comment in the paper but it is of note that not all symptoms associated with depression distinguish between the irreversible dementias and this reversible syndrome.

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ELECTROSTIMULATION AND OPIATE WITHDRAWAL

DEAR SIR,

The paper by Gossop *et al* (*Journal,* February 1984, **144,** 203–208), which has just been brought to my attention by Dr Connell, comparing electrostimulation with oral methadone in opioid withdrawal, contains several theoretical and factual errors. The techniques as described are certainly *not,* as claimed, "the same as the 'NET' (neuro-electric therapy) used by Patterson".

Moreover, I have never advocated "acupuncture techniques", also claimed by the authors, because acupuncture, as practised by experts in Hong Kong and China, had little or no effect on drug addiction. Electro-acupuncture was simply a means by which we serendipitously discovered that electric signals were a significant therapeutic tool.

One fault in design lies in comparing drug-free patients with those receiving a potent opioid (methadone). A more valid comparison would be 10 days after each group had completed the withdrawal treatment, despite the authors' admission of design "weakness" in comparing a 10 day treatment (NET) with a 21 day treatment (methadone withdrawal—MW). The 10 day post-treatment results show a distinct advantage in the symptoms graph (page 206) for NET as against MW.

One of the greatest benefits of NET is the reduction of the chronic withdrawal period from many months—up to 18 months in methadone addiction (Cushman, 1978)—to 1 to 2 weeks, occasionally up to 4 weeks, after commencement of NET (Patterson, 1983).

Further, only 8 cases out of 24 completed Gossop's study. In my detailed examination of the withdrawal symptomatology in 102 consecutive cases treated over one year, there was only one drop-out before completion of the 10 days NET (Patterson, 1984). Also, according to the authors, there was no objective reporting of symptomatology by staff. In my much larger study, although there was no comparison group, symptoms and signs were recorded 4 times daily by trained nurses for the first 6 days and twice daily for the next 4 days. This was in addition to once daily self-reporting by the patients. It is well known that addicts exaggerate their symptoms, yet Gossop's study bases its findings on such unreliable data.

"All the subjects in the study used a variety of other drugs on an occasional basis". Apparently no effort was made to compare patients using the same drug or drug combination, not is it stated how many in each group were using each different drug.

One of the basic tenets of NET is that the current frequency has to be altered for each different group of psychoactive drugs and occasionally for different drugs within the same group, the problem becoming much more complicated with drug combinations. There is no evidence from the article that this fact, although repeatedly mentioned in my several publications, has been grasped by the participants in this study. It is not surprising that they had so little success if, for example, they used "for opiates and benzodiazepines 400 Hz".

Their report provides no follow-up although it was completed in June 1982 and not published until 1984. I have twice published my follow-up results (Patterson, 1984), the second including patients treated up to 8 years previously.

Finally, the letter from Dr E. P. Larkin (*Journal,* June 1984, **144,** 670–671) suggesting using NET and MW together ignores the findings of Man and Chuang, quoted in Gossop's article, in which 30 days of MW was given to both control and study groups. They themselves dismissed the study as "meaningless" because 83 per cent were found to be using drugs illicitly although in-patients—another factor which Gossop and colleagues appear not to have investigated. In my 12 years' experience, there has been consistent clinical evidence that concurrent administration of drugs diminishes the beneficial effects of NET.

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