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Action on Smoking and Health

SIR,—The second report of the Royal College of Physicians—*Smoking and Health Now*[1]—once more gives clear evidence of the disastrous health consequences of cigarette smoking for the people of this country. The first report resulted in a temporary reduction of cigarette smoking. The College is determined to do all it can to effect a permanent reduction in what is acknowledged to be the major environmental health hazard today.

It has therefore decided to sponsor Action on Smoking and Health (A.S.H.). A.S.H. is planned as an independent national organization with a small but active full-time staff. It will straddle many professions and walks of public life and its aims will be:

(1) to provide information on smoking for the benefit of the health of the community at large,

(2) to stimulate and support research into the problems of smoking and health,

(3) to consult regularly with other bodies actively concerned with the smoking problem to strengthen and harmonize their efforts,

(4) to influence public opinion-forming bodies who are at present uninformed and unconcerned,

(5) to act as an authoritative voice speaking for all individuals and organizations seeking to influence public and private attitudes towards smoking.

The solution of the smoking problem will require a long-term effort, and A.S.H. will need to be securely based and be able to function effectively over a number of years.

A.S.H. will be launched at the Royal College of Physicians on 20 January and a number of representative organizations and individuals are being invited.

In the past many doctors have felt frustrated at their inability to speak up and take action on the problem of cigarette smoking. The founding of A.S.H. now provides an opportunity for the profession to take a lead and it is hoped that organizations and individuals who accept its aims will join A.S.H. in concerted action. Further particulars can be obtained from: The acting General Secretary, Action on Smoking and Health, The Royal College of Physicians, 11 St. Andrew's Place, Regent's Park, London N.W.1.—We are, etc.,

ROSENHEIM
K. P. BALL
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J. E. O. DUNWOODY
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Royal College of Physicians, London N.W.1.

1 Royal College of Physicians of London, *Smoking and Health Now*, London, Pitman, 1971.

Restless Legs

SIR,—Hardly anyone will dissent from the propositions in your leading article (26 December, p. 758) that most patients with "restless legs" show no signs "either of systemic disease or psychoneurosis," and that many of them "become obsessed with the severity of their symptoms." However, every disabling syndrome having a chronic, fluctuating course is regarded as a nervous manifestation of invalidism until its true pathology is discovered. History of medicine abounds with such examples. At present we are still in the taxonomic stage as far as "restless legs" are concerned, and this calls for strict accuracy in the terminology used. It is of some consequence, therefore, that in the two articles on restless legs (26 December, pp. 774 and 796) the term "nocturnal" myoclonus is used in different connotations. Dr. J. D. Spillane noted (26 December, p. 796) that "nocturnal myoclonus may of course be the presenting complaint unassociated with restless legs," an observation which his Case 2 illustrates abundantly.

To overcome the ambiguity of "restless legs unassociated with restless legs" it seems to me necessary to accept "nocturnal" myoclonus as a variant of the syndrome of restless legs. Several other variants can also be recognized, for example, pain and myoclonus group; pain group; and "sleep" pain group.[1]

The restless legs group represents, of course, by far the commonest variant; it is also associated with nocturnal myoclonus, as the spouse of the victim will readily confirm. The term restless legs by being descriptive is also restrictive and cannot without confusion be applied to most of the variants mentioned, especially since the arms may be affected—a clinical feature which did not escape Thomas Willis.[2]

A more comprehensive nosonym is therefore, required, and I suggested the term "dyslysis" because the disorder is one attendant upon relaxation of the limbs.[1] In the light of present-day neurophysiological concepts it can be claimed that relaxation of limbs is as much a "positive" phenomenon as is the motor counterpart. The disorder of the mechanism whereby relaxation of the limbs is attained is probably in most cases genetically determined, as is suggested by the frequent incidence of this condition among several members of one family. Such predisposition frequently remains latent and becames overt as a result of the influence of a great many different factors—for example,