Her husband could not hear these voices and she became increasingly disturbed, afraid to go to bed at night, feeling that people were doing this just to annoy her. She began to feel that eyes were upon her during the day and that people could influence her heart, which felt as if it were pounding.

The family reported that the patient had always been a good wife and mother. She had never previously been to a psychiatrist. She had no medical problems except moderate obesity and denied taking any medication, including amphetamines. When asked specifically about diet pills she reported taking Tenuate (diethylpropion hydrochloride), 25 mg *tid*, starting 3 months prior to onset of her symptoms.

She appeared anxious and frightened. She knew that her fears were unfounded but the voices seemed real. The patient's thoughts were otherwise coherent and logical and she expressed them at a normal rate. The sensorium was clear. She was treated as an outpatient with trifluoperazine (Stelazine), up to 10 mg/d, and her diet pills were stopped. She gradually became asymptomatic in 6 weeks. The trifluoperazine was discontinued 8 weeks later, and at follow-up 1 year later the patient was well.

Physicians should be aware of the potential dangers of diet pills and that patients may not consider these agents "medicine" and thus deny taking medication.

I do not know whether these patients' psychoses were due to the pills or whether they had underlying "psychotic potential". However, both had a relatively good premorbid personality and no previous psychiatric illness. Psychotic symptoms developed 1 to 3 months after the patients started to take the pills, and both recovered quickly when the pills were discontinued and relatively small doses of neuroleptics were given for a short time. Because the effectiveness of these diet pills has never been validated and because of their potential harm, it is unwise to use them in the treatment of obesity.

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Waiting years

To the editor: The Nov. 20 cover of *CMAJ* showed a rather old man — well dressed, shoes polished — walking slowly, looking at the ground in a deserted park. At once he seemed to me like a poor old man waiting to die. His despondent expression did not suggest the "golden years" he should be looking forward to.

The cover should have depicted a healthy man, around 65, dressed casually, playing golf, gardening, spending time with his grandchildren or fishing. As it stands, the cover should have been entitled the "waiting years" rather than the "golden years".

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Problem-oriented v. disease-oriented audits

To the editor: Mr. Korcok's excellent discussion on the use of criteria or standards in peer review (*Can Med Assoc J* 115: 937, 1976) should be read by all physicians. As one involved in medical audit in a 400-bed acute-care hospital, I would like to make one or two comments.

I am not aware of any convincing evidence that retrospective audits using preselected criteria have any significant effect on the pattern of practice in a hospital. McSherry[1] in New York and Nelson[2] in Utah found that such audits had no effect on physicians' performance as measured by repeat audits after a suitable interval. In my opinion there is no such thing as "ideal" or "optimal" standards for any disease. Even for common conditions like cholecystitis and pneumonia, management of the patient can vary greatly, depending upon severity of the disease, complicating factors and host response. The criteria of process and outcome will (or should), therefore, vary from patient to patient. Determination of serum electrolyte concentrations may be unnecessary in a young person with respiratory tract infaction but would be mandatory in an old, dehydrated man with pneumonia. When physician committees are asked to set criteria, they understandably err on the side of safety. The criteria agreed upon are meant to cover all situations, with the result that criteria lists become extensive. Adherence to such lists is bound to increase the workload without corresponding benefit to the patient.

In our experience a problem-oriented audit carried out on a suitably selected problem area, such as excessive ordering of blood, underuse of blood components or inappropriate use of a particular antibiotic, is less time-consuming and more useful than a disease-oriented audit. The results of a problem-oriented audit can be presented to the medical staff in an educational format, and the response can be gratifying.

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Insomnia in cancer patients

To the editor: To test anecdotal accounts that patients with cancer commonly have insomnia we have administered an 18-item questionnaire to 47 patients consecutively referred for radiotherapy to the Norris Cotton Cancer Center in Hanover, New Hampshire. In 45% of the patients, total sleep time per week averaged less than 50 hours, and in 23% it averaged less than 40 hours. The patients reported as much difficulty in getting to sleep and staying asleep as the neuropsychiatric patients studied by Weiss, Kasinoff and Bailey.[1] Compared with the 100 hospitalized medical and surgical veterans studied by Johns and associates[2] our patients slept for fewer hours per week.

The most important factor affecting ability to get to sleep and to stay asleep was depression ($r = -0.361$; $P < 0.01$), with reported anxiety and pain controlled. The reported interference of pain with sleep was negatively related to depression ($r = -0.323$; $P < 0.05$), with anxiety controlled.

This pilot study confirms the clinical impression that sleep is more often and more severely disturbed in cancer patients than in the general population[3] and in patients with nonmalignant medical conditions.[2] Contrary to our expectation, insomnia was positively correlated with reported symptoms of anxiety and depression but *not* with pain. These preliminary results suggest the need for a more comprehensive study of the prevalence and severity of insomnia in various categories of cancer patients. It is worth studying the psychological and physiological intervening variables.

We suggest that all cancer patients should be asked about difficulties in sleeping and that, if insomnia is reported, the patient should be asked about symptoms of depression and anxiety. If such symptoms are reported, the patient should be given a suitable psychotropic drug, such as thioridazine hydrochloride (Mellaril). Johnston[4] reported relief of anxiety, depression and insomnia in patients with terminal cancer given thioridazine, 75 mg daily.

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