The drug industry does *not* "pay" $250 000 annually to the Canadian Pharmaceutical Association to subsidize CPS publishing costs. Individual drug manufacturers who see fit to "advertise" their products in the one specific section of CPS (and only one section — the pink pages) do so voluntarily on a "value received" basis. This participation by 80 companies partly (not "largely") defrays publishing costs. Where has Bell been all this time to believe that advertising revenue does not support most professional literature and other literature available on a regular basis?

The first of his "main findings" is a misleading distortion. We suggest that he count again.

His second "finding" — that "the selection of drugs for inclusion is under the exclusive control of the drug industry" — is wrong. The continuation of the sentence that refers to paying "to have drugs of its choice only included in certain sections" is a destructive distortion of fact. Inclusion of product names in the pink pages is outlined in the lead-in paragraph of that particular CPS section. The product recognition section is not yet all that we wish it ultimately to be, but we are thankful that many companies see fit to help us help those who very often need this quick reference, adjunctive information, and we are indeed appreciative of the extra trouble to which manufacturers go to provide actual dosage forms for CPS photographers and lithographers.

The third "finding" is also a distortion of fact. Ask the manufacturers themselves if they "control" CPS monographs. Naturally, the first information on a manufacturer's product comes from that manufacturer. The CPS editors and advisers take it from there. Thus CPS editorial production typifies a high degree of cooperative input of expertise from pharmacy, medicine and industry, including the manufacturers' medical directors.

Bell's stated fourth "finding" is his opinion only. Maybe his opinion is shared by others, maybe not. In any events, if a drug product is legally marketed for use by health care professionals in Canada, we deem it to be a responsibility of CPS to at least include a description for professional reference. It is the prerogative of agencies other than CPS to say whether a product should be marketed or used, or both, in clinical practice.

Bell's fifth "finding" is wrong. We suggest that he look again at CPS. We suggest that those who read his letter might also wish to do so and, among other things, check the general (generic) monographs against the relevant brand-name monographs.

Writing on behalf of all involved in the production of CPS, we make no claims that it is perfect. What is? But a degree of relative perfection is indeed continuously sought, and the tangible responses of thousands indicate progressive enhancement is being recognized.

Presumably Bell's proposed production of an alternative compendium, even if the suggestion had any basis for practical implementation, would have all the elements of perfection. Impossible!

Finally, on behalf of the editors, the editorial advisory board and their consultants and, indeed, the medical directors and product researchers of the pharmaceutical industry, I cannot do other than express deep concern and objection that Bell, in his letter's final sentence, accuses CPS of being dishonest and unreliable (in any manner).

While Bell's letter is devoid of objectivity, we do not object to its publication but we ask that these comments by us, invited by him, be published concurrently.

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Diet pill psychosis

To the editor: I have recently seen two cases of psychosis that occurred shortly after the patients began using "diet pills" prescribed by their family doctors. Physicians should be aware that although amphetamines have been removed from the market and are no longer recommended in the treatment of obesity because of their ineffectiveness and their potential for producing habituation and psychoses (especially paranoid states), the newer diet pills have the same risks. All the diet pills currently listed in the "Compendium of Pharmaceuticals and Specialties" are amphetamine analogues and presumably work in the hypothalamic area, either depressing the appetite centre or stimulating the satiety centre. However, it is not unlikely that these drugs, like amphetamines, also act on other areas of the brain such as the nearby limbic system, reticular activating system, midbrain or median forebrain bundle.

The two cases reported below are examples of psychoses precipitated by currently available diet pills that could easily be mistaken for schizophrenic illnesses.

Case 1

A 20-year-old woman was referred for

psychiatric consultation because of a 2-month history of psychiatric symptoms. She complained of feeling "uptight" and she had the constant feeling that she had seen before everything and everyone she met (déjà vu). She felt that nothing that was happening was new but that she had lived it all before. She also felt that her mother had been trying to poison her and that people at her college were playing games on her, such as turning the clock back, because they did not like her. She imagined that she could speak three different languages and that these languages would create arguments inside her; she felt as if the Holy Spirit and the Devil and herself were in conflict.

Results of physical examination, hematologic study and urinalysis done by the family doctor were normal. The patient reported no past medical illnesses and denied taking any medications or "street drugs" — specifically lysergic acid diethylamide and amphetamines. She had never been to a psychiatrist, nor was there any evidence of psychiatric illness in her family. Both she and her family described her as likeable but shy, quiet and nervous. The family denied any suggestions of previous thought disorder, confused thinking or inappropriate affect.

Developmental milestones in all areas had been normal although her parents had fought constantly during her childhood and had separated when she was 5 years old. The patient lived with her father until she was 15 years old and then lived on her own until the onset of these symptoms. She had a few good friends and several social interests including dating and dancing.

She was polite, cooperative and immediately likeable although she seemed anxious, scared and perplexed. Her thoughts and speech were not hurried but she was delusional, firmly stating that she had met the examiner before and she felt that she knew what he would say before he said it. There was no evidence for looseness of associations. The sensorium was clear as to time, place, person, concentration and memory.

The provisional diagnosis was acute schizophrenic reaction and the patient was treated as an outpatient with trifluoperazine (Stelazine), 15 mg *qhs*; she took this medication for 3 weeks, after which time she felt "50% better". The patient then told me that she had been taking diet pills, phentermine (Ionamin), 30 mg/d for 3 months, beginning 1 month prior to the onset of symptoms. She had not mentioned these pills previously as she did not consider them medicine. The diet pills were stopped and trifluoperazine was continued. Within 3 weeks she felt "back to normal" and discontinued all medication. Follow-up 2 months later showed no recurrence of symptoms.

Case 2

A 48-year-old woman was referred for psychiatric consultation because of paranoid ideation of 4 weeks' duration. She had been hearing voices (usually female) through the wall of her apartment, which were keeping her awake at night; she couldn't make out what they were saying.

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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