Correspondence

Letters to the Editor should not exceed 500 words.

Overcrowding in Psychiatric Hospitals

SIR,—Recently there has been a focusing of public attention on the overcrowding present in psychiatric hospitals. It is my view that blame for these conditions must rest with the medical staff of the hospitals concerned. With energy and skill many patients in psychiatric hospitals can now be improved and the great majority discharged after only a few weeks' stay. A careful review of all patients in long-stay or medium-stay wards carried out at consultant level can result in many so-called "chronic" patients being treated and greatly improved, and even, in many cases, discharged from hospital. It is essential in psychiatric hospitals that every patient should be carefully reviewed by a consultant at frequent intervals, whether he or she be in a short-stay or a long-stay ward.

At Rubery Hill Hospital a "male division" of 375 beds was taken over in 1962. At this time all beds were full, and overcrowding was said to be present on the 12 wards which composed the division. A regimen of careful review and active treatment of every patient was instituted, and every long-stay or medium-stay patient was reviewed by the consultant at very frequent intervals. Within one year this unit was able to empty and convert a 25-bedded ward to a female admission ward. A year later a further 25-bedded ward was emptied and again made into another female admission ward. Unfortunately, this process was slowed owing to the forced acceptance of 40 long-stay patients from neighbouring hospitals to enable these psychiatric hospitals to set up child psychiatric units. However, these 40 patients could be accepted from these hospitals and accommodated in the empty beds that had been created. At the present time many beds have been taken down and much greater spacing of beds and the policy of curtaining the beds has been carried out on a number of wards. The unit, with only one consultant in charge, now admits 650 patients a year, which is two-thirds of all the admissions to the hospital. Very few of these admissions ever leave the short-stay admission wards.

The unit long ago abolished all waiting lists, and all patients are admitted at once. At the present time the unit has 70 unoccupied beds. Hence it can be shown that over a period of about six years approximately 160 long-stay patients have been freed. I am fully convinced that this can be done in every psychiatric hospital in the country, with the full use of modern treatments by energetic doctors. It has been said that there are no chronic patients in mental hospitals, only neglected ones. The blame for this neglect must rest with the medical profession and can be shifted on to no one else.—I am, etc.,

Rubery Hill Hospital, Birmingham. C. ENTWISTLE.

Anencephalus and Spina Bifida

SIR,—Your leading article "Anencephalus and Spina Bifida" (16 March, p. 660) does service in drawing attention to the importance and complexity of the factors, genetic or otherwise, which determine the incidence of these common malformations. It will be a loss to embryological thought if the wider epidemiological aspects, which after all can be collected and analysed from hospital records alone, obscure the important morphological problems raised by anencephaly, problems which can only be solved, or at all events brought into focus, by detailed examination of each anencephalic foetus. Among them are the causes of the erratic sex incidence, the reason for wide variations in the associated hydramnios, the dysgenesis of the adrenals, and often the perfect development of the foetal trunk despite the absence of any pituitary bodies.

Perhaps the main interest from an obstetrical standpoint is the marked tendency of anencephalic pregnancies to continue beyond term if there is no associated hydramnios present and the foetal trunk is well developed. This was pointed out over 50 years ago by both Ballantyne and Fothergill, and lends point to the view that in normal pregnancy the onset of labour is mediated by a normal foetal brain.—I am, etc.,

PERCY MALPAS.
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Vaccination Against Measles

SIR,—Dr. R. M. Forrester (23 March, p. 764) asks the important question whether future mothers will acquire sufficient antibody from measles vaccination to protect their infants during the first 9 months of life. This was one of the cautionary points which I also raised when reviewing the whole question of routine measles vaccination as a community health measure.[1]

If, in the event, babies do become more susceptible to measles in the first few months of life, this could be a serious matter. There are, however, two possible means of dealing with such a situation. A booster dose of measles vaccine might be given routinely during pregnancy. Alternatively, if it was found that babies lost their transmitted maternal antibody more quickly, it should be possible to give measles vaccine earlier than 10 months of age and still get a satisfactory immunity response.—I am, etc.,

Health Department, City of Oxford. JOHN F. WARIN.

REFERENCE
1 Warin, J. F., *Roy. Soc. Hlth J.*, 1967, 87, 261.

Intramuscular Injections

SIR,—I read with interest the article (23 March, p. 744), leading article (p. 721), and correspondence (30 March, p. 836) concerning intramuscular injections into the buttocks.

There are three accepted sites for intramuscular injections, the deltoids, the buttocks, and the lateral aspect of the thighs. The first two of these sites are not far removed from the circumflex and sciatic nerves respectively. Every year there are cases reported of mis-

placed intramuscular injections injuring one or other of these nerves. There are probably very many cases that are not reported in the literature, since this is now a recognized hazard of injection at these sites.

The lateral aspect of the thighs has many advantages for intramuscular injections. Six areas may be used before an injection has to be repeated in the same site. A large volume of injectate can be accommodated. There are no important nerves in the neighbourhood. The skin should be cleaner than the buttock. The patient does not have to sit on the injection site. There is usually less discomfort in the thigh than in the buttock or shoulder. The only disadvantage common to all sites is the presence of blood vessels.

I would therefore advocate that all intramuscular injections should be given in the lateral aspect of the thighs, and that the deltoid and buttock be abandoned on account of the dangers that may accompany the not-so-rarely misplaced injection.—I am, etc.,

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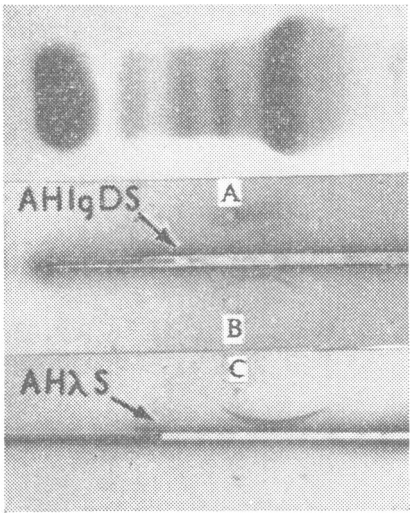
IgD Myeloma

SIR,—Since the first description by Rowe and Fahey,[1] several cases of IgD myeloma have been reported.[2–4] In 1966 one case was also described in Italy.[5] This variety of plasmocytoma is however uncommon; thus we think it could be useful to report here a case that we have recently observed.

The patient was a 71-year-old man in good clinical condition who had been complaining of cervical and lumbar pain since August 1967, and was seen in October in the rheumatological centre of this hospital. *X*-rays of cervical, thoracic, and lumbar spine revealed diffuse osteoporosis with signs of spondyloarthrosis. Because of an increased E.S.R. and of a dysproteinaemia the patient was transferred to this institute.

The clinical examination was negative. E.S.R.=135 mm./hour. Serum electrophoresis showed total proteins 8.5 g./100 ml. and gammaglobulins 3.65 g./100 ml. A marked M band was present in the fast-λ region (see Fig.). There was marked proteinuria and a narrow band of Bence Jones protein was detected by electrophoresis. Bone marow was difficult to obtain, but its appearance was typical with many myeloma cells present. *X*-rays of skull revealed widespread osteolytic lesions that were not present in the spine, ribs, or pelvis. The immunoelectrophoresis showed a reduction of IgG, IgA, and IgM. With an antiserum against the heavy chains of IgD (kindly provided by Professor C. Ricci) the paraprotein gave a typical thick bowed arc, and the light chains of the myeloma protein and the Bence Jones protein were λ type. Albumin and other proteins were also observed in the urine, but no clinical symptoms of renal failure were present.



A is normal serum, B is diluted patient's serum, C is patient's urine.

This case was not different, so far as the haematological and clinical findings are concerned, from other myeloma types. It is interesting that the light chains are of λ type: this occurs in one-third of myelomata, but is much more frequent in IgD plasmocytoma.[3]—We are, etc.,

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REFERENCES

1 Rowe, D. S., and Fahey, J. L., *J. exp. Med.*, 1965, **121**, 171.
2 Hansson, U. B., Laurell, C. B., and Bachmann, R., *Acta med. scand.*, Suppl. No. 445, 1966, 89.
3 Hobbs, J. R., *et al.*, *Lancet*, 1966, **2**, 614.
4 Zawadski, Z. A., and Rubini, J. R., *Arch. intern. Med.*, 1967, **119**, 387.
5 Ventruto, V., and Quattrin, N., *Haematologica*, 1966, **51**, 545.

Long-term Administration of the Pill

SIR,—Mr. P. C. Steptoe (30 March, p. 836) asserts that "the long-term use of these [oral contraceptive] pills carries with it the definite danger of producing irreversible sterility." This is contrary to the conclusions reached by the W.H.O. Scientific Study Group on Oral Gestogens,[1] which was that "there is no evidence that the fertility of women is impaired after the long-term use of oral contraceptives (five or more years)." Mr. Steptoe's findings in ovarian biopsies in long-term users are not original, and his implication that they represent ovarian damage is not borne out by his own statement that many of the patients with secondary amenorrhoea can be induced to ovulate with clomiphene.

It seems probable that the secondary amenorrhoea which may follow cessation of oral contraceptive use in a small and at present undetermined proportion of women is due to disturbance of hypothalamic gonadotrophin-releasing factor production, a condition which arises spontaneously often enough. As yet we have no means of knowing whether the prevalence is greater in women giving up oral contraception than in comparable women who have never used it. Other unconnected situations may also occur: one of my patients, referred because of secondary amenorrhoea on stopping oral contraception, was found on investigation to have adrenal hyperplasia. I am quite sure she had this before she started oral contraception and she responded in the expected manner to corticosteroid therapy, with conception soon afterwards.

To involve the thalidomide tragedy in this context, as Mr. Steptoe does, seems irrelevant and even irresponsible.—I am, etc.,

G. I. M. SWYER.

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REFERENCE

1 Scientific Study Group on Oral Gestogens, *Wld Hlth Org. techn. Rep. Ser.*, 1966, 326.

Gastrectomy and Vagotomy

SIR,—I am grateful to Mr. H. Taylor and Mr. D. G. A. Eadie (23 March, p. 766) for pointing out that the Polya gastrectomy referred to in my recent paper (3 February, p. 288) was carried out using either a retrocolic or antecolic loop of jejunum anastomosed to the gastric remnant. I should, of course, have made this clear.

Mr. Taylor is a strong and persuasive advocate of the "no-loop" gastrectomy and would no doubt maintain that this particular technique should have been used in the trial I reported. However, Mr. Taylor[1] finds it necessary to warn his patients that "they must not eat too much, too quickly," and reported that "several patients had changed their jobs to get more favourable conditions for meals during the day." These do not impress me as the attributes of a good operation, even if it is free of other sequelae such as bilious vomiting or recurrent ulcer. It is difficult to believe that these sequelae are completely eliminated by the "no-loop" technique and it would be helpful to have some comparative facts and figures derived from a properly planned prospective trial.

It is difficult to design a perfect clinical trial but I believe that my paper provided a useful comparison of symptoms after two gastric operations as they are commonly performed.—I am, etc.,

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Royal Postgraduate Medical School,
London W.12.

REFERENCE

1 Taylor, H., and Eadie, D. G. A., *Brit. med. J.*, 1967, **1**, 15.

Dealing with Attempted Suicide

SIR,—Not infrequently would-be suicides refuse any form of medical attention. In most such cases doctors are confronted with an individual who allegedly has ingested an overdose of drugs and subsequently refuses a stomach wash-out or other appropriate measure. On such occasions general practitioners, casualty officers, or mental welfare officers contact the psychiatrist by telephone—more often than not in the middle of night—and ask for further directions. Though some of the suicide attempters may be acutely disturbed or under the influence of alcohol, others need not necessarily display any gross psychological abnormalities. A proportion of these cases are animated by exhibitionism, and their refusal of a stomach wash-out is due to their secret knowledge of the futility of such a procedure. They have either not ingested any drugs at all or only small quantities of an innocuous kind. However, it is always prudent to give them the benefit of a doubt, as this is the surest way of avoiding tragedy.

The problem arises: Is the psychiatrist or any doctor justified—on moral, medical, or psychiatric grounds—to enforce treatment by putting such an individual on a compulsory order? I believe that he is. Some have remarked that doctors had no authority to enforce a blood transfusion if a person objected on religious grounds. They think the situation is analogous with suicide attempters. This analogy is not quite correct, for the individual refusing blood transfusion on religious grounds does not object to other forms of treatment, nor does he necessarily