their continued use for longer. Otherwise there seems no alternative to putting more reliance on proguanil in spite of its obvious shortcomings.

The occurrence of pregnancy during long term residence in a malarious area should be regarded in the same way as for the short term visitor. In general, Fansidar and Maloprim should be avoided, but where the chance of infection is high, as in tropical Africa, the very real risks of malaria in pregnancy must be balanced against the possible toxic effects of the drugs.

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Letter from . . . Chicago

Below the diaphragm and above

GEORGE DUNEA

It was 4 am as the phone rang, and the room was dark and cold. "It's service calling, doctor, Mrs B wants to speak to you." I put on a cup of tea to restore my equanimity before dialling. "Hello doctor," I recognised the sing song voice, "I didn't know if I should call you—but my mouth has been awfully dry and I have been drinking a lot of water and passing a lot of urine—and the pit of my stomach feels funny and my colitis is acting up—and did you say I should take the bran or the Metamucil, doctor?" "Mrs B, do you know it is 4 o'clock in the morning?" I tried. "Doctor, I am sorry, but. . . ." "Mrs B," I cut her off, "is Mr B out of town again?" "Yes," she replied, "and do you know that my throat is so dry I can hardly swallow, and why does my stomach feel so high? Should I be taking more vitamins?"

Some doctors would call Mrs B a crock,[1] assign her to the department of psychoceramics, or refer to her as turkey or a gomer[2] (get out of my emergency room). Psychiatrists are more tolerant, at least according to Alistair Cooke, because if they play their cards right they may look forward to a lifelong relationship.[3] But other doctors might place Mrs B in the category of the "hateful patient," perhaps halfway between the dependent clingers who evoke aversion and the manipulative help rejectors who cause feelings of guilt and inadequacy.[4] For at bottom there always remains the fear that an organic disease is lurking in the background, waiting to declare itself or perhaps even yet to be described. And did not Ms Polly Murray report some years ago how she was labelled a hypochondriac and told she was bored and depressed until at last she was found to have Lyme disease?[5] Perhaps it is these doubts that tend to make the hypochondriacs such odious patients, especially those suspected of having read all the textbooks and infiltrated all the postgraduate courses.[6] They frequently outlive their doctors, battening on their élan vital like Count Dracula, and often will have buried two or three of them before moving on to a new victim. No wonder, then, that as they come with their lists of complaints, these "patients with the little paper"[7] give rise to the impulse of seizing the list and tearing it up before symptom number four, underlined in red, comes up for consideration.[6]

But Amelia B is not a hateful patient—except for her disconcerting habit of calling at 4 am. Yet her list of symptoms is very long. For years she had suffered from "colitis," but did quite well when the former doctor—needless to say now also dead and buried—initiated a 10 years' course of treatment for amoebiasis. Somewhere in the dim past she was also given thyroid extract; and according to the prevailing fashions she received bromides, belladonna, phenobarbitone, dicyclomine, and diazepam. She also needs laxatives, bismuth, much reassurance, and diuretics when her stomach feels high. She calls when her eyes pull up, worries that her throat goes all the way down and looks blue, and might as well mention that her eyes look blue also. Her kidneys are pressing together, and gas seems to go up and wants to go down again. There is a pain in the navel going to the back, she is not eating right because everything turns sour, she has an acid vaginal discharge, and she needs a barium enema but can't have it "because of her bowels." She once visited another doctor—presumably also dead and buried by now—who added a psychotropic drug to her therapeutic salad, so that with the diuretic her serum sodium dropped to 112 mmol(mEq)/l. She was then thoroughly examined in a teaching hospital for inappropriate secretion of antidiuretic hormone.

Mrs B also has to take bran and Metamucil "for her bowels," sometimes prune juice as well, and vitamins and calcium lactate "for her bones." She is only 52 years old but her skin, dry and wrinkled, contrasts unfavourably with her young looking, suntanned husband, who travels a lot but when in town brings her to the doctor. He knows it is her nerves but just wants to be sure. Mrs B does not have hypopituitarism. She has always had a subclavian bruit, which the vascular people say should be left well alone. She does not know how to drive, says everything is fine between her and her husband. Long interviews to get to the bottom of it all were tried but were unsuccessful. Everything at

Cook County Hospital, Chicago, Illinois, USA
GEORGE DUNEA, FRCP, FRCPED, attending physician

home was fine, but she complained about her stool coming out in little lumps. And "I am always cold doctor. Could I be needing more thyroid?"

For a long time I worried about Mrs B, wondering if the intima of her blood vessels was not as wrinkled as her skin, for why should she have that subclavian bruit? Then I thought of more tests for hypopituitarism, for why would she look so white? But then she has had her endocrine orchestra studied time and again, especially after a skull *x* ray examination showed a suspicious sella turcica, a difficulty resolved by costly computed tomography. Then the phone would ring again and she would say her circulation was bad, her eyes infected, she had heaviness under the diaphragm, and her whole system had changed since the trouble with the pituitary.

Vague entity of hypochondriacism

Yet who can doubt by now that her trouble resides well above the diaphragm, above even the sella turcica. Somatisation is what cripples Mrs B and constitutes the most frequent problem for which patients consult their doctors.[8 9] Psychiatrists offer a long differential diagnosis, but in the context of Amelia B one can rule out hysteria or Briquet's disease, schizophrenia, obsessive compulsive disorder, grief reaction, malingering, and conversion disorder. With reasonable confidence one can also exclude anxiety state, hysterical personality disorder, borderline personality, chronic factitious illness, and probably even depression. What is left is this vague entity of hypochondriasis, which some psychiatrists say should be diagnosed by its positive features[1] rather than by exclusion. Hypochondriacs are believed to have a shaky sense of selfworth, have feelings of incompleteness, need another person to provide a supporting relationship, and, while not malingering, derive a benefit, perhaps subconscious, from their illness.[8 9]

Among the authors who have written about this maelstrom of functional disorders Barsky has emphasised that the Mrs Bs of this world visit doctors for hidden reasons such as anxiety, grief, frustration, fear, and social isolation.[10] They may have no diagnosable psychiatric illness,[10] but "meeting the doctor, talking, and being touched by him are important, pleasurable, and real interpersonal transactions for lonely people."[10] "Being accepted as a patient then helps coping with the stress. It allows persons to relinquish responsibilities, avoid challenges, and postpone obligations, and provides an acceptable means of gaining sympathy, attention, and support"—also allows one to control and manipulate people.[10] Katon has emphasised the secondary gains resulting from being ill, such as avoiding work, duties, sex, and close relationships as well as gaining attention, justifying dependence, earning rest, and punishing others.[9] In some primitive societies somatisation of psychological distress is the only institutionalised way of seeking help, to complain of psychological symptoms being culturally unacceptable and stigmatised.[9] Neurasthenia, neurocirculatory asthenia, and DaCosta's syndrome, now diseases of the past, fall into the same category as hypochondriasis.

But, most importantly, the Mrs Bs of this world do not seek a cure. They do not wish to be told that there is nothing the matter.[1 8 11] They wish to keep coming, to be treated sympathetically, to be told one understands how much they suffer. They need to be heard out, without too much reassurance, and without new tests for each new symptom. Some psychiatrists suggest regular appointments no longer than 15 minutes, with an eventual attempt to lengthen the intervals between visits and shift the conversation from somatic symptoms to other concerns.[1 11-13] Which is about all one can do for Mrs Amelia B. She must have been a pretty woman once, before she became wrinkled like a prune and turned white from staying indoors. Surely, all is not well between her and her suntanned always travelling husband. But at least no cancer has ever declared itself, no glandular disorder, no Lyme disease. Her husband, when in town, calls for reassurance, then tells me it's all in her mind. But Amelia B is doing fine. Only last week she phoned, this time mercifully during the daytime: "My bowels have not moved for a week, but there was some action today. Very scant, however. And I took some Petrolagar with the Librax. It seems to work better than the bran. Last week the other doctor took me off the Bentyl (dicyclomine hydrochloride) because I was swallowing hard and my diaphragm was shaking. I also have a nasal discharge, going to the right. My blood pressure changes all the time. Any my whole body feels as though it is on fire. . . ."

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Is it advisable for a woman to use an ultraviolet sunbed if she has an intrauterine contraceptive device made of copper?

More than 90% of ultraviolet radiation impinging on the skin actually enters[1]: the depth to which it penetrates soft tissue is wavelength dependent, but even the longer wavelengths penetrate only just beneath the epidermis[2] and so will not affect directly an intrauterine device. Copper containing intrauterine devices do not have systemic effects and do not alter serum copper concentrations, and there is no reason to suspect that they would affect the skin's response to ultraviolet light. Exposure to ultraviolet light increases skin blood flow,[2] but so far as I know skin blood flow is not related to uterine blood flow or menorrhagia. Recent discussion[3 4] about the dangers of sunbeds has concerned itself mainly with two aspects—their direct effects on the skin and eyes and their generalised effects on the immune system. Solarium exposure alters systemic immune function[3]—possibly by affecting lymphocytes as they pass through cutaneous blood vessels[1]—and this may play a part in human skin cancer.[1] Whether such immunological changes might alter the endometrial response to an intrauterine device is debatable. This uterine inflammatory response, which seems to be the main mechanism of the device's contraceptive action, is more pronounced with copper containing devices than with inert ones, but it is not known whether it could be altered by ultraviolet irradiation of the skin. I would think such an effect is most unlikely. I would not advise anyone to expose themselves unnecessarily to even the mildest of possible carcinogens, but at present there is no particular reason to warn women with intrauterine devices to avoid this fashionable eccentricity.—JAMES OWEN DRIFE, senior lecturer in obstetrics and gynaecology, Leicester.

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