

- ⁵ Szlachter NB, Moskowitz J, Bigelow B, Weiss G. Iatrogenic endometriosis: substantiation of the Sampson hypothesis. *Obstet Gynecol* 1980; **55**, suppl: 52-3.
- ⁶ Kaunitz A, Di Sant' Agnese PA. Needle tract endometriosis: an unusual complication of amniocentesis. *Obstet Gynecol* 1979; **54**:753-5.
- ⁷ Czernobilsky B, Silverstein A. Salpingitis in ovarian endometriosis. *Fertil Steril* 1978; **30**:45-9.
- ⁸ Brosens IA, Koninckx PR, Corveleyn PA. A study of plasma progesterone, oestradiol-17 β , prolactin and LH levels, and of the luteal phase appearance of the ovaries in patients with endometriosis and infertility. *Br J Obstet Gynaecol* 1978; **85**:246-50.
- ⁹ Dmowski WP, Rao R, Scommegna A. The luteinized unruptured follicle syndrome and endometriosis. *Fertil Steril* 1980; **33**:30-4.
- ¹⁰ Hammond CB, Haney AF. Conservative treatment of endometriosis: 1978. *Fertil Steril* 1978; **30**:497-509.
- ¹¹ Hasson HM. Electrocoagulation of pelvic endometriotic lesions with laparoscopic control. *Am J Obstet Gynecol* 1979; **135**:115-21.
- ¹² Hirschowitz JS, Soler NG, Wortsman J. Sex steroid levels during treatment of endometriosis. *Obstet Gynecol* 1979; **54**:448-50.
- ¹³ Chimbira TH, Anderson ABM, Cope E, Turnbull AC. Effect of danazol on serum gonadotrophins and steroid hormone concentrations in women with menorrhagia. *Br J Obstet Gynaecol* 1980; **87**:330-6.
- ¹⁴ Chamness GC, Asch RH, Pauerstein CJ. Danazol binding and translocation of steroid receptors. *Am J Obstet Gynecol* 1980; **136**:426-9.
- ¹⁵ Menon M, Azhar S, Menon KMJ. Evidence that danazol inhibits gonadotropin-induced ovarian steroidogenesis at a point distal to gonadotropin-receptor interaction and adenosine 3', 5' cyclic monophosphate formation. *Am J Obstet Gynecol* 1980; **136**:524-30.
- ¹⁶ Stillman RJ, Fencel MDeM, Schiff I, Barbieri RL, Tulchinsky D. Inhibition of adrenal steroidogenesis by danazol in vivo. *Fertil Steril* 1980; **33**:401-6.
- ¹⁷ Noble AD, Letchworth AT. Medical treatment of endometriosis: a comparative trial. *Postgrad Med J* 1979; **55**, suppl 5:37-9.
- ¹⁸ Rönngren L, Ylöstalo P, Järvinen PA. Effects of danazol in the treatment of severe endometriosis. *Postgrad Med J* 1979; **55**, suppl 5:21-6.
- ¹⁹ Fraser IS. Danazol—a steroid with a unique combination of actions. *Scott Med J* 1979; **24**:147-50.
- ²⁰ Ward GD. Dosage aspects of danazol therapy in the treatment of endometriosis. *Postgrad Med J* 1979; **55**, suppl 5:7-9.
- ²¹ Mettler L, Semm K. Clinical and biochemical experiences with danazol in the treatment of endometriosis in cases of female infertility. *Postgrad Med J* 1979; **55**, suppl 5:27-32.
- ²² Audebert AJM, Larrue-Charlus S, Emperaire JC. Endometriosis and infertility: a review of sixty-two patients treated with danazol. *Postgrad Med J* 1979; **55**, suppl 5:10-3.

Fish poisoning

A variety of fishes and other marine creatures have toxic components that may produce illness. Shellfish are the most notorious—especially mussels, cockles, oysters, scallops, and queenies—and outbreaks of toxic food poisoning are not uncommon in Britain, especially in the summer.^{1 2} The toxin comes from the ingestion by the shellfish of certain species of planktonic dinoflagellates, which in warm summer conditions multiply rapidly, giving rise to so-called "red tides." These dinoflagellates produce a powerful curare-like neurotoxin in the digestive and respiratory organs of the shellfish. The toxin is harmless to the host but affects man, animals, and birds. It is water-soluble and heat-stable, and cooking does not appreciably destroy its poisonous properties—consumption of a fish bouillon has been known to produce temporary paralysis.

Clinically, the symptoms usually include a rash and some gastrointestinal upset; but more serious is the neurotoxic effect, which can cause loss of feeling in the hands, tingling in the mouth and tongue, weakness of the limbs, and difficulty in breathing. No direct antidote is known, so the treatment has to be symptomatic, together with general resuscitative measures if needed.

Recently, poisoning from vertebrate fishes has aroused considerable interest. On page 948 a report of ciguatera fish poisoning indicates the medical impact of new ethnic groups in the community. Apparently, any fish can become a source

of this illness in man if it ingests material which is either toxic or the precursor of a toxin. Though more common in tropical waters, ciguatera poisoning could occur in some fish which are now sold in Britain, such as the red snapper.

The clinical features of ciguatoxin poisoning include an initial tingling of the lips, tongue, and throat; gastrointestinal symptoms, muscle weakness, and paralysis may follow. Death occurs in fewer than 10% of cases. Again the treatment is symptomatic. The message here is that if the traditional fish in our diet are to be replaced by new species there will be a risk of unfamiliar types of fish poisoning.

Several fish in common use (members of the families Scombridae and Scombridae) tend to produce a scombrotin type of food poisoning.³ Fresh mackerel, tuna, and bonito are edible with no ill effects; but if these fish are allowed to spoil, owing to microbiological action in poor storage conditions, the histidine in the tissue changes to histamine. This (or possibly some other, unidentified toxin) produces an allergic reaction together with nausea and vomiting. Mackerel should always be cooked and eaten fresh, as spoilage can occur rapidly and cause scombrotic illness. Recently several incidents^{4 5} have been reported of people developing flushing, headache, urticarial rash, and vomiting and diarrhoea, starting 30 minutes to two hours after eating smoked mackerel. This is highly suggestive of the presence of scombroid toxin. Similar outbreaks have also been associated with canned mackerel, tuna, and bonito, and, in addition, with canned non-scombroid fish such as sardines and pilchards. The canned sardines most frequently responsible have been Moroccan, and the trade has voluntarily agreed to withdraw certain batches of 4½ oz (130 g) cans. This highlights the need for some checking of the storage and canning methods in the country of origin of imported canned foods.⁶

¹ Clarke RB. Biological causes and effects of paralytic shellfish poisoning. *Lancet* 1968; **ii**:770-1, 2.

² McCollum JPK, Pearson RCM, Ingham HR, Wood PC, Dewar HA. An epidemic of mussel poisoning in north-east England. *Lancet* 1968; **ii**:767-70.

³ Anonymous. Fish poisoning. *Lancet* 1979; **iii**:1059-60.

⁴ Communicable Disease Surveillance Centre. *Communicable Disease Report* 1979; Nos 17, 40, 41, 42.

⁵ Communicable Disease Surveillance Centre. *Communicable Disease Report* 1980; Nos 2, 27, 33.

⁶ Scottish Home and Health Department. *The Aberdeen typhoid outbreak*. Edinburgh: HMSO, 1964.

Prescription for social work

For every publicly aired difference between doctors and social workers there are, no doubt, many instances of constructive co-operation. But the persistent disquiet in the medical profession—voiced at successive Annual Representative Meetings^{1 2}—about the effectiveness of social service departments suggests deficiencies in the contribution that social workers make to health care in the community. Nevertheless, doctors, with their scientific background, should be prepared to base any criticisms on hard evidence rather than publicity-catching anecdotes. Despite choosing a pejorative title, the authors of a recently published book, *Can Social Work Survive?*,³ make a convincing attempt to do this. Dr Colin Brewer, a psychiatrist, and June Lait, a sociology lecturer, have prepared a substantial body of evidence to support their catalogue of deficiencies in social work. Furthermore, they are

not afraid to criticise the medical profession while carefully constructing their case for an independent inquiry into social work.

The medical profession was never enthusiastic⁴ about the pattern of social work proposed in the Seebohm Report⁵ and introduced in 1970.⁶ The first decade of operation has largely justified those misgivings, and few doctors would disagree with the book's condemnation of the top-heavy bureaucracy of social service departments, the lack of intellectual rigour in assessing the value of social work, and social workers' predilection for psychotherapy to the exclusion of behaviour therapy, with the inevitable clashes with doctors over the care of acutely ill mental patients. The authors suggest that social workers would be more use if they were seconded to health, housing, education, and supplementary benefit agencies rather than being isolated, as at present, in a separate department. Thus social workers should be prepared to specialise and cast off the fashionable generic cloak wrapped around them by the Seebohm Report.

The aims of social work have never been very clearly defined and the outside world might be forgiven for assuming that too many social workers see their task as putting an imperfect world to rights rather than giving practical help where it will be effective. GPs know their limitations in helping patients whose troubles have a social as well as a medical cause: a touch of the same realism could do wonders for social work. Brewer and Lait put it bluntly in a letter replying to criticism of their book: "We . . . believe in recognising a hopeless case when one sees it, and urge social workers to concentrate on areas where their skills have been shown to be effective, instead of advertising themselves as Universal Cure-Alls."⁷ To be expected to cope expertly with delinquency, truancy, pregnancies in the unmarried, child abuse, compulsory hospital mental admissions, and accommodation for the elderly is an unfair demand on any individual, however well trained or experienced he or she may be, and Brewer and Lait leave their readers in no doubt that they see the training of social workers as being as diffuse and soft-centred as the social service departments they criticise.

Admittedly, doctors often find it difficult to assess objectively the value of their treatments. But in the past 50 years or so increasingly refined techniques have been developed for scientific analysis in medicine. Perhaps social workers should not be judged too harshly for not having developed such rigorous techniques in their first decade as an organised profession—though, as the book reports, trained social workers originated over a century ago. Nevertheless, Brewer and Lait make a valid point in highlighting the reluctance of social workers to submit their activities to similar evaluation. Of the several studies on social work analysed by the authors, one—the Leeds truancy study⁸—stands out: firstly, because it was a controlled trial and, secondly, because the social workers were unaware their work was being evaluated and so presumably were uninfluenced by the study. Briefly, the study showed that truants whose cases were merely adjourned by the magistrates' court subsequently had a much better attendance record and lower crime rate than those referred to a social worker for supervision. So the result suggests that intervention by social workers was harmful. Iatrogenic disease is not unknown in medicine, but doctors recognise its risks and are more willing than social workers appear to be to prevent it.

The medical profession has had—and continues to have—more than its fair share of public criticism and public inquiries since its registration and disciplinary machinery was set up

over 120 years ago. With today's rapid rate of change social workers, who as yet have no GMC-type body, should not be too surprised that their public tribulations have started so early in their professional existence, though some of them did not help their cause by striking for several weeks in 1978, when anecdotal reports implied that neither clients, local authorities, nor other professional colleagues were greatly inconvenienced by their absence. Despite their book's title, Colin Brewer and June Lait clearly see social workers as having valuable skills; and the BMA, though it believes that social services should come back under the aegis of the Department of Health, has no wish to smother the infant profession. Mr Patrick Jenkin's announcement of an inquiry into social work⁹ is, therefore, welcome—and Brewer and Lait can share the credit with the British Association of Social Workers,¹⁰ which had also been pressing for this traditional British solution. In contrast to the "outside-expert" approach of the Royal Commission on the NHS, which was chaired by Sir Alec Merrison and included no hospital clinician among its members, the social work inquiry is to be headed by Mr Patrick Barclay, chairman of the National Institute of Social Work. A wide range of interests and skills will be needed in the other members if the inquiry is to be seen as independent and to find ways for investing scarce resources in social work to practical effect.

¹ Anonymous. *Br Med J* 1979;iii:152.

² Anonymous. *Br Med J* 1980;281:249.

³ Brewer C, Lait J. *Can social work survive?* London: Temple Smith, 1980.

⁴ British Medical Association. *Br Med J* 1969;ii:72-6(S).

⁵ Committee on Local Authority and Allied Personal Social Services. *Report*. Cmnd 3703. London: HMSO, 1968.

⁶ *Local Authority Social Services Act 1970*. London: HMSO, 1970.

⁷ Lait J, Brewer C. Getting nowhere fast. *The Sunday Times* 1980 Sep 14:36.

⁸ Berg I, Consterdine M, Hullin R, et al. The effect of two randomly allocated court procedures on truancy. *British Journal of Criminology* 1978;18:232-44.

⁹ Anonymous. *The Observer* 1980 Sep 21:2.

¹⁰ Anonymous. *Social Work Today* 1979;10:7.

Employment of the disabled

The recent introduction of self treatment in haemophilia has dramatically improved the management of the severe disease, reduced dependence on hospital, and increased social independence. Treatment with factor VIII concentrate given by the patient himself with minimal fuss at home or at work usually takes only 15 minutes. This change might be expected to result in an improved employment rate in haemophiliacs and an increased use of further and higher education.

These social factors were assessed by Stuart and others in the *BMJ* in May¹ in a report of the results of a questionnaire sent from four haemophilia centres in Britain to 636 patients of all grades of severity aged 16 to 65 years. Sixty per cent of the respondents to the questionnaire were under the age of 35; and 37% practised self care (half of these having done so for more than three years). The hope had been that self treatment, which costs about £2000 per patient per annum, would be cost-effective in enabling more haemophiliacs to return to or remain in employment. In fact, the overall unemployment rate had remained high at 17.5%, at a time when the overall rate in Britain was 6.9%. There were large regional differences: nearly one-third of the haemophiliacs in Glasgow had been unable to find work. These facts raise many questions.

Half the patients had registered themselves as disabled. Did