Devonshire Colic

SIR,—The report of a case of lead poisoning from home-made cider manufactured in Surrey (11 January, p. 98) is interesting. Here in Devon, the home of cider making, we have eradicated the disease these hundred years. But it used to be so common that it was known as the Devonshire colic. It was just over 200 years ago that Sir George Baker read his classic paper on the *Cause of the Endemical colic of Devonshire* to the College of Physicians, and had it printed and sent down into Devon, "with a particular view to giving to the inhabitants of the county of Devon the earliest intimation of their danger; in order that they may take the proper steps to preserve their health, and to secure the value of their property."

Things move slowly in these parts, and it took a hundred years to get the message over to all the farmers and stop them mending their presses with lead. It was done, however. The lesson to be learnt from the case at Guildford is that history repeats itself in medicine as in all other things.—I am, etc.,

R. M. S. McCONAGHEY.

Dartmouth, Devon.

REFERENCE

1 McConaghey, R. M. S., *Med. Hist.*, 1967, **11**, 345.

Elderly in Hospital

SIR,—The article by Dr. R. W. Parnell and others, "Changing Use of Hospital Beds by the Elderly" (21 December, p. 763) focuses attention on a serious aspect of social medicine. It is also likely that their account of conditions in the Birmingham region applies to the country generally.

The steady increase in our aged and infirm, which is both numerical and proportional, is placing an ever-growing burden on medical resources, including what are known as welfare facilities, but Parnell and his collaborators have shown that in the Birmingham region, far from expanding, geriatric beds have decreased in number in the years from 1961 to 1967, and that their turnover has gone down appreciably too. Hitherto disaster has not overtaken us because the acute medical and psychiatric sectors to which large numbers of elderly people, predominantly females, are being directed, have managed to speed up discharges of all types, and also in a small measure because there has been a very modest contribution from the slight growth in the number of welfare places provided by local authorities. Those who practise acute hospital medicine and surgery, or psychiatry, have responded to the challenge by running ever faster, and it is no exaggeration to say that a major function of some of them when going round their wards is to find patients for early discharge. But there is a limit to what the acute side can do, and the time may come, even where there is still a willingness to put up extra beds, when it will grind to a standstill.

On the geriatric side, in contrast, the old overcrowding has been greatly diminished by marked reduction of bed complements, and this, coupled with new geriatric units built to high specification, is inevitably proving an attraction to stay put in places where conditions are often as good as, or even better than, in welfare homes, and where additionally the patient is not likely to be placed on the transfer list because of incontinence.

Many of the aged continue to cling to independence even when they are clearly in need of institutional care, and fortunately there is still a tremendous filial and other affection for old people sometimes amounting to obsessional devotion. But who is to blame busy folk, some of them not even relatives, when they experience a sense of relief once a failing old person for whom they cared hitherto is admitted to a comfortable place? This is not an advocacy to go back to former conditions, which Sheldon[1] pungently stigmatized as providing no more than "human warehouses," but an attempt to look at the problem squarely and to ask where the present trend is taking us. The community must realize that more twilight care calls both for greater capital expenditure and for a larger number of able-bodied helpers possessed of a high degree of selflessness, and while this is obviously a long way off one wonders whether it was a good plan to create a separate specialty of geriatrics. Most of us, except for paediatricians, now have to deal with a large proportion of old people, and in that sense reintegration of geriatrics into the main stream of medicine could lead to a better global appreciation of the problem and to a more equitable distribution of a burden weighing so heavily on a section which nowadays often merits the title of "acute" only by courtesy.—I am, etc.,

A. M. NUSSEY.

Selly Oak Hospital, Birmingham.

REFERENCE

1 Sheldon, J. H., Report to the Birmingham Regional Hospital Board on geriatric services, 1961. Birmingham.

Referral of Mentally Subnormal Patients to Hospital

SIR,—A study of patients referred to hospitals for the mentally subnormal provides useful information about the demands made on these hospitals, and about the number of problems with which they may be expected to cope in a given period.

The Subregional Admission Bureau 3 of the Leeds Regional Hospital Board serves a population of 840,986. The numbers of patients referred to the bureau during two periods of 12 months are related to the population in the Table below.

Area	Population	No. of Patients Referred		Referral per 10,000 of Population	
		1966	1967	1966	1967
County boroughs	391,841	70	78	1·8	1·9
Municipal boroughs	175,288	29	32	1·7	1·8
Urban districts	217,304	24	21	1·1	0·9
Rural districts	56,553	2	4	0·4	0·8
Total	840,986	125	135	Overall rates 1·5	1·6

Each referral represented a problem for which a local health authority or a family doctor sought help from the hospital service. Patients referred for short-term care under the provisions of Circular 5/52[1] were not included.

During the two periods slightly more male than female patients were referred. Approximately 50% of all the patients were under 16 years of age, 40% were under 12 years. In terms of intelligence quotients, subnormal (I.Q. 55 to 70) and severely subnormal (I.Q. below 55) patients were referred in nearly equal proportions. Just over 50% of the patients referred were admitted to hospital, and one-third of these admissions were on a long-term basis. Sixty per cent. of the referrals presented problems of behaviour and social adjustment. One in ten patients required nursing care. The others came for accommodation or advice. Fifteen per cent. of the referrals had previously been inpatients or outpatients at hospitals for the mentally subnormal.

The similarity in the pattern of referrals during the two periods suggests that the number of mentally subnormal people in an area who are likely to need help from the hospital service during a certain period is a predictable figure.—I am, etc.,

D. A. SPENCER.

Westwood Hospital, Bradford 6, Yorks.

REFERENCE

1 *Ministry of Health Circular* 5/52, 1952.

Amantadine Hydrochloride and the Elderly

SIR,—In the last five years there have been a number of reports on the value of amantadine hydrochloride in preventing infection with type A strains of influenza virus. Opinions have varied considerably as to its value in man, and the position was thoroughly reviewed by Sabin,[1] who concluded that further carefully controlled field-trials were needed.

Last winter a trial of the drug was carried out on geriatric patients in an acute ward, a rehabilitation ward, and three long-stay wards. The drug was given from 24 December 1967 to 31 January 1968 in a dose of 100 mg. twice daily. Cases of laboratory confirmed influenza A2 occurred in the hospital between 27 December 1967 and 13 January 1968. On three of the wards a double-blind system was used, amantadine and a placebo being given in identical capsules. On the remaining two wards the same dose of active drug was given in a syrup to 12 patients, the remaining 28 patients being untreated. A total of 70 patients received the active drug. The mean age of these patients was 77 years and the mean duration of the drug treatment was 25 days. No undesirable side-effects were noted. During the period of the trial all the cases of clinical influenza except one occurred on the rehabilitation ward, where the double-blind system was in use. In this ward influenza was diagnosed clinically in 11 of 29 patients receiving the placebo and in six of 25 patients receiving amantadine. Laboratory tests confirmed the diagnosis in the placebo group, but in the amantadine group one case diagnosed as clinical influenza was not confirmed by the laboratory and a further two patients appeared to have had subclinical influenza.

This trial showed that amantadine hydrochloride can be given to incapacitated old people without significant side-effects. The results are not statistically significant but suggest that the drug may have had a prophylactic value. Further studies are proposed