Silicone Barrier Cream

SIR,—Recent correspondents have emphasized how useful silicone barrier creams may be in such conditions as napkin rash, bed sores, and colostomy leakage maceration (*Journal*, May 19, p. 1169). One correspondent has pointed out the high cost of such creams. A cream which has met with some enthusiasm and appears very useful in all these conditions, and which costs 5s. per lb. (0.45 kg.) for ingredients, is as follows :

Silicone M.S. 200	10 ml.
Emulsifying wax *B.P.*	10 g.
Titanium dioxide	10 g.
Solution of azorubrum	0.2 ml.
Methyl hydroxybenzoate	0.02 g.
Distilled water to	100 g.

—I am, etc.,

London, W.2. M. H. PAYNE.

SIR,—One use of "wet" barrier creams which appears to be overlooked is in the common cold, especially in the acute coryzal stages. Adequate applications of a wet barrier cream to the nose and upper lip will prevent or reduce the discomfort caused by skin erosion. Similar applications are very useful in cold or frosty weather.—I am, etc.,

Epsom, Surrey. W. W. KAY.

High-grade Defectives

SIR,—There have been a number of cases recently where high-grade mental defectives have been released from the Order by order of the judge. The remarks of the judge often hinted at wrongful detention, and the not unexpected press publicity tended, I feel, to bring the mental deficiency services into unjustified disrepute. If it is felt that these high-grade cases who have been correctly certified under the present Acts should not in future be detained in mental deficiency hospitals, then the remedy lies in changed legislation and not in piecemeal discharges in which proceedings have been initiated by various societies or by legal action. I personally feel that in general a mental deficiency colony is not the place to send high-grade defectives who have been charged with an offence in court or who have been sent to prison or approved schools. When such cases arrive in a mental deficiency hospital and see low-grade cases they naturally feel resentful that they themselves are classed with these other patients. I make every effort to see that such high-grade cases do not remain more than 12 months in hospital, but unfortunately they are cases where the period of detention is all out of proportion to the minor crime which they first committed. It must be remembered that low-grade defectives are sent to a mental deficiency hospital because their basic lack of intelligence precluded them from managing outside hospital. The high-grade defectives, however, are not admitted to a mental deficiency hospital primarily because of their mental deficiency but because of superimposed behaviour disorder and instability. The purpose of hospital admission in their case is to treat the behaviour disorder and instability, and when this treatment is completed these patients should be discharged.

The average mental deficiency hospital does not have the training facilities to deal properly with these two entirely different classes of patient. It seems to me there are two alternative procedures to the present state of affairs : firstly, that such cases as I have been referring to be admitted to smaller hospitals entirely separate from any low-grade institution. Here training suitable to their needs should be given and the original Order should only last six months, and, if renewed, subsequent Orders should only be for six months. The second alternative is that certain approved schools for both sexes should be set apart for feeble-minded cases only. Such approved schools should be run by staff qualified in mental deficiency, and the patients should be in the clinical charge of a consultant psychiatrist. Either of the above alternatives would ensure that high-grade patients would be given training suitable to their aptitude and would also enable each case to be reconsidered at regular intervals, a procedure which would prevent any patient being detained for a day longer than is strictly necessary.—I am, etc.,

Driffield. J. NEWCOMBE.

Maladjusted Children

SIR,—The little candle I lit in your correspondence columns (*Journal*, February 4, p. 293) seems to have been of about as much use as an atomic bomb. Although the Commission on Maladjusted Children suggested delayed action in setting up child guidance clinics, presumably because of the shortage of psychiatrists and other trained staff, it seems that very little publicity has been given to this. Your public relations department, if it has not already done so, might communicate with directors of education asking them to circularize teachers of the need for educational psychologists, with a note of salary advantages, and your columns could push the shortage of psychiatrists to encourage young physicians to take it up.

The report also emphasizes the need for more instruction for undergraduates and graduates. This is no doubt very wise, but it would mean years before there is any result. There is nothing very new in suggesting that assistant medical officers of health should be trained in this work so that they could treat minor maladjustments and learn to recognize serious ones at once. This has been recommended for some time by the medical officers of the Ministry of Education. In practice I find it is not done, because of lack of training. I would suggest that it could be easily included in the D.P.H. course, and would give school doctors something interesting and valuable to do. For those who have already taken the D.P.H. I would suggest a regular course in each region where there is an effective child guidance service ; it could be arranged during school holidays when school doctors are less busy, and in many areas like Birmingham many doctors could attend without any interference with their daily work. Alternatively most authorities would probably agree to their doctors having a half-day a week to attend such a course, even during school sessions.

Considering the enormous cost and unhappiness due to mental disease, this lack of speed in instituting child guidance is quite extraordinary. There is no doubt that laying the basis of a sound personality in childhood will do much to prevent mental disease, and it is a preventive measure that will bring rapid returns. I look forward to your assistance in keeping my little candle alight.—I am, etc.,

West Bromwich. MAX PARK.

Cerebellar Softening

SIR,—Although cerebellar softening is a rare event compared with the frequency with which areas of cerebral encephalomalacia develop, it does not perhaps quite attain to the class of "pathological curiosity," as was implied by Mr. B. Fairburn and Mr. L. C. Oliver (*Journal*, June 9, p. 1335). Anyone who has made careful necropsy studies of atherosclerotic subjects will be able to recall several instances of the condition. Moreover, the healed small infarcts of the cerebellum, appearing externally as slit-like areas of cortical atrophy and which may be of less than 1 cm. in size, are almost as commonly encountered in the "arteriosclerotic" brain as are the more generally recognized areas of tissue destruction in the region of the basal ganglia. The former lesions are seen histologically to be surrounded for varying distances by glial fibrosis of the white matter and are just as certain indications of the circulatory inadequacy of the brain in the presence of arterial disease as are the more familiar changes in the basal ganglia. As in the cerebrum also, infarction of the cerebellum is more likely to be small and clinically unremarkable than of apoplectic proportions. The symptomatology of the cerebellar "little stroke," comparable to the cerebral variety described by Alvarez,[1] has yet to be established.