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## Briquet's syndrome - some diagnostic considerations

I read with interest the case report by Harris *et al.* (March 1991 *JRSM*, 167) on Briquet's syndrome.

There are a few complexities in diagnosing and conceptually understanding Briquet's syndrome which I would like to highlight here. Firstly Briquet's syndrome is not a diagnosis of personality. The authors highlight a Briquet's syndrome patient having an underlying personality of hysterical type rather than antisocial and psychopathic, which is not too palatable an observation. Moreover, primary male relatives have an increased prevalence of alcoholism, drug abuse and antisocial personality disorder, which makes this assertion further suspect. Whether the underlying personality makes a substantial contribution towards aetiology or are other genetic, environmental, social, cultural or neuropsychological factors as important, if not more, is not yet clear.

Conceptually, characteristic of Briquet's syndrome is involvement of multiple systems and a particularly high frequency of sexual complaints. For a diagnosis of Briquet's syndrome of St Luis criteria[1], patients need to have at least one symptom from nine out of 10 symptom groups described. DSM IIIR's[2] somatization disorder which is considered equivalent to Briquet's syndrome requires at least 14 out of 25 symptoms in a female to make such a diagnosis. The list of seven symptoms used in the case report of which presence of only two or more symptoms suggest a high likelihood of this disorder seems to be an oversimplification and indeed a conceptual mistake.

I would be sceptical of labelling recurrent tendoachillis pain which culminated in a left below knee amputation as a Briquet symptom although detailed information is not available. A patient with predominant pain symptoms or somatic symptoms which cannot be explained medically, but which do not qualify the stringent criteria for Briquet's syndrome should not be labelled as such. This point attains further significance and one needs to be very careful about it, as, diagnosing a patient 'Briquet's' carries connotation of extreme somatization and a very poor prognosis which may bias future treatment. It is also important for physicians not to be distracted by this diagnosis whenever a patient presents with a fresh complaint.

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## Honey and healing

Further to the letters of McInerney (February 1990 *JRSM*, p 127) and Somerfield (March 1991 *JRSM*, p 179) I had also used honey successfully in the treatment of chronic ulcers, particularly of foot ulcers in leprosy patients whilst in Mysore, South India, from 1951 to 1967. A problem with honey was that it was sometimes messy, leaking out from the edges of dressings and also that it attracted flies. On returning to this country I reverted to its use again for chronic ulcers and for neurotrophic diabetic foot ulcers, but later I changed to using sugar paste made according to the formula below.

I have used this now for 10 years and find it to be very useful in separating moist slough and promoting the healing of granulating wounds. It has proved very acceptable both to patients and to the nursing staff alike.

Formula for sugar paste:

| | |
|---|---|
| Caster sugar | 400 g |
| Icing sugar | 600 g |
| Glycerine BP | 480 ml |
| Hydrogen peroxide soln 30% BP (100 vol) | 7.5 ml |

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## Immunology of the tonsils

Dr A H Hodson in a letter (January 1991 *JRSM*, p 58) maintains that few tonsillectomies were undertaken on African children because they 'were not prone to tonsillitis'. He goes on to suggest that the absence of cow's milk in the diet could have had a bearing.

There might well be a simpler explanation. From 1950 to about 1965, I attempted to assist the African population with their ear, nose and throat problems, working in Salisbury, Rhodesia, now Harare, Zimbabwe. Many children with recurrent tonsillitis were referred for consideration of tonsillectomy, and in those in whom it was thought the operation might be beneficial, surgical treatment was advised.

This was usually refused because at that time surgery would not be accepted unless it was obviously necessary as a life-saving procedure, all other avenues, including traditional healers, having previously been explored. Additionally in their hierarchy it is the 'mai', the grandmother who is the absolute head of the family and who looks after and controls all aspects of the family and children's welfare, including discipline, and if she said no it was no. The parents would accept this decision, and would have been very unwise to do otherwise.

The situation is very different today. 'European medicine' is accepted much more readily and my colleagues undertake tonsillectomy on as many African children, if not more, than on the patients of any other racial group.

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In West Cameroon, the rainfall exceeds 300 inches per year, no milk is drunk, and tonsillitis is very rare (January 1991 *JRSM*, p 58). In Tobruk, in Libya, the desert comes down to the seashore and the rainfall is less than 2 inches per year. In the 1960s no milk was drunk, and florid tonsillitis was extremely common. One day I sent an 11-year-old child to the hospital with instructions that a tracheotomy set be