to fast and efficient relief of acute headaches, but the patients had to use it daily or almost daily (in one case alternating it with ergot preparations) to prevent recurrence. Treatment consisted of abrupt withdrawal of sumatriptan and introduction of prophylaxis against migraine. Subsequently, daily headaches resolved in all patients.

All of these patients had a long history of misuse of drugs for migraine and were misusing those drugs when they switched to regular use of sumatriptan. Therefore our data provide no evidence that sumatriptan has addictive properties in patients without a history of uncritical use of drugs for headache. Possibly, however, sumatriptan has a similar risk of misuse to that associated with analgesics and ergot compounds in people with chronic headache with previous drug dependency. The long term effects of daily use of sumatriptan are unknown. Although sumatriptan given for 7-10 days alleviated rebound headache when ergot preparations were withdrawn in a small number of patients who misused them,[4] this finding needs confirmation.

Sumatriptan is approved only for the treatment of acute migraine attacks. We believe that it should not be prescribed to patients who are taking analgesics and ergot compounds daily and should be prescribed with caution to patients with a history of misuse of analgesics and ergot compounds.

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Enforced hysterectomies

EDITOR,—I am not surprised that Caroline Richmond has collected 11 cases of women who have had hysterectomies against their will.[1] In my research,[2] in which 500 women were questioned, over a fifth stated that their experience of obstetric or gynaecological procedures was "very distressing" or "terrifying." Indeed, on a clinically validated questionnaire,[3] 30 women were found to have post-traumatic stress disorder as a result of their experiences. Many described their treatment as resembling an assault, which accords with others' findings.[4]

As a general practitioner, I have received letters about patients from gynaecologists to the effect that "while I was in there, I decided it was better to take it all away, rather than have to go back in later if she develops ovarian cancer." Prophylactic oophorectomy is, in my experience, carried out in many cases without proper discussion with the patient, who is often devastated after the operation to find that she is rapidly undergoing postmenopausal aging, which cannot be reversed by hormone replacement therapy.

Until women are involved in the decision making process affecting their own bodies, and are given information, choice, control, and the freedom to withhold consent, my concern is that many will continue to be traumatised by a system which is fond of its own power.

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Reforming the NHS reforms

EDITOR,—In his paper discussing both historical and developing complex issues facing everyone involved in health care in Britain A W Macara, the chairman of the BMA's council, gives a clear summary of the current situation.[1] Sadly, this is marred by many phrases indicating that the government needs to "reinstate" and "restore." One thing that any government is unlikely to do (probably because it can't, not because it won't) is to reinstate or restore anything.

The first step in promoting change is to recognise that a problem exists—which Macara outlines. The second is to accept responsibility for doing something about it and not to blame others. The medical profession would do well to stop "looking to government to restore the . . . key values" and thinking that "resolution of these issues requires a resolve by government." No: it requires doctors to take charge.

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Minerva taken in by myth

EDITOR,—Minerva reports that the breast implant of a woman diver exploded during ascent from 30 m, causing major injuries to her chest wall and fracturing two ribs. This apocryphal tale can be traced from Minerva's source (*Diver Magazine*) through the newsletter of a small diving club back to a United States newspaper, the *National Enquirer*, which is renowned for its sensational stories, but not for their accuracy. Under the headline "Ka-boob!", the accident was alleged to have occurred in Mexico.

Women divers with breast implants are naturally concerned by such stories, particularly when credence is added by publication in a major medical journal. Before such an implausible report is repeated, surely the accuracy and provenance of the story should be checked.

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1 Minerva. *BMJ* 1994;308:1050. (16 April.)

Gulf illness

EDITOR,—Recently, the Gulf war has been held responsible for a new mystery illness, the "Desert Storm syndrome" or "Gulf illness." I wish to describe the steps being taken by the defence medical services to investigate these claims. During the past year we have assessed patients who have developed symptoms which they maintain were caused by service in the conflict in the Gulf in 1990-1. Because about half of the troops who served in the Gulf have left the services it has not been simple to identify, let alone gain access to, all those who claim to exhibit such symptoms.

For those who are still serving, referral for assessment is a simple, well established procedure. For those who have left the services and write direct to the Ministry of Defence for help, we ask that they first see their general practitioner to arrange a formal referral. The assessment is then carried out. The procedure for ex-service personnel has been repeatedly publicised on television and radio and in the press.

A register of all referrals is maintained at the Defence Medical Services Directorate, and all assessments are conducted at one service hospital for clinical consistency. A detailed medical and occupational history is taken. The particulars of the patient's experience in the Gulf are determined; this includes precise locations, movements between locations, and the timings of those movements. In addition, memorable events experienced by the patient are noted.

A complete medical examination and routine screening blood tests follow. Subjects with specific, localising symptoms and signs have the relevant special investigations, which may include endoscopy, biopsy, electroencephalography, electromyography, computed tomography, and magnetic resonance imaging. We try to avoid using too rigid an investigative protocol, preferring to assess each patient as required.

So far 33 Gulf veterans have been referred for assessment. Ten have had a complete assessment and been discharged from hospital follow up. Eleven have had initial consultations and are awaiting follow up to discuss the results of investigations. Twelve are awaiting their initial hospital consultation.

The symptoms described are diverse and non-specific. They include fatigue, weakness, muscle or joint pain, headache, hair loss, poor concentration, diarrhoea, depression, mood swings, disturbance of sleep, breathing difficulties, and cough. Most patients describe three or four symptoms from this list, but no consistent symptom complex has emerged. The commonest symptoms are fatigue and weakness. Consistent findings have been an absence of physical signs and no abnormality on investigation. Patients who have completed the assessment have responded well to the reassurance it gave them.

In summary, we have no evidence to support the claim that a medical condition exists that is peculiar to those who served in the Gulf conflict. Medical statistics that we have compiled also indicate that the incidence of the diverse symptoms alleged to make up the syndrome has not increased. There is no doubt that the symptoms reported are real; what is in doubt is whether the non-specific symptoms of Gulf illness have a higher prevalence in Gulf veterans than in the general population. American work indicates that they do not.[1]

Neither chemical nor biological weapons were used by Iraq, but the threat they posed was well known to all personnel who went to the Gulf. The circumstances of the conflict were therefore highly stressful, and we bear this in mind in our continuing investigation of Gulf illness.

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