other than the loss of anxiety—the "secondary gain"—is known as hysterical manipulation, and this tends to be a feature of the more or less permanent personality of the patient.

(3) The term is also used in connexion with a particular type of psychopathology with fixation at the stage of family rivalry ("Oedipus complex"). Typically the 5-year-old girl who is hostile to her mother and attracted to her father attempts to seek his attention by behaving in a histrionic and seductive way. If these traits are carried on into later life then the hysterical personality results. Because of the unhealthy attachment to the father, the superficial seductive approach may cover an underlying frigidity and inability to relate to men of her own age. In addition in her personal relationships, including those with her medical attendants, a seductive approach often changes fairly rapidly to a hostile approach.

The hysterical personality is also described where the patient uses as a defence mechanism frequent denial and forgetting of those things that may be injurious to his self-esteem (and in exaggerated forms will produce amnesias and fugues).

(4) The term is used for the clinical manifestations of the illness, in particular the tendency to mimic organic illness. This (unconscious) feature is not always distinguished from (conscious) malingering.

(5) The term is frequently used, not only by the laity, in the sense of behaviour which shows loss of control and acting-out of problems. In fact, the hysterical personality is sometimes not distinguished from the psychopathic personality (they need not be coexistent).

There are other ways in which the word is used, but it would be difficult to be exhaustive. The description would not be complete without adding that "hysterical" is frequently used in a pejorative sense in the same way as the word "neurotic."

The patient with the hysterical personality, who exaggerates the symptoms and behaves in an attention-seeking and demanding way, is very likely to be misdiagnosed when suffering from a physical illness (and even when suffering from a psychiatric illness). This may explain some of the difficulty in the series quoted.

It is important to be able to diagnose the illness hysteria. It is also important to avoid misdiagnosing other illnesses when they occur in a hysterical personality.—I am, etc.,

Edinburgh 10. R. G. PRIEST.

## Advisory Service for Parents of Mentally Handicapped Children

SIR,—I entirely agree with the view expressed by Mr. A. B. Nutt (15 January, p. 166) that reference of retarded children to an eye department is often of considerable value, particularly for the correction of an unsightly squint as well as for refractive errors. My reason for not describing this specialist service in detail, as well as many others, was not failure to recognize their importance but limitation of time. A major advantage of reference to clinics such as I have described is the ready availability of specialist services.

Dr. V. P. Seidel (22 January, p. 233) wonders how I would view a closer association between special clinics in comprehensive training centres. Clearly such an association is very desirable. At the present time I think we should encourage development of advisory services as I suggested by paediatricians, by psychiatrists, and by local authority medical officers, but I hope that eventually a comprehensive service will be provided which will be fully integrated.

Incidentally at the present time if clinics are run by psychiatrists working in the area of mental retardation there is no reason why these should necessarily be in psychiatric hospitals. They can often be located in general hospitals or paediatric departments convenient for the population served.—I am, etc.,

BRIAN H. KIRMAN.

Queen Mary's Hospital for Children, Carshalton, Surrey.

## Seminoma and Undescended Testicle

SIR,—It seems possible that the cases described by Dr. T. F. Sandeman (8 January, p. 107) represent examples of retrogression in testicular seminoma associated with viable metastases.[1] The presence of a hyalinized calcified testis in the first case is a highly suggestive finding, and the clinically atrophic testis in the second case is consistent with the diagnosis. Serial slicing and careful histological examination of any scarred areas is essential to exclude the diagnosis.

It has been suggested that where there has been a previous scrotal operation—e.g., orchidopexy—alterations in the lymphatic drainage may allow metastases to inguinal nodes,[2] and some case reports[3] lend support to this. Because seminoma is rarely if ever seen in prepubertal children,[4] and because time lapses of more than 20 years between development of the primary tumour and appearance of metastases are unusual, it seems unlikely that both cases had testicular tumours at the time of orchidopexy. It would seem reasonable, therefore, to explore the left testis in Case 2.—I am, etc.,

The London Hospital, London E.1. D. J. EVANS.

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3 Witus, W. S., Sloss, J. H., and Valk, W. L., ibid., 1959, **81**, 669.
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## Psoriasis and Phenindione

SIR,—I have been intrigued recently by a condition in one of my male patients, aged 71, who has suffered for many years with fairly severe psoriasis, chiefly involving the hands and arms. In the past his rash has responded variously to ung, ammon. hydrarg. with picis carb. and Synalar ointment.

In December 1964 he had a fairly severe pulmonary embolus and was admitted to hospital and treated, amongst other things, with phenindione. He continued with the phenindione on an out-patient basis for several months, and the interesting thing was that while on the drug his psoriasis virtually disappeared completely. The phenindione was stopped at the end of September 1965, and since then his psoriasis has gradually recurred until now it is again very active.

I have never heard of this response before, and I would be more than interested to learn if any of your readers have had any similar cases to mine.—I am, etc.,

New Milton, Hants. H. M. TUDDENHAM.

## Food-poisoning

SIR,—In your interesting leading article (15 January, p. 118) you point out that in its ordinary form *Clostridium welchii* is incapable of causing food-poisoning. It has however been shown quite clearly[1] that haemolytic non heat-resistant strains of *Cl. welchii* can cause food-poisoning if they gain access to the food after it has been cooked. This fact is perhaps not widely recognized, and thus it is possible that in some outbreaks with the clinical picture of *Cl. welchii* infection bacteriological confirmation is not forthcoming because only non-haemolytic heat-resistant strains are looked for.—I am, etc.,

Ruchill Hospital, Glasgow N.W. R. J. FALLON.

REFERENCE


1 McKillop, E. J., *J. Hyg. (Lond.)*, 1959, **57**, 31.


## Compulsion in the Treatment of Alcoholics

SIR,—I would like to comment on Dr. P. D. Scott's letter (29 January, p. 291) regarding the report of the B.M.A. subcommittee, of which I was a member, giving evidence to the Royal Commission on Penal Reform. I too am unhappy about the final report, though I allowed my name to be put to it, and I would like to support many of Dr. Scott's points.

The subcommittee concentrated on one small section of the problem—namely, alcoholism—on the grounds that this was truly medical. It sought to lift alcoholism out of the realms of penology by calling it a "disease," for which, therefore, punishment was inappropriate. The grounds on which this justification was made were never stated, and indeed they cannot be stated, since if alcoholics are to be regarded as diseased, so are the compulsive takers and drivers of motor-cars, or any of the so-called "psychopaths" who make up the hard core of our prison population. It could be argued that this is a social rather than a medical problem, and that as such it is outside the realms of medicine. Nevertheless, doctors having once taken this step into the province of social science ought to have the courage of their convictions. Alcoholism is a major social problem; alcoholics do indeed suffer greatly, but they also cause great hardship to others. The same, however, could be said of most of the socially inadequate individuals who make up the recidivist prison population.

Prisons exist to protect society, hospitals to protect the individual, and the decision on to which of these a prisoner should be sent will rightly depend on the extent to which he is a danger to society or to himself. The important thing is that whichever is the destination at which a man finds himself the best possible efforts should be made to rehabilitate him, and this applies to prisons just as much as hospitals. The attempt to excuse a man from prison on the grounds that he is suffering from a respectable disease such as "alcoholism" could, with as much or as little justification, be applied to persistent thieves on the grounds that they are suffering from "kleptomania," and evades the important issue of how they should be treated.

In my view there is certainly a grave need for more institutions dealing with alcoholics and drug addicts, both inside and outside the

penal system, but since the major part of the problem is a social one, so also the "cure" must be viewed in social rather than medical terms. I agree entirely with Dr. Scott that voluntary effort has not failed, it has simply not been tried. Society is reluctant to accept its own responsibility in this matter and is only too ready to hand this over to the "experts," whether these be medical or criminological. The community needs help to look after its own misfits and rejects, and I am only sorry that the subcommittee did not pay more attention to this aspect of the problem, however necessary the setting up of special institutions might be in addition.—I am, etc.,

Tavistock Clinic, London W.1. H. M. HOLDEN.

## Psychopathic Personality

SIR,—Editorial juxtaposition of book reviews on psychopathic personality, forensic science, and social anatomy (22 January, pp. 223 and 224) provides an opportunity to suggest that "social surgery" may be the correct analogy for the management of "character disorders."[1] Whatever the origin of underlying delay in maturation of emotional control, these patients are presumably no more to blame for their condition than is a child with congenital heart disease for his.

This is not to condone the community nuisance of their socially disruptive behaviour—far from it—but rather to use, develop, and refine the tools provided by our legislative "instrument" makers. The operative procedures involved can be as successful as those of cardiac surgery, not forgetting the important role of nursing and special aftercare for a gradually lessening disability, nor the need to use suitable drugs such as chlordiazepoxide as "anaesthetics."—I am, etc.,

Sevenoaks, Kent. J. P. CRAWFORD.

REFERENCE

[1] Rosen I. M., *Dis. nerv. Syst.*, 1965, **26**, 221.

## Woodworm and Dysentery

SIR,—I was interested to read Dr. Mair Thomas's letter "Woodworm and Dysentery" (1 January, p. 52). A school toilet room which is warm, kept airy, and supervised is, I fear, a counsel of perfection, desirable though it most certainly is. Many rural areas have only just emerged from the "Elsan" age, and equipping them with running water and water closets has been an expensive business. Unfortunately even where large sums have been expended deterioration and a poor standard of cleanliness are very common. Devoted caretakers are a dying or dead race and lavatory cleaning is usually very perfunctory and far below the standard we should expect in our own homes. I feel, therefore, that there should be an entirely new concept in the structure of school and other public lavatories. Many if not all of Dr. Thomas's improvements should be aimed at, but above all the prime object should be "cleanability." It should be possible to clean sanitary blocks with a powerful hose and to entirely alleviate any structure or equipment which necessitates cleaning by hand, which is inevitably distasteful. Such construction would initially be expensive, no doubt; but I feel that unless this concept is accepted lavatories will continue to be a menace to health.—I am, etc.,

Cirencester, Glos. MARY E. WALTERS.

## Hypochondriasis

SIR,—In your issue (15 January, p. 167) Dr. N. B. Kreitman describes a patient with paranoid features in addition to his hypochondriasis, and notes that this is a combination that Bleuler thought never occurred. Although it is true that Bleuler stated this, this should be looked upon as a curiosity rather than a clinical fact.

Kraepelin[1] described such cases in 1915, making a point that hypochondriasis is often connected with the delusional system. For example, that his body complaints are due to someone destroying his nervous system with electricity. In his survey in 1936 Brown[2] describes a number of cases of paranoid psychosis with hypochondriasis and submits detailed case reports in his appendix. Nor can the occurrence of a paranoid personality with hypochondriasis be looked upon as a rarity. In his recent study Kenyon[3] describes paranoid personalities in 11.8% of his patients with primary hypochondriasis, and in 9.6% in those with secondary hypochondriasis.—I am, etc.,

The Maudsley Hospital, London S.E.5. D. P. GOLDBERG.

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[3] Kenyon, F. E., *Brit. J. Psychiat.*, 1964, **110**, 478.

## The Casualty Consultant

SIR,—Having read Mr. K. G. Pascall's extremely well-reasoned letter (20 November, p. 1247) on this subject, I was amazed to read the letter by Mr. J. C. Scott (4 December, p. 1371) attacking Mr. Pascall's ideas. Mr. Pascall seems to be well informed and has the practical approach to the subject, whereas Mr. Scott seems to be concerned only with the orthopaedic aspect of casualty work.

The plea for changing the title of the casualty department to the more cumbersome accident and emergency service made in the "Sir Harry Platt Report" does not, in any way, alter the function, buildings, staff, service offered, or conditions of service within the casualty department. Simply changing the name of an essential service cannot alter the service, and in my view such a change was unnecessary.

The suggestion that consultant supervision for an accident and emergency service is something to which an effective answer has already been found in practice means that many departments have nominal consultant cover only. The actual specialized cover in a large number of the major centres in the country has been given for many years by experienced senior casualty officers, and only a few places have full-time consultant orthopaedic cover.

To suggest that the major part of casualty work concerns fractures is misleading. Even when the work load represented by trivial conditions, which are dealt with in the casualty department, is discounted, fractures still do not represent the major problem. To the casualty department come all sorts of emergencies which cannot be regarded as orthopaedic or general surgical cases. The poisoned patient, the medical emergency, the psychiatric problem, and even the social emergency, to mention but a few, are the "emergency situations" which must be dealt with speedily and efficiently in the casualty department. To shrug off this essential work by suggesting that to deal with them is not a necessary or desirable aim would mean that the casualty service would be inadequate. Of course, it is of little concern to the orthopaedic surgeon what happens to these problems, nor should it be—he is not a "casualty consultant." It should be remembered that the Ministry has laid down that such emergencies as poisoning, etc., should be dealt with in the casualty department.

Finally, I would suggest that recognition of the specialty of casualty consultant is realistic and not obsolete. A visit to Leeds General Infirmary, a famous teaching hospital, where the casualty services are efficiently run and controlled by an eminent consultant in casualty, readily demonstrates this point.—I am, etc.,

Littleover, Derby. JOHN COLLINS.

## Intrauterine Contraceptive Devices

SIR,—An unusual complication from an intrauterine contraceptive device (I.C.D.) has recently come to my notice. A 35-year-old woman, para nine, had a standard-size Margulies spiral inserted in June 1965. Since the uterus was very bulky no beads were cut off the tail, because it was felt that otherwise the whole device might be drawn inside.

Six weeks afterwards the I.C.D. was in a satisfactory position and the patient was quite happy. Later, however, her periods became much heavier, until in January 1966 she was admitted to hospital with "flooding."

At this time the end bead was discovered to be buried in the lateral vaginal wall to a depth of 5 mm., and moderately strong traction was required to dislodge it. One feels that had the tail been directed posteriorly instead of laterally the end result might eventually have been a recto-vaginal fistula.

It is realized that the usual practice of leaving only 1 or 2 beads protruding was not followed in this case, in which 5 beads were left outside the cervical canal. In addition, the patient was not a suitable candidate for the use of an I.C.D. because of menorrhagia due to her abnormally large uterus. Nevertheless, it is felt that attention should be drawn to the danger of the possibility of fistula formation with this particular device if too much tail remains in the vagina.—I am, etc.,

The Ulster Hospital, Dundonald, Belfast. M. R. NEELY.

## Trials of Physical Therapy

SIR,—I was interested to read your leading article on "Vaccine Therapy in Asthma" (22 January, p. 186). For over 25 years a large number of asthmatics have been treated by breathing exercises at the Victoria Hospital for Children, and when it closed in the Paediatric Physical Medicine Department at St. George's Hospital, Tooting. Ages ranged