

# BRITISH MEDICAL JOURNAL

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SATURDAY 29 SEPTEMBER 1984

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We may shorten letters to the editor unless the authors specifically state that we may not. This is so that we can offer our readers as wide a selection of letters as possible. We receive so many letters each week that we have to omit some of them. Letters must be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by *et al*; and the first and last page numbers of articles and chapters should be included.

## Motor neurone disease: can we do better? A study of 42 patients

SIR,—In the survey on motor neurone disease by Drs P G Newrick and R Langton-Hewer pain was a problem for 64% of the patients and was not well controlled (1 September, p 539). In a large survey of 100 patients in the terminal stages of motor neurone disease 40% complained of pain and three types of pain were identified.<sup>1</sup> These were musculoskeletal pain from stiff joints which had restricted movements and altered muscle tone, muscle cramp, and pain from skin pressure, as the patient is less able to move spontaneously.<sup>1,2</sup> The treatment will vary according to the cause—non-steroidal anti-inflammatory drugs for musculoskeletal pain, diazepam or quinine bisulphate for cramp, and analgesics, including opiates, for skin pressure pain. All these treatments should be combined with careful positioning of the patient and physiotherapy.

Opiate analgesics can be safely used for these patients in the control of symptoms of pain, dyspnoea, cough, restlessness, and, on occasion, feelings of hunger. In the large series 84% of the patients received morphine or diamorphine orally as a mixture in chloroform water or as slow release morphine sulphate.<sup>1</sup> The starting dose is usually 5 mg of an oral mixture or 10 mg slow release morphine sulphate, and for many patients a single night

time dose may be sufficient. Occasionally, however, regular daytime administration may be necessary. The dose can be increased slowly and titrated to the patient's pain, and when opiates are used in carefully selected doses they effectively control these distressing symptoms. Patients should not be denied this relief. By controlling distress opiates do not necessarily shorten life but may lengthen it, and treatment has continued for over five years in one patient. All the symptoms experienced by the patient must be carefully assessed and then treated, and much can be done to reduce the distress of this disease.

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1 Saunders C, Walsh TD, Smith M. Hospice care in motor neurone disease. In: Saunders C, Summers DH, Teller N, eds. *Hospice: the living idea*. London: Edward Arnold, 1981.

2 Oliver DJ. *The control of symptoms in motor neurone disease*. London: St Christopher's Hospice, 1984.

SIR,—Dr P G Newrick and Dr R Langton-Hewer (1 September, p 539) have shown deficiencies in the care of patients with motor neurone disease. Viewed from general practice this indicates shortcomings in management for

which the primary care team should be responsible. Their study did not consider whether this was so or how the "general practitioner's close interest and involvement" are to manifest themselves. It is premature therefore for them to conclude that, "The GP is unlikely to have the necessary skills to manage the disease effectively."

They suggest that a key worker (possibly a nurse) be appointed, but her job description in many ways matches that of the primary care team. The tasks proposed do not seem so esoteric as to be impossible for us, and individual difficulties could be met by specialised nursing and medical advice for the primary team—as is happening in other forms of domiciliary terminal care.

N E EARLY

Ashover, Derbyshire

SIR,—I found the article by Dr P G Newrick and Dr R Langton-Hewer extremely interesting because I had to cope 10 years ago with a close family member with motor neurone disease. It is a particularly unpleasant disease, but the symptom that was the most distressing to this patient was loss of support and control of the head. Splints and collars were un-