statistical tests . . . since the population samples studies are not homogeneous with regard to distributions of age or IQ', does not hold. There is hardly any difference in age distribution: Mean and S.D. $27 \cdot 15 \pm 9 \cdot 59$ vs. $27 \cdot 63 \pm 6 \cdot 00$. The difference in IQ's of the experimental and control groups was precisely one of the findings of the study, a fact which indeed is of interest, since the difference of the distribution of educational level and occupation of brothers and fathers between the two groups was to the advantage of the patients with 47,XXY and not to the patients of 46,XY.

Finally, it should be mentioned that to secure an unbiased attitude on the part of the examiner the psychological investigation was carried out blindly, the psychologist possessing knowledge of neither anamnestic data, psychiatric evaluation, or results of physical and cytogenetic examinations.

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PEMOLINE IN OVERACTIVE MENTALLY HANDICAPPED CHILDREN

DEAR SIR,

Amphetamine has been described as a useful drug for the treatment of overactivity in mentally handicapped children.

Response has been demonstrated in children suffering from behaviour problems associated with an abnormal EEG, certain types of epilepsy and in some aggressive psychopaths. A panel appointed by an American Department of Health, Education and Welfare reached the conclusion that no dangers exist for children if amphetamine treatment is properly applied and therefore gave it their seal of approval in the treatment of hyperkinetic children (American letter, *British Journal of Hospital Medicine*, August 1971).

Spencer (*British Journal of Psychiatry*, August 1970) reporting the results of a double blind trial with pemoline (Ronyl) concluded that it may be of value in the treatment of overactive mentally subnormal children. I therefore made the following trial.

Nine overactive, severely subnormal children, aged between 12–16 years were given a trial dose of pemoline 20 mgs. t.d.s.; their previous medication (usually anticonvulsant and/or major tranquillizer) continued unchanged during the trial. The patients' response was assessed at weekly intervals based mainly on clinical observations: Hyperactivity, Aggressiveness, Destructiveness, and Antisocial activities.

The result was that four of the children, during the first week of the trial, showed a marked deterioration in all aspects of their behaviour so that pemoline had to be discontinued during the second week and they soon reverted to their previous behaviour pattern; of the remaining five children, after eight weeks of treatment, two showed no response, two improved with prominent reduction of overactivity, and one showed remarkable improvement in all aspects.

The result of this study, despite the small number involved and the disadvantages of having as criterion clinical observations only, seems to show that pemoline may be a drug of valuable assistance in the treatment of some overactive, destructive, mentally subnormal children.

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MEDICAL PRACTICE

DEAR SIR,

The figures of patient turnover given recently for a general medical unit of 60 beds under two whole-time consultants (1), are of interest to compare with those of the psychiatric 'firm' serving the statistically typical population of the Parliamentary constituency of Gravesend and North Kent (about 100,000 people). This 'firm' has one whole-time consultant and about 25 admission beds (there being no rigid allocation). Like the medical unit, the psychiatric 'firm' runs four weekly out-patient clinic sessions, but also a day hospital and a longer-stay in-patient commitment now mostly unrelated to its present catchment area.

TABLE

Annual average numbers of patients per whole-time consultant over a three-year period

	Gravesend psychiatric 'firm' (1969–72)	'Uxbridge' medical unit (1968–70)
Admissions . .	245	704
Rate per bed . .	10	24
New out-patients . .	431	523
Reattendances . .	1,623	2,270