Dr Winton's advice to confine ourselves to currently available contraceptives would be appropriate if the existing methods were completely effective and entirely free from side effects, but, unfortunately, this is not the case. It would seem wrong to abandon a new approach to contraception before its potential has been fully explored.

PETER W HOWIE
ALAN S MCNEILLY

Department of Obstetrics and Gynaecology,
Ninewells Hospital,
Dundee DD1 9SY

1 Alberts JL, Francois F, Josserand F. Study of side effects reported in patients under dogmatil. *Sem Hop Paris* 1985;**61**: 1351-7.
2 Edwards JG, Alexander JR, Alexander MS, Gordon A, Zutchi T. Controlled trial of sulpiride in chronic schizophrenic patients. *Br J Psychiatry* 1980;**137**:522-9.
3 Mielke DH, Callant DM, Kessler C. An evaluation of a unique new antipsychotic agent, sulpiride; effects on serum prolactin and growth hormone levels. *Am J Psychiatry* 1977;**134**:1371-5.
4 Rama Rao VA, Bailey J, Bishop M, Coppen A. A clinical and pharmacodynamic evaluation of sulpiride. *Psychopharmacology* 1981;**73**:77-80.
5 McMurdo MET, McEwen J, Lewis M, Marnie M, Howie PW, McNeilly AS. Dose response of prolactin release following oral sulpiride (1 mg-50 mg). *Scott Med J* (in press).
6 Honda F, Sattoh Y, Shimomura K, *et al*. Dopamine receptor blocking activity of sulpiride in the central nervous system. *Jpn J Pharmacol* 1977;**27**:397-411.
7 Laville C, Margarit J. Influence du sulpiride sur l'activite et la vigilance chez la souris. *Pathologie et Biologie* 1968;**16**:663-5.
8 Laville C. Chimie et pharmacologie du sulpiride. *Lille Médical* 1972;**17** (suppl).

Efficacy of feverfew as prophylactic treatment of migraine

SIR,—Dr E S Johnson and his colleagues (31 August, p 569) are to be congratulated on attempting to assess the efficacy of feverfew as prophylaxis for migraine. They state that their study provides evidence that feverfew prevents attacks of migraine, but a few points need consideration.

They suggest that feverfew reduced headache frequency because the frequency increased significantly ($p<0·02$) in the placebo group but there was no significant change in the feverfew group. This "before and after" analysis is inappropriate to the parallel group design. The correct analysis is to compare the results for the two groups directly. When this is done for the data presented in table I the headache frequency does not differ significantly between the two groups. This is also true if the baseline values are subtracted first. The authors suggest that migraine attacks in the feverfew group were significantly ($p<0·05$) less likely to be accompanied by nausea and vomiting. However, the numbers of migraine attacks used as denominators in table III do not tally with the numbers calculated from table I. For example, the feverfew group appear to have had $8\times6\times1·69=81$ attacks, and not 93 attacks as stated in table III.

Table II shows clearly that patients could distinguish between feverfew and placebo treatments; the reason is not clear, but evidently the study was not "blind." This is particularly disturbing because the patients in the study all believed that feverfew was an effective remedy. The significant preference for feverfew shown in table V may simply be a measure of patient bias in what was in effect an open study.

It is also interesting to consider the limitations of a study which is in fact a controlled withdrawal of treatment. The authors acknowledge that the incidence of side effects caused by feverfew was probably underestimated, because patients with troublesome side effects would have discontinued feverfew and would not have been eligible for the study. For the same reason, the study would tend to overestimate the efficacy of feverfew. Those who found the herb ineffective would stop using it and therefore not be included. Finally, any effect observed in such a study could be a consequence of treatment withdrawal and not necessarily evidence of a therapeutic action. The authors accept the existence of a therapeutic action. The authors accept the existence of a "post feverfew syndrome," which includes aches and pains, joint and muscle stiffness, anxiety, and insomnia. Is it not possible that headaches, nausea, and vomiting are manifestations of this syndrome?

P C WALLER
L E RAMSAY

University Department of Therapeutics,
Royal Hallamshire Hospital,
Sheffield S10 2JF

**The authors reply below.—ED, *BMJ*.

SIR,—We thank Drs Waller and Ramsay for their comments and in particular for drawing attention to our inadvertent omission from the text of the between groups analysis.

As stated, we used the Wilcoxon rank sum test for comparisons between the two treatments. The difference in headache frequency was significant ($p<0·05$) when the end point was the mean of the last three months but not when it was the mean of 0-6 months. When the baseline values were subtracted significant differences ($p<0·05$) were also evident for both 4-6 months and 0-6 months. For the comparison of the 4-6 month end points we included the earlier values of two patients taking placebo who subsequently withdrew. This tended to understate the differences in headache frequency, as did the under-recording in cases 10, 15, and 17, so our calculations probably minimised the apparent benefit of feverfew. We now realise that errors occurred in table I: two in the 4-6 months column (the value for case 6 should have read 0·67 and that for case 8 0·67, making the mean (SEM) 1·54 (0·61)) and one in the 0-6 months column (the value for case 6 should have been 1).

The apparent discrepancy for differences in the number of headaches calculated from the data in table I and the number of migraine attacks used as denominators in table III was explained in the legend of table IV. Three patients taking feverfew recorded a total of 12 episodes of visual symptoms characteristic of their migraine attacks. Although these auras were occasionally associated with nausea and vomiting, they were not followed by headaches, possibly owing to the consumption of analgesics (table IV).

The assertion that this study was not blind is untrue. Non-blindness implies prior knowledge of which treatment was active and which was placebo. Our patients knew at the outset they would receive either feverfew or placebo but, apart from breaking the capsules (and they did not), they could not discover which. In any study in which the active treatment is noticeably more effective than the placebo those patients who consider they are not benefiting would be more likely to guess retrospectively that they had not been taking placebo and those who were benefiting that they were taking the active drug. We think that the high rate of correct guessing was a true reflection of the efficacy of feverfew treatment.

The suggestion that the headaches, nausea, and vomiting suffered by the placebo takers were manifestations of the "post feverfew syndrome" is of interest, since withdrawal headaches occur when patients taking daily ergotamine suddenly stop treatment.[1] However, our patients identified their headaches as being identical with those formerly associated with their migraine attacks. The headaches were intermittent, unlike most of the other post-treatment symptoms, which lasted for several days or weeks. Furthermore, in those who suffered from classical migraine the headaches were associated with characteristic migraine auras.

D M HYLANDS
P J HYLANDS

Department of Pharmacy,
Chelsea College,
London SW3 6LX

E S JOHNSON
N P KADAM

City of London Migraine Clinic,
London EC1M 6DX

K D MACRAE

Charing Cross and Westminster Medical School,
London W6 8RF

1 Rowsell AR, Neylan C, Wilkinson M. Ergotamine induced headaches in migrainous patients. *Headache* 1973;**13**:65-7.

Griffiths in action

SIR,—Dr Jack Bavin (24 August, p 543) complained about the recent appointment of the unit general manager of the mental health unit. I have no quarrel with Dr Bavin's views about the "achievements of a high order" produced by the previous teamwork and the consensus approach. He will recall that this point of view was strongly argued in Gloucester's response to the Griffiths report.

However, Griffiths is here and we have to face up to it. We have tried very hard, through consultative documents and open meetings, to explain that Griffiths is the most radical change ever made in NHS management and that the unit general manager's job is a new job and not the unit administrator's job with a new title.

It was unfortunate that the successful candidate did not meet Dr Bavin. We involved medical staff closely in the selection process and valued their views. We were faced with a situation in which the shortlist for the acute unit was considerably stronger than the shortlist for the mental health unit. It also became clear that some of the excellent candidates for the acute unit job would be willing to accept other unit general manager posts. In this circumstance we felt that we had a duty to the mental health unit to appoint the best candidate, even though he had not met the appropriate medical representative. The existing unit administrator was not dismissed; the unit general manager post was not his to lose. In fact he has now been appointed as a unit general manager in another authority.

Since 1982 we have worked closely with Dr Bavin and his colleagues to establish a clear direction for mental health services. The unit general manager and I look forward to working with everyone in the unit to provide the best possible service for the patients whom we serve.

KEN JARROLD

Gloucester Health Authority,
Gloucester GL1 1LY

Improving prescribing

SIR,—I was pleased to read Dr Tessa Richards's account of the recent DHSS conference on prescribing (21 September, p 832) since this was virtually my only source of news about this meeting.

As chairman of the Association of Medical Advisers in the Pharmaceutical Industry (AMAPI) I wrote to Mr Norman Fowler to request an invitation to this meeting but received no reply or acknowledgment. This is extraordinary when one considers that it is largely AMAPI members who sign off the data sheets and advertisements for