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Inpatient treatment must remain an option

EDITOR,—Paul Dedman's editorial on home treatment for psychiatric disorder ends with the curious sentence "Whether it can fully replace the functions of the acute psychiatric inpatient unit has not been established."[1] Setting aside the fact that all the studies Dedman discusses found inpatient treatment to be necessary despite intensive home treatment programmes in some cases and the fact that patients with acute psychiatric illness and their relatives must be given the choice of inpatient treatment, you cannot treat at home patients who have no insight into the fact that they are ill and therefore do not accept treatment. If they are so seriously ill as to require compulsory treatment this can be given only in hospital. Even if a community treatment order was to come into being it would not apply to those becoming ill for the first time.

Possibly Dedman is differentiating between intensive care facilities and acute psychiatric inpatient units, although these are often combined. If so it is important that this is made clear as already too many of the most seriously mentally ill patients are being deprived of the right to effective treatment and optimum mental health because of a shortage of suitable inpatient places. Too many receive inadequate or no treatment as part of care in the community, whereas with effective treatment they would be leading independent or nearly independent lives.

A brief admission to hospital for treatment of schizophrenia or manic depression should be equated not with institutional care but with admission for treatment of diabetes or cardiac disease.

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1 Dedman P. Home treatment for acute psychiatric disorders. *BMJ* 1993;**306**:1359-60. (22 May.)

Innovative services merit investigation

EDITOR,—Paul Dedman has summarised research indicating that home based care can often be a safe and effective alternative for people with acute psychiatric disorders.[1] He concludes that home treatment can be useful but questions whether it can ever fully replace acute hospital inpatient facilities.

There are straightforward reasons why home based care should never completely replace psychiatric hospital inpatient units. A prerequisite for such care is that the patient has an adequate home in which to be cared for; this is often not the case, especially in inner cities. Home based care is facilitated by family and friends and is often not practical when people are living alone. There will always be people who are too disturbed to be managed safely outside hospital. Finally, providing people with a respite from their normal environment can be beneficial and may give relatives a much needed break.

In view of these limitations home based care must be viewed as just one—not the only—possible alternative to admission to the hospital. Other options are rarely considered, let alone provided, in the United Kingdom. Crisis houses in the community have been used widely for people presenting with acute psychiatric problems[2] and are praised by many users. Acute day care has been shown in Britain to be effective for people with a range of acute psychiatric disorders,[3] but such care is still predominantly provided for those with long term needs. Family placement schemes have also been developed successfully in the United States[4] but rarely attempted for mentally ill patients in the United Kingdom.

The challenge facing those responsible for planning and developing mental health services is to provide a range of acute services that accurately reflects the widely differing needs of people presenting in crisis. Imagination and courage are needed to create innovative services with close liaison between agencies, which may challenge traditional professional hierarchies. The most effective and practical mix of services for differing populations must be determined, as well as efficient organisational structures to coordinate them. The alternative is that increasingly vocal and disgruntled users of mental health services will vote with their feet and that we will let people down when they need us most.

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Benign prostatic hyperplasia

Poorly correlated with symptoms

EDITOR,—Loose use of the terms "benign prostatic hyperplasia" and "prostatism" has clouded clear thinking on the management of dysfunction of voiding in men.[1] Benign prostatic hyperplasia is a histological term, and the condition can be found histologically in 70% of men aged over 75. Hence benign prostatic hyperplasia is rarely proved and cannot be used as an indication for treatment. Prostatism is a collective noun used to describe lower urinary tract symptoms in older men.

Unfortunately, the correlations between the symptoms that elderly men suffer, the presence of benign prostatic hyperplasia, and the presence of bladder outflow obstruction are poor (P Abrams *et al*, second international consultation on benign prostatic hyperplasia, Paris, 29 June 1993). Symptoms may be caused by obstruction, although this is the weakest correlation of all. More commonly, symptoms are due to detrusor instability, which becomes more common with age: it is not entirely clear that it is secondary to outflow obstruction, as Kirk states. Symptoms may also be due to intravesical disease such as stones, tumours, or inflammation.

Through discussion with their patients doctors need to decide whether they wish to treat symptoms or bladder outflow obstruction. If they wish to treat symptoms it is not necessary to show that the patient has an outflow obstruction. If they wish to treat obstruction, however, they must prove that obstruction exists. This can be done only by obtaining data on pressure and flow. Measuring the urinary flow rate is better than assessing the patient on the basis of his symptoms or the results of physical examination alone. Flow rates alone, however, fail to identify those patients with a low flow rate due to underactivity of the bladder, who will not benefit from surgical procedures, and those patients who have normal flow rates but high voiding pressures and obstruction.

David Kirk rightly points out that when we assess new treatments we must recommend only those that are of proved efficacy.[1] This is an exciting time with regard to the treatment of elderly men with dysfunction of the lower urinary tract, but the situation is not quite as simple as Kirk's editorial might lead readers to believe.

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1 Kirk D. How should new treatments for benign prostatic hyperplasia be assessed? *BMJ* 1993;**306**:1283-4. (15 May.)

Don't rush in to early surgery

EDITOR,—Having read in the recent article by David Kirk,[1] I speak as an octogenarian and also a very ex-urologist, with a foot, so to speak, in both camps.

Some 40 years ago one of David Kirk's illustrious predecessors pointed out, to our surprise at the time, that in old age the prostate tends to regress and symptoms improve, contrary to the views which everybody held. I can vouch for the truth of this in my own experience. The advice, therefore, so often given, that things are bound to get worse—and that the earlier the operation is done, the better—is often bad advice. To advise surgery, for example, for an initial episode of acute retention is extremely unsuitable. If the precipitating circumstances are known, as they often are, avoiding the recurrence of such a situation will often result in the patient having no further trouble.

The craze for doing emergency prostatectomy for all cases of acute retention, which lasted for a short time just after the war, benefited only one group of people—the keen young surgical registrars who had the chance of performing prostatectomies, a chance they rarely got in a routine list. I was a "Millin man," and although transurethral resection is infinitely less traumatic at the time, it can be followed by more long term complications than the open operation of the bad old days. So my advice to the elderly is to keep away from the keen young urologist.

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1 Kirk D. How should new treatments for benign prostatic hyperplasia be assessed? *BMJ* 1993;**306**:1283-4. (15 May).

Management of patients in persistent vegetative state

Give proper rehabilitation a chance

EDITOR,—Raanan Gillon does not seem to know the true meaning of persistent vegetative state.[1] The word vegetative, according to the *Oxford English Dictionary*, means an organic body capable of growth and development but devoid of sensation and thought. People in a persistent vegetative state are not in a permanent coma or unconscious. They are awake, with eyes open and moving. They follow normal sleep patterns. With primitive reflexes they respond to light, sound, and pain.

In Tony Bland's case, it seems that his parents could not bear to see him in this state and hence were unable to mourn appropriately. Little attempt seems to have been made, however, to improve his quality of life. All photographs show him in bed,