but for patients such as this (a subordinate judge) in whom memory disturbance can be incapacitating. It is just as safe and almost as simple.

I fully agree, however, that further inquiry is needed, and we are working on this.

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## GLUCOSE TOLERANCE IN DEPRESSION

DEAR SIR,

What Dr. van Praag writes in his letter about "averages" in clinical investigations (*Journal*, September, 1968, p. 1195) is, I believe, of fundamental importance to all those actively engaged in psychiatric research.

It has long been my conviction that the study of sub-groups, as these are at times discerned in the collection of research information, merits the greatest possible care and detailed analysis. Yet the very existence of such sub-groups is often missed, either because of inappropriate statistics which "iron out" the meaningful clusters of data or (which has the same practical effect) because of the attitude of the research worker who analyses them.

I had the opportunity to participate in the discussion of this problem in a symposium during the last International Congress of Psychiatry in Madrid, and was delighted to see that at least the mathematicians are fully aware of the difficulties in medical research; they are making use of electronic devices to help in the extensive analysis of amassed research data, with the very aim of recognizing significant clusters. Welcome as this new development might be, it cannot, however, replace the inquiring eye of the clinician who has an intimate knowledge of his material. Dr. van Praag's letter is a typical proof of this.

My own experience is in line with Dr. van Praag's findings about a category of patients whose psychiatric disorder is probably correlated with disturbance of metabolism. Some of this research work done at the Bethlem Royal Hospital under W. Linford Rees was with puerperal depression, where the tendency in certain sub-groups to emerge was obvious in a number of metabolic parameters studied—including glucose (Jacobides, 1957); although the deviations from the norm were never deemed great, especially as they were gauged by the single methods of Glucose Tolerance Test and Insulin Sensitivity Test and not by the elaborate biochemical assessments of Dr. van Praag. It is hoped that the findings from puerperal psychotics will be published in some detail and that they will give support to the conclusion of Dr. van Praag, viz. that "averages can be deceptive in biological psychiatry". I can only add to this important epigram that averages can be *a menace* when they let meaningful information from a sub-category or even from a single patient be drowned and irrecoverably lost!

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## TREATMENT OF PREMATURE EJACULATION

DEAR SIR,

In reply to the letter of Dr. Ahmed (*Journal*, September, 1968, p. 1197), I would like to make the following points: Dr. Ahmed reports that patients receiving a 1 per cent. solution of methohexitone sodium feel intense pain along the site of the vein. Having regularly used a 2·5 per cent. solution of methohexitone sodium, as recommended by Friedman (1966), I have never received any complaint of pain. It has been my experience that patients may complain of unpleasant giddiness during the induction period, but this can be avoided by the anaesthetist injecting the drug very slowly (Kraft, 1967).

The first patient's symptoms of enuresis, frequency of micturition and premature ejaculation, which Dr. Ahmed attributes entirely to anxiety, might also be interpreted in terms of passive male urethral eroticism (Fenichel, 1946). During his treatment, as the duration of erection increased, there was a parallel decrease in his frequency of micturition, which is of theoretical importance, as it provides a link between analytic and behaviour-orientated approaches to treatment in this field (Kraft, 1969).

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