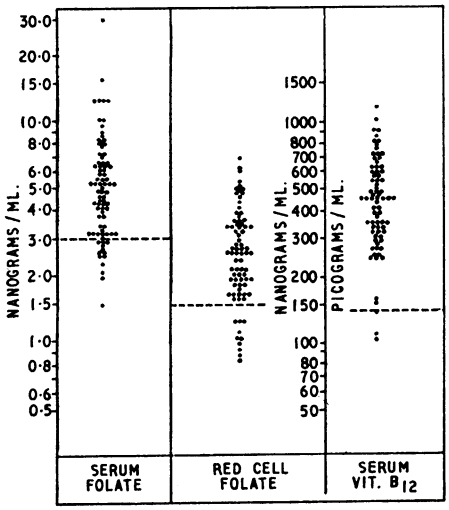
Folic-acid Deficiency in the Elderly

SIR,—The article by Drs. A. D. F. Hurdle and T. C. Picton Williams (23 July, p. 202) underlines the often poor folic-acid status of elderly patients resulting from inadequate diet rather than malabsorption.

In our investigations on 81 randomly selected hospital admissions in the over-70 age group, attention was focused mainly on the red cell folate values, which would appear to be a better indicator of the body folate stores than serum folate levels.[1 2] There was no evidence of an age-dependent decline of red cell folate, but 10 patients (see Fig.) had



subnormal values; they were suffering from debilitating diseases (such as cancer, senile dementia, cerebral thrombosis, arthritis, uraemia), and their dietary folate intake was apparently poor. None of these patients showed haematological evidence of megaloblastosis. Among nutritional megaloblastic anaemia cases diagnosed in our department over the last six years 69 out of 97 belonged to the age group in question. A randomly selected group of twelve such patients showed no evidence of malabsorption using a folic-acid absorption test.[3]

Like Drs. Hurdle and Picton Williams, we too found dietary inquiry a most unrewarding experience, but in all cases where it was possible to take a reasonable dietary history there was little doubt left in our minds about the inadequacy of folate intake in megaloblastic patients. We would echo the authors' views on the need for up-to-date information on folic acid consumed in the diet; food tables at present available are out of date for reasons referred to by them. As an example, we assayed, without previous conjugase treatment, a sample of tinned orange juice (one of the most popular brands on sale in this country), the folate content of which was found to be 6.7 μg. (*L. casei*) and 5.8 μg. (*S. faecalis*) per 100 ml., respectively, compared with trace amounts given for "orange juice, canned" by the standard reference book in use in this country.[4]

Obviously there is a wide scope of activity for social workers to give dietary advice to the elderly. Artificial supplements of folic acid in this age group cannot be recommended because of the potential hazard of delaying the haematological signs of Addisonian anaemia while neurological damage develops. Even so-called "safe" doses—that is, 0.4 mg. daily—can have this cumulative effect if administered over a long enough period.[5 6] Fortunately nutritional megaloblastic anaemia is a condtion which can be easily detected even in its early or mild forms by haematological means.—We are, etc.,

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Haemophilic Boy in School

SIR,—May I congratulate the authors of this article (23 July, p. 224) on their brave attempt to find facts on which could be based a reasonable plan of education for haemophilic boys. The questions raised—of normal school, home tuition, special school for the one condition, general physically handicapped school—are common to all handicapped children, and for "haemophilia" could be read a number of other disorders. Each has its own special problem: of prostheses for the limbless, of mobility for the motor-handicapped, and of supervision and treatment of urinary infection and micturition control in many conditions, including spina bifida.

England can be proud of its provision for special education, and, although a good case can be made for the special school for the single handicap, the lesson is that many solutions must be available. Flexibility is the key. This means that each family must have the chance of free discussion with both educationists and doctors, that social welfare and, later, the youth employment service both have a role to play. Like parents, all school personnel must be fully informed of the best medical management, which is a responsibility for the local Child Health Service. For even if "education is not a subject that would normally be discussed in a medical journal," it is very much the concern of the paediatrician who has moved away from being preoccupied with the acute diseases of children. In the total concept of child health, as in the life of the child, an important place is occupied by education.—I am, etc.,

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Psychiatry in General Teaching Hospitals

SIR,—Congratulations to Dr. William Sargant on his most interesting and excellent paper (30 July, p. 257). He is, of course, fooling us all, physicians and psychiatrists alike. Few psychiatrists will be able to resist frank admiration of his superb brand of psychotherapy. He disarms sceptics of psychotherapy by bluntly stating it is all useless and drugs do far more, and wins over avid psychotherapists by his subtle methods which are obvious only to them. His enthusiastic personality is one of the most potent psychotherapeutic forces in psychiatry today.

While few of us can hope to equal Dr. Sargant as a psychotherapist, there is one point he makes upon which I would like to comment. The neurotic, he states with apparent surprise, is far less suggestible than the organically ill patient. Any psychiatrist worth his serotonin knows this. The reason is that the neurotic has something to gain from his symptoms, while the physically ill has everything to lose from them, and will readily accept even the most obvious reassurance.

I agree with Dr. Sargant that the new antidepressive and anti-psychotic drugs and E.C.T. are more effective today than most psychotherapy. But psychotherapy still plays an important role in all psychiatric treatment. Dr. Sargant's skill lies in apparently damning psychotherapy while in fact practising it.—I am, etc.,

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SIR,—I was interested in Dr. W. W. Sargant's article on psychiatric treatment in general teaching hospitals (30 July, p. 257), in which he claims enormous success for the treatment of atypical depression, with the monoamine oxidase inhibitor group of drugs.

Can anyone explain why in the *British National Formulary*, 1966, it says of these drugs, " . . . and the evidence is unconvincing that they are more effective than a placebo" ?—I am, etc.,

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1 *British National Formulary*, 1966, p. 61.

SIR,—Lest Dr. William Sargant's lecture (30 July, p. 257) be taken as presenting too rosy a picture of the state of therapy in the psychiatric field, one should not fail to note his insistence on a "good previous personality" for a satisfactory outcome, whatever the illness—schizophrenia, depression, phobic anxiety. The vital question—as yet unanswered—is what percentage of all patients who suffer from these illnesses have a good previous personality? If in fact such cases are a minority of the total, then the major problem remains unsolved—namely, how to cure those who have a prognostically bad personality, and if this is impossible, perchance how to prevent the development of such bad personalities.—I am, etc.,

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Treatment of Ulcerative Colitis

SIR,—In view of the continuing correspondence arising out of Mr. S. O. Aylett's article (23 April, p. 1001) on colectomy and ileorectal anastomosis, I would like to refer to a study carried out by Dr. G. S. Moss and myself. This concerned 93 patients with ulcerative colitis who were treated by subtotal colectomy and ileostomy. The fate of the remaining rectal stump was followed. Some 72% have had it removed because of continuing local or systemic symptoms. In 91%