CORRESPONDENCE

Correspondents are asked to be brief

Hyperactive Children

SIR,—Your leading article on what you call "hyperactive" children (10 February, p. 305) took much too wide a view, and the very well-recognized and well-recognizable syndrome of hyperkinesis got completely hidden from sight behind a welter of side issues. The only psychopathological disturbance in hyperkinesis is overactivity, and there is only one cause of overactivity and that is hyperkinesis. Domestic and educational stresses do not cause hyperkinesis any more than does parental alcoholism or criminality, parent-child conflicts and sibling rivalry (which are universal problems anyway), repression at school (which is a necessity), or parental drug addiction. Hyperkinesis can certainly leave all these things in its wake.

What alarms me is the suggested treatment of hyperkinesis, in which, I agree, drugs have an important role. The use of methyl phenidate and, more important, of dexamphetamine is fraught with the danger of addiction, which is a certainty if the upper limit of age is accepted as 16 years. Any child who continues to be called "hyperkinetic" after the age of 12 is not suffering from the hyperkinetic syndrome, and the use of stimulant drugs is contraindicated. Diphenhydramine is an antihistamine, one of the side effects of which is drowsiness, and soporifics in general are not only useless in treatment but can be positively dangerous by increasing the accident-proneness which already exists in hyperkinesis. The phenothiazines are sometimes symptomatically useful, but medication with such drugs even for a relatively short period leads to obesity, which is possibly more incapacitating. The most effective drug in my experience is the butyrophenone haloperidol, which is available in a drop bottle, one drop containing 0·1 mg of the drug. Effective dosage can be reached by trial and error and the safety margin is very large. A starting dose of one drop twice daily can be increased, according to response, by one or two drops each dose, the average effective dose being between four and 15 drops daily. Adverse side effects are rare and can be reversed by reducing the dosage without impairing the symptomatic response, and there is no recorded case of addiction.—I am, etc.,

G. F. J. GODDARD

Halifax, Yorks.

SIR,—In your leading article (10 February, p. 305) you state that minimal cerebral dysfunction is one of the causes of hyperactivity in children.

Cerebral function is either normal or abnormal, and no child should be branded as having a dysfunctioning brain, however minimal, unless he suffers from neurological disorder or mental handicap.—I am, etc.,

RUDOLPH PAYNE

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Influenza Outbreak

SIR,—I was most interested to read the letter from Dr. C. S. Goodwin and others (13 January, p. 109), in which they demonstrated clearly the effectiveness of influenza vaccine among geriatric patients. I have also observed the same sort of feature in the recent outbreak.

In the Border group of hospitals in Wales the geriatric wards for continuing care and rehabilitation are scattered in the peripheral hospitals. In one such ward, at Bronllys Hospital, where patients were vaccinated (with Admune which, like Influvac, does not contain influenza virus A/Eng/42/72), none of the 15 patients suffered from influenza, whereas in other wards where patients were not vaccinated 14 of the 25 patients at Llandrindod Wells Hospital developed influenza and one died, and 15 of the 46 patients at St. David's Hospital, Brecon, developed influenza and four died. These facts obviously suggest that elderly patients do benefit from influenza vaccine.

However, I believe that there is still a great deal of doubt about the wisdom of vaccinating elderly patients in a continuing care (long-stay) type of ward, even though people generally agree that geriatric patients in acute and rehabilitation wards should be vaccinated.

I would welcome the views of the medical profession at large on this particular issue.—I am, etc.,

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