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.

REFERENCES

[1] Kraepelin, E., *Psychiatrie*, 1915, **4**, 1406.
[2] Brown, F., *J. ment. Sci.*, 1936, **82**, 295.
[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