

presence of psychiatric disturbances (mainly depression) in the anamnesis. Some authors (Lopez-Ibor 1972, Blummer *et al.* 1979, de Bertolini *et al.* 1982) have proposed that chronic pain, particularly in patients without an identifiable medical illness, could be the manifestation of a 'masked' depression. We therefore carried out a study on the psychological aspects of our patients.

The patients had two interviews with a psychiatrist. They then completed the Italian versions of the Eysenck Personality Inventory (Bruni 1978) and the Zung Self-Rating Depression Scale (SDS) (Zung *et al.* 1965). Pain levels were then assessed using an analogue scale: patients were presented with a sheet of paper on which a 10 cm line was drawn and were asked to indicate the severity of their pain by marking the line with a cross, having considered that 0 cm meant 'no pain' and 10 cm meant 'my pain is as bad as it could possibly be'. The Eysenck mean scores obtained were as follows: neuroticism 14.6 ± 5.5 ; extroversion 11.2 ± 3.1 ; psychoticism 5.7 ± 2.9 . The neuroticism mean score almost touches the 'normality' maximum threshold, and the extroversion and psychoticism mean scores fall within the norm for Italian mean scores. The data derived from the SDS were more intriguing: the mean SDS score was 48.4 ± 12.2 (score of moderate depression: Biggs *et al.* 1978).

All patients were given the same treatment, amitriptyline 75 mg daily, and after 45 days were retested to evaluate depression and intensity of pain. The SDS average score was 42.1 ± 8.8 . Ten patients reported a striking mean improvement of 75.45% of the painful symptoms, 2 did not report any improvement and 2 experienced a worsening of symptoms (these 2 patients had interrupted the antidepressive therapy and their SDS scores also worsened at the retest).

Given the small size of the sample our data are only indicative, but they are nevertheless interesting since they concern patients who do not respond to the usual analgesia therapy and respond only partially to cryoanalgesia; in fact, only 6 of 17 such treatments had been helpful in relieving symptoms in the 10 selected patients suffering from perineal neuralgia.

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4 December 1981

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Migraine: effect of digoxin

From Dr B W Johansson

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Dear Sir, Migraine, first described by Hippocrates 2500 years ago, is still a challenging disease, and often very difficult to treat. In its classical form it is characterized by a vasoconstriction of the cerebral blood vessels resulting in ischaemic symptoms, such as visual disturbances, hemiplegia or aphasia, followed by a vasodilation producing headache.

Ergot alkaloids are the drugs of choice in treating a severe attack of migraine, but the number and severity of attacks can often be reduced by regular treatment with drugs of different chemical structure, such as β -blockers, spironolactone, or clonidine. I would like to report a little-known effect of digitalis, used for centuries in the treatment of cardiovascular disease.

I have observed that digitalis can improve both paroxysmal supraventricular tachycardia (PST) and migraine when they occur in the same patient. This has been the case in the following patient, in whom the PST is probably a migraine equivalent.

A 59-year-old woman has had 'acropallor' of Raynaud type for as long as she can remember, migraine since the age of 25, and PST since the age of 49. The migraine is of the classical type, with an aura consisting of an uncharacteristic stretching feeling in her neck and visual disturbances before the headache starts. The PST attacks are not followed by urina spastica. Both the migraine and the PST responded well to propranolol and to pindolol, but in each case the drug had to be stopped because of severe depression. Digoxin 0.25 mg daily has had an excellent effect, not only on her PST but also on her migraine attacks, which have been reduced both in number, from one or more a week to less than one a month, and duration, from 3 days to one.

This double effect of digitalis needs confirmation, but it may be worthwhile trying digitalis in patients with migraine, especially in those who also have PST. This combination was first described by Hoffman (1910) and reported by Thomas & Post (1925) to be common. Myhrman (1947) published a series of 61 migraine patients, of whom 24 reported a history of PST.

I report this case because I think that it throws interesting light on the pathophysiological and therapeutic aspects of migraine, and because I should be very interested to hear if any colleagues have had a similar experience.

Yours faithfully

B W JOHANSSON

11 November 1981

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James Neild's legacy

From Dr William A R Thomson

The Athenaeum, London SW1

Dear Sir, I am writing to you at the suggestion of Dr F G Neild to correct the penultimate paragraph of his fascinating paper on 'James Neild (1744-1814) and prison reform' (November 1981 *Journal*, p 834).

I have it on the authority of Buckingham Palace that the sum bequeathed by J C Neild to Queen Victoria was £233 000. Her Majesty did not rebuild Balmoral Castle out of this legacy, but the Mausoleum at Frogmore was paid for out of it.

Yours faithfully

WILLIAM A R THOMSON

21 December 1981

Book reviews

Advanced Medicine, vol 16

A J Bellingham (ed) pp 384 £16

London: Pitman Medical 1980

This is an excellent book, wide ranging, and well written. Who enjoys what depends on individual interest, but all parts are authoritative, interesting and instructive.

My personal choice is for part III, Update in Diabetes, in which much recent work is set out clearly and helpfully discussed. Only very wise doctors will read this section without at least some instruction.

Next I must say how much I enjoyed the very first paper (on breath sounds) by Paul Forgacs. I think it a great tribute that he found new things to say and new inferences and conclusions to draw from such simple data, simply obtained and simply set out, but elegantly discussed and evaluated. And I was also grateful for the article on the immotile-cilia syndrome, a masterpiece of serendipity and erudition (Dr Mossberg).

I read the other parts of the book with varying degrees of interest and instruction. I came across nothing that was demonstrably wrong, but I thought that in one or two of the more technical articles the writing was a bit opaque. All in all, a most enjoyable and exciting book. A good read for physicians and for Membership candidates and both of them the better for it.

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Advanced Medicine, vol 17. D P Jewell (ed)

pp 335 £16 London: Pitman Medical 1981

This is the latest product of the very successful symbiosis between the Royal College of Physicians and Pitman Books Ltd. The association has the essential ingredients of success; excellent clinical scientific material brought together under the sponsorship of the Royal College, a high publishing standard by Pitman, and rapid publication as a result of good collaboration between authors, editor and publisher. The Advance Medicine Conference, the proceedings of which are found in this volume, was held as recently as February 1981, and the reviews of such highly topical and important subjects as endorphins and prostaglandins in clinical medicine are therefore as up-to-date as one can find today. There is something for almost everybody - limitation of infarct size, a new look at anticoagulants in myocardial infarction, hypertension, occupational asthma, gastrointestinal infections, mechanisms of drug-induced liver damage, acute leukaemia, and molecular clinical pharmacology, to mention only some of the chapters. This volume has been prepared for practising clinicians and is pleasantly free from excess erudite scientific theory, while at the same time whetting the appetite for the answers to some of the questions posed by recent advances in medical science.

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