some strikingly characteristic thick-walled muscular arteries in subsynovial and par-articular tissues, sites which may be subjected to similar forces.—I am, etc.,

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¹ Little, J. M., and Goodman, A. H., *British Journal of Surgery*, 1970, 57, 708.

Aldosterone Excess and Adrenal Carcinoma

SIR,—We read with interest the report by Dr. R. V. Brooks and his colleagues of an adrenal carcinoma associated with hyperaldosteronism (22 January, p. 220). We were surprised, however, at the statement that the only similar case described was that by Foye and Feichtmeir.¹ To our knowledge, eight other cases have appeared in the literature.²⁻⁸ With the possible exception of the two patients of Harrison,⁷ for whom no details are given, these cases all had features which could differentiate them from the much more common form of "primary" hyperaldosteronism due to benign adrenocortical adenoma or hyperplasia. Thus the malignant tumours were large, often palpable, and in some instances displaced the kidney recognizably on the excretion urogram or renal arteriogram. Possibly all would have presented distinctive features on adrenal venography. Secondary deposits appeared in all except perhaps the cases of Conn *et al.*,⁴ Harrison,⁷ and Biglieri *et al.*⁸ As in the recent case report of Dr. Brooks and his colleagues, additional noteworthy characteristics included excessive production of corticosteroids other than aldosterone and rapid clinical progression with profound muscular weakness.

While, therefore, we agree with the recent comments by Dr. Brooks and his co-workers that the clinician should be alert to the possibility of adrenal carcinoma in patients with aldosterone excess, that detailed steroid studies should be performed in all cases, and that careful radiological steps should be taken to delineate the tumour when one is suspected, we do not accept their general conclusion that spironolactone has no place in the long-term treatment of hyperaldosteronism associated with adrenocortical adenoma or hyperplasia. The great majority of cases of this type do not show the above mentioned features of adrenocortical carcinoma (in our own series of over 100 we have not so far encountered a single example of carcinoma). However, many of these patients have long-standing hypertension, some are elderly, and may have suffered one or more strokes. Others are unsuitable on other grounds or are unwilling to undergo operation. For these reasons we believe that definitive spironolactone therapy is worthy of consideration as an alternative to adrenal surgery in some instances. This is particularly relevant to those who, on biochemical grounds, are more likely to have bilateral benign hyperplasia of the adrenal cortices than a discrete adenoma.⁹⁻¹¹—We are, etc.,

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- ¹ Foye, L. V., Feichtmeir, T. V., *American Journal of Medicine*, 1955, 19, 966.
- ² Brooks, R. V., McSwiney, R. R., Prunty, F. T. G., and Wood, F. J. Y., *American Journal of Medicine*, 1957, 23, 391.
- ³ Zimmermann, B., Moran, W. H., Rosenberg, J. C., Kennedy, B. J., and Frey, R. J., *Annals of Surgery*, 1959, 150, 653.
- ⁴ Conn, J. W., Knopf, R. F., and Nesbit, R. M., *American Journal of Surgery*, 1964, 107, 159.
- ⁵ Crane, M. G., Harris, J. J., and Herber, R., *Annals of Internal Medicine*, 1965, 63, 494.
- ⁶ Neville, A. M., and Symington, T., *Cancer*, 1966, 19, 1854.
- ⁷ Harrison, J. H., *Annals of Surgery*, 1966, 164, 609.
- ⁸ Biglieri, E. G., Slaton, P. E., Schambelan, M., and Kronfeld, S. J., *American Journal of Medicine*, 1968, 45, 170.
- ⁹ Ferris, J. B., *et al.*, *Lancet*, 1970, 2, 995.
- ¹⁰ Aitchison, J., *et al.*, *American Heart Journal*, 1971, 82, 660.
- ¹¹ Brown, J. J., Ferriss, J. B., Fraser, R., Lever, A. F., and Robertson, J. I. S., in *The Medical Uses of Spironolactone*. Ed. G. M. Wilson. P. 27, Amsterdam and New York, Excerpta Medica, 1971.

Care of the Mentally Handicapped

SIR,—Dr. A. Shapiro produces no evidence for his criticisms (29 January, p. 308) of *Better Services for the Mentally Handicapped*.¹ This document is seriously concerned to provide facilities which appear to have been regarded by Dr. Shapiro as unnecessary luxuries in existing hospitals. He has asserted that "All these facilities, clinical and social, can only be provided in a large hospital if the costs are not to rise enormously," and the experimental unit which works under optimal conditions with high staff ratios is criticized for creating "hot-house conditions."²

Dr. Shapiro does not cite any references to the experiments of which he is so critical. However, the child-care staff ratio at any time of the day in the well-known Brookland's experiment was, on average, one to eight children.³ It averages one to five children at any time of the day in the new Wessex units. These include (on the basis of geography) all of the non-ambulant, severely behaviour disordered and children with and without severe incontinence requiring residential care from that area up to age 16.⁴ Commonsense suggests that for someone caring for these children for eight or 12 hours continuously, such ratios are not generous and are urgently needed also in large hospitals.

There is also evidence in existing hospital policies of widespread therapeutic nihilism towards the profoundly handicapped and severely behaviour disordered. In 1968, subnormality hospitals in England and Wales reported to the Department of Health that nearly one-third of their residents were neither working, nor receiving educational, social, or vocational training because of "severe mental or physical handicap," "disturbed behaviour," or "senility." Only one hospital in England and Wales reported that this occurred entirely because of "lack of facilities."⁵

Given the necessary resources and opportunity, the Command Paper proposals of treatment-oriented hospitals serving smaller catchment areas offer exciting new possibilities for the residents, their families, and the staff of all disciplines who work with them. These proposals require detailed programming, consultation, and managerial sophistication of a high order. Implementation will be beset by many problems, not the least of which will be shortage of money and sites. What is so badly needed now are some early successes which can, in their turn, generate more optimism and more

confident and specific demands for the necessary additional resources.—I am, etc.,

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- ¹ Department of Health and Social Security. *Better Services for the Mentally Handicapped*. Cmnd. 4683. London, H.M.S.O., 1971.
- ² Shapiro, A., *British Journal of Psychiatry*, 1970, 116, 353.
- ³ Tizard, J., *Community Services for the Mentally Handicapped*. London. Oxford University Press, 1964.
- ⁴ Kushlick, A., *Royal Society of Health Journal*, 1970, 90, 255.
- ⁵ Department of Health and Social Security. *The Facilities and Services of Psychiatric Hospitals in England and Wales 1969*. Statistical Report Series No. 10. London, H.M.S.O. 1970.

Whittingham Committee of Inquiry

SIR,—The Committee of Inquiry into Whittingham has been less than fair to the Chairman of the Medical Advisory Committee in stating that "... the acceptance for so long by the Board, the Hospital Management Committee and his colleagues of a virtually absentee Chairman who was heavily committed elsewhere was profoundly mistaken."¹ In fact the medical administrative structure was not merely "accepted" by the Board but created by it, and that the individual who accepted the post of Chairman was merely at the receiving end of the Regional Hospital Board's arrangement.

The actual position was that the Senior Administrative Medical Officer of the Manchester Regional Hospital Board personally contacted the doctor concerned and strongly urged him to take up the post, knowing full well that at the time his sessions at Whittingham Hospital were limited, and, as a matter of fact, were reduced on the instructions of the Regional Hospital Board in April 1962 to one session per week. The Board knew full well at the time that the doctor undertook no routine clinical duties at Whittingham Hospital and his other commitments did not allow him to give more than a very limited amount of time, namely one session per week, to the hospital. In spite of these circumstances, during the whole of his term of office as chairman he did not miss one meeting of the Medical Advisory Committee, he was available when required to advise the chairman of the Hospital Management Committee, and he made a monthly report to the Hospital Management Committee. Moreover the minutes of the Medical Advisory Committee, which frequently referred to the problem of long-stay patients, were made available as a routine to the Hospital Management Committee.

The emotive phrase "a virtually absentee Chairman" lifted, as it was, out of context by the lay press, is therefore demonstrably unfair.—I am, etc.,

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- ¹ *Report of the Committee of Inquiry into Whittingham Hospital*. Cmnd. 4861, London, H.M.S.O., 1972.

Unplanned Pregnancy in an Epileptic

SIR,—A woman graduate, aged 28 years, who for several years had been taking phenytoin 100 mg twice daily, sulthiamine (Ospolot) 50 mg daily, and Folex (ferrous gluconate and folic acid) 3 tablets a week for epilepsy, had also taken an oral contraceptive containing 0.05 mg ethinyl oestradiol and 3 mg norethisterone acetate