there was clear sensory deficit to pin prick around the trunk two levels below the elicited tenderness.

The diagnosis was made early and decompression was performed early and there were no neurological complications in any of them. One of the six, however, died but that was because of the lack of experience of the other consultants who insisted on relying on the effectiveness of heavy antibiotic treatment. By the time the young lady came to surgery her natural immunity was zero and her white count depressingly low.

Surely, the lesson to learn in these days of high tech diagnosis in medicine is that, when there is pus it does not disappear with antibiotic treatment and must be drained. The old fashioned practice of medicine still has its place in our professional lives.

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Tinted spectacles

I was interested to read the account of tinted spectacles as a physical sign of psychoneurosis in a group of 20 patients (mean age 54.65 years, female to male ratio 4 : 1) by Howard and Valori (October 1989 *JRSM*, p 606). However, I would make a plea that such findings should be viewed with caution.

Blepharospasm is a focal dystonia of adult onset which can be severe enough to cause functional blindness. In a recent study of 264 patients[1], the mean age of onset was 55.8 years, and the female to male ratio 1.8 : 1. Bright lights increased the intensity and frequency of spasms in 50.7% of patients, with the result that many sufferers obtain some relief from wearing tinted glasses. The variability of the spasms is a well-recognized feature, so that they may not be evident on a visit to the doctor. Unfortunately, blepharospasm patients are commonly misdiagnosed as suffering from some psychiatric disorder, and this error can be magnified if the wearing of tinted glasses is taken as a sign confirming psychoneurosis. Since effective treatment, in the form of local injection of botulinum toxin, is available, it is crucial that blepharospasm patients wearing tinted glasses should be correctly diagnosed, and not labelled as 'psychoneurotics'.

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Reading the paper by Howard and Valori (October 1989 *JRSM*, p 606) reminded me that about 30 years ago the consultant ophthalmologist to whom I went for refraction persuaded me to have my prescription lenses tinted. From his successor I gathered that he had so persuaded most of his patients, for reasons not apparent to the successor, who did not renew the advice. Readers inclined to act on the authors' conclusion about psychological distress should perhaps pause to discover on whose initiative the spectacles are tinted.

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