The bad publicity which lithium medication has accrued is more a reflection of bad practice than a problem with the medication. The British National Formulary (BNF) and monthly index of medical specialties (MIMS) have unwittingly contributed to the confusion by retaining out of date information. For example, the kidney scare of the '70s has now been discounted (Waller & Edwards, 1989). Yet the BNF still lists kidney changes as a side effect of therapeutic use quite separately to polyuria. It is not clear what kidney changes are referred to. MIMS states that "treatment should be initiated in hospital". Such alarmist reactions are outdated and do not reflect current specialist opinion.

We have published a guide to prescribing which should facilitate safe practice and confidence building (Srinivasan *et al*, 1992).

D. P. SRINIVASAN

Garlands Hospital
Carlisle CA1 3SX

N. J. BIRCH

Biomedical Research Laboratory
School of Health Sciences
University of Wolverhampton
Wolverhampton WV1 1DJ

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Prescription charges and recurrent depression

DEAR SIRS

Following the publication of Dr Vincenti's letter (*Psychiatric Bulletin*, July 1992, **16**, 444) suggesting that sufferers from recurrent depression should be exempted from prescription charges, this matter was considered recently by the College's Executive and Finance Committee. Under the present system, individuals suffering from certain chronic medical conditions are entitled to receive free NHS prescriptions, although this does not extend to include patients suffering from long-term mental illnesses.

The British Medical Association's General Medical Services Committee has undertaken a review of the arrangements for prescription charges in response to many complaints both from patients and from the profession that the present system is inequitable and anomalous. The College's Executive and Finance Committee shares the view expressed by the British Medical Association that the present level of charge may act as a disincentive to some patients in obtaining necessary medical treatment. However, the Committee also accepts the view that any extension of the present exemptions would be likely to introduce further anomalies, and raise disproportionately the burden on those paying charges. For this reason we would support the British Medical Association's position that the present system be revised, and the overall burden of charges be spread more equitably. The British Medical Association is currently considering making an approach to the Department of Health on this issue, and I would propose that this be supported by the College.

Professor A. C. P. SIMS
President

Attendance at multidisciplinary case meetings

DEAR SIRS

Your anonymous correspondent (*Psychiatric Bulletin* July 1992, **16**, 445) highlights an area that we have long considered cause for concern. His finding, that on his own unit, over three-quarters of multidisciplinary care meetings proceeded in the absence of at least one ward or community key-worker does not surprise us. In fact it accords perfectly with experiences we gained during our rotational training as registrars. We have also made the further observation that there appears to be an inverse relationship between multidisciplinary staff attendance at so-called "staff groups" and attendance at case meetings where the welfare of actual patients is supposedly advanced. Psychiatrists are of course far from perfect, but we do seem to indicate that we take our responsibilities for the welfare of our patients seriously by at least attending care meetings, be they ward or management rounds or case conferences. We can only hope to inspire members of other disciplines by our shining example in this respect or at least shame them by raising the issue at the next meeting of the navel-gazing unit staff group!

ROBERT HOWARD
DIPANKAR BANDYOPADHYAY

Institute of Psychiatry
Denmark Hill
London SE5 8AF

Sporting philias

DEAR SIRS

I am deeply grateful to Dr Barrett for his brave and self-revelatory piece (*Psychiatric Bulletin*, July 1992, **16**, 454). As a long-term sufferer from the same syndrome, with intermittent remissions occasioned by examination neurosis, marital disharmony, and "child care and the growth of love" (à la Bowlby) I too have grappled with this disorder. Treatment is difficult, but one should perhaps accept the positive side.

For example, I have seen an Albanian league football match which has enriched my insight into the nature of paranoia as generated by the dictator Enver Hoxha. I have also been able to understand more closely the nature of culture-bound syndromes by witnessing certain behaviours at an international match between Cambodia and South Korea. The ability to communicate more fully with one's working-class patients has also been vital, males from such a background having a particular wariness of disclosing themselves to over-learned mind doctors.

My own perception had been that this was an isolated problem, with no-one else in the world of psychiatry at any level seeming to be in the slightest bit affected by the importance of, for example, being near a radio at about 4.30 p.m. on a Saturday afternoon. I have had to avoid or miss a number of conferences, because certain groups seem to hold formal meetings around this time. However, useful forms of desensitisation include trying to write match reports for one's local club's Fanzine, while regular five-a-side indoor games with social workers can be useful in the multidisciplinary context. Medication has never helped, although a brief trial of lithium significantly suppressed post-goal euphoria, and made it difficult to go to more than home games, in view of the accompanying polydipsia and polyuria. In retrospect, a non-sympathetic spouse can be of immense benefit, as can a range of carefully planned weekend activities around the whole of one's family that make it impossible to go away for any length of time. Likewise, by intermittently travelling to selected away league grounds, for example York City on a Tuesday evening in January, one can develop useful cognitive avoidance techniques.

Perhaps there is a need though for a Special Interest Group? A more psychologically aware approach to soccer, and an understanding of the needs of its aficionados may well benefit the current depressed state of the English game. In addition, insights may be gained into the needs of the unemployed male youth that now threaten the fabric of urban society. Finally, I can inform Dr Barrett, whom I am sure is not ignorant of the fact, that Stoke City did make it to Wembley, but did not unfortunately get promoted. Perhaps he would allow me to discuss further strategies and therapeutic techniques by coming to Stoke City's next visit to Leyton Orient.

T. H. TURNER

Hackney Hospital
London E9 6BE

DEAR SIRS

In response to Dr Barretts' letter on philic disorders (*Psychiatric Bulletin* July 1992, **16,** 454), I would like to add my own thoughts.

I, too, am a male married Caucasian psychiatrist in my 30s. Two years ago I developed a similar acute-onset philia for golf. An innocent visit to a driving range with a friend was remarkable only for the rapidity of the blistering of my hands until a casually-struck ball flew in a perfect arc and for a remarkable distance. While the ball was in the air I was overcome by an intense affect akin to ecstasy. Within weeks I had begun to play every week. I now dream about golf, read magazines about golf and accept only those wedding invitations which take me to regions offering access to recommended golf courses.

I consider that sporting philias are both common and adaptive but in extreme cases there is considerable overlap with other psychiatric syndromes. For example, there is subjective awareness of the compulsion to play, tolerance to ever-increasing amounts of golf, a characteristic dysphoric withdrawal syndrome of depressed mood, irritability and autonomic arousal, primacy of golf-seeking behaviour and a stereotyped pattern of play. Periods of abstinence are followed by rapid reinstatement and, needless to say, the withdrawal symptoms from golf can only be relieved by another 'round'. I consider that there is both a psychological and physical dependency syndrome. Phenomenologically speaking, the urge to play golf is intrusive, recurrent and sometimes perceived as senseless but it has never yet been ego-dystonic.

I endorse the validity of the philia as an entity while drawing attention to the possibility of overlap with addictive behaviours and obsessive compulsive disorder. I would be extremely interested to hear a psychodynamic formulation of the behaviour of a grown man dressing up to hit a very small ball with a very long club. Finally, I would speculate that 5HT uptake inhibitors will not help this or any other philia, but if Dr Barrett anticipates seeing Stoke City at Wembley he might well benefit from a neuroleptic.

M. A. MCPHILLIPS

St Mary Abbots Hospital
Kensington, London W8 5LQ

DEAR SIRS

Ken Barrett's letter (*Psychiatric Bulletin*, July 1992, **16,** 454) raises an interesting point. Fortunately he is willing to realise the necessity for treatment. Many "philias" are themselves harmless, but I fear this is not the case here. I refer to the SSC (supporting Stoke City) component of the complaint. I would recommend sublimating his desire to a more successful football team to avoid a constant sense of frustration and even failure.

I should know. I am in danger of developing a similar "philia" for the national rugby team. I live in Wales...

SIMON MANCHIP

Whitchurch Hospital
Cardiff CF4 7XB