uncomplicated chronic renal failure without regular dialysis treatment. In 1954, however, Wheeler *et al.* reviewed 160 cases of gynaecomastia collected over a 10-year period.[3] Bilateral gynaecomastia was noted in four patients in whom chronic pyelonephritis or chronic glomerulonephritis was the underlying disease. Hypertension and decreased renal function were present in three, and atrophic testes were noted in two of these patients. Although we have also observed gynaecomastia in the non-dialysed uraemic patient, its incidence seems to be greatly increased by maintenance haemodialysis. The resemblance to refeeding gynaecomastia is indeed striking.—We are, etc.,

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R. L. LAWTON.
MARGERY O. FEARING.

Renal Dialysis Center,
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Iowa.


REFERENCES

1 Freeman, R. M., Lawton, R. L., and Fearing, M. O., *Ann. intern. Med.*, 1967, **66**, 1049.
2 Richardson, James. Personal communication.
3 Wheeler, C. E., Cawley, E. P., Gray, H. T., and Curtis, A. C. *Ann. intern Med.*, 1954, **40**, 985.


SIR,—I have sent to the Glasgow University writers on gynaecomastia (30 December, p. 779) details of a case of uraemia with gynaecomastia.

A man of 68 years with chronic nephritis and hypertension had been treated over a long period with methyldopa and bendrofluazide or frusemide, with recent addition of promethazine hydrochloride or trimeprazine tartrate to allay itching.—I am, etc.,

Tewkesbury, Glos. D. M. WILKINSON.

## Malaria in Britain

SIR,—The letter by Professor B. G. Maegraith and Dr. D. H. Smith (20 January, p. 179) prompts me to report a case of malaria which occurred recently in north London.

A 60-year-old man had come from Jamaica 12 days ago to take a postgraduate course at a theological college. There had been several cases of influenza in the college, and when the patient developed malaise, anorexia, and a moderate pyrexia after five days the presumptive diagnosis was of a similar viral infection. When I first saw him three days later he had also been taking penicillin for three days to treat concurrent pyorrhoea and facial pain (thought to be of dental origin), and an appointment had been made for him to see a dental surgeon.

I was called because of a vague worsening in his condition. I found an intelligent man who was rather sleepy and whose speech tended to falter to a halt before the sentences were complete. Although he was possibly anaemic, with a temperature of 100.5° F. (38° C.) and a raised erythematous rash on the trunk, he was not jaundiced and the liver, spleen, and lymph glands could not be palpated. Apart from the faltering cerebration there were no abnormal neurological signs. He also told me that he had had two days of diarrhoea at the start of his illness.

I asked for hospital admission for him as a case of a "P.U.O.," of possible malarial or even typhoid origin, with a penicillin skin reaction. He was admitted to the local infectious diseases hospital, where *Plasmodium falciparum* malaria was diagnosed. He is reported to be improving after 24 hours' treatment, although his mental condition is still somewhat confused.

I have recently seen many patients with influenza-like illnessess, some of whom had not long returned from abroad. As Professor Maegraith and Dr. Smith suggest, it would have been easy to miss the diagnosis at its relatively early stage (and blame some of his symptoms on an unfortunate reaction to penicillin).—I am, etc.,

London N.2. M. F. GREEN.

## Community Child Care

SIR,—I write as the editor of a book, *The Community's Children*,[1] recently published. I am grateful for the encouraging notice you gave it in your leading article (20 January, p. 134) under the above heading.

However, in restricting your comment to the suggestion that voluntary workers in the community should, under supervision, be encouraged to take more practical interest in the lives of children in care, I feel you have missed the whole point of the book.

One page alone out of 93 mentions the role of such helpers. The main recommendation, on the contrary, is for an increased recruitment of professional staff to the child care services, and the provision of better training facilities and improved working conditions for them.

The book sets out to provide a basic knowledge about the child care services (with particular reference to children in long-term residential care) for the concerned general public, members of local authority committees, and professional workers in related fields. It should be of interest to all those readers of the *B.M.J.* who, in the course of their general practice or clinic work, come into touch with children living away from their homes, the staff who look after them, or parents who are not fulfilling their parental roles. It is hoped that this book will be of some service to such doctors in helping them to understand the background of these family breakdowns, the types of substitute care provided, and the strains and stresses to which all concerned are subject.

Finally, the number of children in England and Wales living away from home in 1965 was 79,000, not 19,000 as stated in the leading article.

Inner London Education Authority, Greater London Council, London S.E.1. JESSIE PARFIT.


REFERENCE

1 *The Community's Children*, 1967. Longmans in association with the National Bureau for Co-operation in Child Care.


*** We corrected the figure of 19,000 to 79,000 in our issue of 3 February, p. 328.—ED., *B.M.J.*

## Improving the Psychiatric Services

SIR,—I was most interested to read Dr. J. H. Raphael's letter (30 December, p. 806). May I first firmly state that I agree to the utmost that treatment should be tempered with humanity and common sense? I should like to make it clear that there was no question of a blanket "*x* weeks in and *x* weeks out" service. Every patient was most carefully assessed by interview. An assessment was also made of the home set-up, support from the relatives, and so on before this system was adopted in an individual case. I would agree that shuttling old people about can affect them adversely; and one is always happier to have patients staying at home and coming up to the day hospital, unless there is really severe disturbance and difficulty at home. Our service was certainly not run with unfeeling uniformity, and I am sure that geriatric services should be flexible to the patients' response.

I admit that if some miraculous cure for the ills of old age was arrived at I with many others would wish it to cause a happier end to life. However, I certainly agree that there is no panacea, and I have not thought there was. I would agree that one should always be sceptical of much-praised schemes with an apparently wonderful simplicity, which some might feel more harnessed to the needs of impact for the doctor than to meet humanely the needs of the patient.

Dr. R. S. Ferguson (13 January, p. 119) asks for statistics on the results of day hospitals and also poses the query of who is to be judge of any improvement to services. May I refer him to the published proceedings of the Symposium on Psychiatric Disorders in the Aged, held in London in September 1965 by the World Psychiatric Association?[1] In this there is a wealth of commentary from many people with experience in running services of this kind, with detail and analysis of the ways these patients can be helped by day hospitals and community facilities. In particular, for a most careful and thorough statistical analysis, may I refer him to the papers by Dr. Peter Sainsbury, Dr. Costain, and Dr. Jacqueline Grad ("The Effects of Community Services and the Referral Rates of Elderly Psychiatric Patients"), and particularly by Dr. Jacqueline Grad and Dr. Peter Sainsbury ("An Evaluation of the Effects of Caring for the Aged at Home")? In this field I think it is vital in assessing benefits to consider very carefully the effect of the phrasing of questions on those answering them. It may be that the primary persons involved may be considered to be the patients. In this case it may be important that before answering queries they be made aware that the alternative to day-hospital care or intermittent periods in hospital may well be a much earlier and/or final consignment to an institution.

The lowly rating of day hospitals in Blackpool could in part be an index to pressure on general practitioners from the offspring of elderly patients. A vocal minority of these may perhaps find the extra care and devotion needed by elderly relatives not to be part of their scheme for "modern living." In such cases it may be that while the patient is only moderately eccentric and with minimal memory upset the relatives try furiously toward their being "put away." In an earlier age (and elsewhere, as in India, where, in addition, there are not such easy ways of getting rid of the old) they would have accepted the trials of looking after the declining as a labour of love, within reason.

The final issue of the quality of being enabled, with help, to live with one's relatives, or in the home one has known for a lifetime, as opposed to consignment to a mass institution, may be hard to analyse statistically.—I am, etc.,

Colchester, Essex. HARRY JACOBS.


REFERENCE

1 *Psychiatric Disorders in the Aged*, 1967. Manchester.


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