Care of Mentally Retarded

SIR,—So you think (28 February, p. 517) that Mr. Crossman was wrong to castigate the medical profession for its indifference to the mentally retarded. But suppose he had asked: "Here in this country, where there are tens of thousands of men, women, and children afflicted in this way, in which medical school is there a professor of mental retardation, a reader, even a full-time lecturer? And how is it that a medical student can go through a course of training and get hardly a reference to the subject?" What answer would you have given?

But then he might well have asked himself: "What interest—before the present scandal blew its top—had I, any of my predecessors, any members of my Department, in this condition?" Would he not have got the same dusty answer?—I am, etc.,

JOHN GIBSON.

St. Lawrence's Hospital,
Caterham, Surrey.

Mentally Subnormal Children

SIR,—Your leading article on mentally subnormal children (17 January, p. 130) voices the concern we all share for the problems inevitably arising out of the transfer of responsibility for severely subnormal children from the Health Service to the Education Service. It reveals, however, an understandable feeling of rejection by those who have worked to build up a service for the care and education of children whom the educational system has ignored. It also shows a lack of understanding of the aims and educational methods of present-day State schools. The educational approach and the training approach are not mutually exclusive. In any good school the former will include the latter. The educational curriculum of good nursery and infant schools is not very different from that which has developed in the best junior training centres for severely subnormal children.

The best development of the whole child—emotional, intellectual, and physical—is surely an aim over which we could not disagree. Such development may require some training (skills which, if they are to be useful, have to be practised to satisfactory performance level), but it also requires learning through experience and understanding and the expression of an individual personality. Normal primary education is no longer formal. It is not geared solely towards the acquisition of literacy and numeracy. Much could be done to alleviate parental resentment and to foster their acceptance of the handicapped child's needs if this were better understood and explained to them.

With the transfer of junior training centres to Education, it need not be taken for granted that there will be a harmful lack of continuity when the children move to work in the adult centres or sheltered workshops.

What is needed now is more positive co-operation between medicine and education—more discussion, working parties, and better communication of plans which will affect staffing and career structures of those already employed in this work.—I am, etc.,

ANN MAVIUS,

Tutor in Teacher Training,
National Association for Mental Health.

Bristol.

Drugs for Gastric Ulcer

SIR,—Those who have compared articles published recently by you on the medical treatment of peptic ulcer (11 October, p. 100) and on liquorice derivatives (17 January, p. 159) may have noted differences in the assessments of the value of carbenoxolone and deglycyrrhizinated liquorice in treating gastric ulcers. In the former article greater weight was given to the value of carbenoxolone as a drug which, despite its side-effects, was well proved, while deglycyrrhizinated liquorice, though having the advantage of fewer side-effects, was less well established. The article in "Today's Drugs" on liquorice derivatives implies, however, that carbenoxolone and deglycyrrhizinated liquorice have equally well proved healing effects. The published evidence is not, I think, in accord with this view.

In the four controlled trials of carbenoxolone treatment compared with dummy tablets published in England alone¹⁻⁴ a total of 91 individuals received carbenoxolone and 73 the control preparation. By contrast, in the three analyses of the value of deglycyrrhizinated liquorice⁵⁻⁷ 30 patients in all received the test preparation and 31 the control, and in two of the trials the numbers receiving the test preparation were only six and eight respectively. Though the results achieved in this pair of trials may have achieved statistical significance, the numbers treated seem inadequate when one considers that gastric ulcer is not a rare disease. I would therefore prefer to see further evidence of the value of deglycyrrhizinated liquorice in treating gastric ulcers.—I am, etc.,

M. J. S. LANGMAN.

Department of Medicine,
General Hospital,
Nottingham.

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Non-specific Aortitis

SIR,—Non-specific aortitis, though thought to be common in the orient, is now known to occur all over the world. The aorta, and branches when involved, may show occlusion or aneurysm. Six patients, diagnosed in life as non-specific aortitis in one case only, and as congestive heart failure in the other five, showed the following necropsy findings. There was extensive densely adherent periaortic lymphadenopathy wherever there was involvement of the aorta. The lymph nodes showed similar changes as described in toxoplasmic lymphadenitis by Stansfeld.¹ The lymph follicles were enlarged irregularly. The pulp of the node was filled with clusters of pale-staining histiocytes. The sinuses were densely filled with macrophages. There was marked periadenitis mixing imperceptibly with the periaortitis.

This led us to send sera from patients clinically diagnosed as suffering from non-specific aortitis for direct haemagglutination test for toxoplasmosis. In three of these the titre was 1:4096 and in one it was 1:16384; namely, strongly positive toxoplasma antibodies. In four other cases where atherosclerosis was the possible aetiological factor of the arterial lesion the test was negative. Indirect haemagglutination test titres of 1:200 are considered as specific for toxoplasmosis.²

Periaortic lymphadenopathy has not been recorded in non-specific aortitis except by Sen,³ who reported chronic lymphadenitis only and in some cases tuberculous changes, which made him suggest tuberculosis as an aetiological factor. Our study of aortas in 250 cases of pulmonary tuberculosis revealed no lesion. In two cases where there was extensive periaortic caseating tuberculous lymphadenitis there was no change in the aorta. Japanese workers who once postulated tuberculosis as an aetiological factor have since changed their view.⁴

Our finding of periaortic lymphadenopathy in all these necropsies, changes in the lymph nodes similar to those described by Stansfeld¹ as occurring in toxoplasmic lymphadenitis, and, lastly, a high titre of toxoplasma antibodies in these patients make us suggest that toxoplasma infection may be an aetiological factor in non-specific aortitis.

We gratefully acknowledge the help received from Dr. Om Prakash of the Microbiology Department of the All India Institute of Medical Sciences, New Delhi, in doing the indirect H.A. test for toxoplasmosis.

—We are, etc.,

C. R. R. M. REDDY,
N. RAMACHANDRA RAO,
A. M. ANEES,
M. RAMAKRISHNA REDDY,
D. PRASANTHA MURTHY,
Y. RAMASUBBAIAH.

Kurnool Medical College,
Kurnool (A.P.),
South India.

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Unnecessary X-rays?

SIR,—The greater part of Mr. A. W. Fowler's letter on unnecessary x-rays (7 February, p. 362) will surely meet with approval by most clinicians whose primary concern is to secure the best treatment of their injured patients rather than to protect themselves from possible medico-legal criticism at some time in the future. The casualty surgeon's task is particularly difficult in this respect. The corollary of Mr. Fowler's recommendations, that out-of-hours "emergency" calls upon understaffed x-ray departments should be kept to a minimum, will also be welcomed.

However, several details of his advice seem to us open to disagreement. Casualty radiographs of the skull are rarely good enough to show the full extent of a fracture or to influence the surgeon very positively in his management of the case. Skull radiographs do not help much in the evaluation