acute exacerbations of SLE. Comparisons of cyclophosphamide, azathioprine, and placebo have also been made in lupus nephritis.[7 8] Cyclophosphamide was found to have a more beneficial effect on urine sediment, proteinuria, and serum complement in one study[7] and produced symptomatic improvement and a fall in DNA antibody titre in the other.[8]

Recently the results of two larger trials using these agents in SLE have been published[9 10] in which the benefits produced were marginal. Hahn and her colleagues[9] carried out a prospective randomised trial comparing prednisone (60 mg per day initially) to prednisone plus azathioprine (3-4 mg/kg body weight per day) in 24 patients with life-threatening SLE. During a mean follow-up period of 18-24 months there were no significant differences in outcome as assessed by the number of deaths, renal and extrarenal manifestations, serum complement levels, and DNA antibodies. There was no convincing evidence of a steroid-sparing effect of azathioprine. In the second study, cyclophosphamide or azathioprine was added to low-dose corticosteroid therapy in 38 patients with diffuse lupus glomerulonephritis. The cytotoxic agents added only marginally to the control of the disease, though it was noted that no SLE-related death, renal or otherwise, occurred among the 12 patients treated with cyclophosphamide.[10]

These important studies throw doubt on the value of immunosuppressive drugs in SLE, but it might be said that the patients were at the severe end of the disease spectrum. In most patients SLE may be a mild disease with a reasonable prognosis,[11] and it is among these patients that any potential therapeutic effect of immunosuppressive agents requires critical analysis. The long-term risk of malignancy, especially in a disease in which immunodeficiency may play an aetiological part,[12] must be high, and the case for therapeutic conservatism is strong. When nephritis is established powerful alternatives to corticosteroids are still required; unfortunately the case for immunosuppressives, on present evidence, remains unproved.

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Nostalgia: a vanished disease

Name me no names for my disease,
With uninforming breath;
I tell you I am none of these,
But homesick unto death.

Witter Bynner 1881-1968

In other countries it was called mal du pays, Heimweh, malatia del pais, and the disease had already acquired a scientific name, nostalgia—a term coined by Johannes Hofer in a work published in Basle in 1678. For more than two centuries the disease appeared in medical textbooks and was the subject of many medical papers. The great Karl Jaspers, for example, wrote a paper[1] in 1910 giving 86 references to it. Since then it has almost disappeared as a clinical entity, but interest in the subject may revive as a result of Professor George Rosen's recent erudite historical review,[2] which ends—too early, one feels—with the American Civil War.

In the main the symptoms were those of what today we would mundanely call an anxiety state or a reactive depression; but some of them—stupor, fever, night sweats, delirium, hallucinations—point with hindsight to other diagnoses. So, too, does the criminal behaviour, including arson, shown by the young foreign servant girls described by Jaspers[1] and the fatal outcome mentioned by various authors.

Bizarre theories of the cause of the disease were suggested. The body fluids were said to be "vitiated"; the Swiss were thought to be specially at risk (hence another name, Schweizerkrankheit) because they missed the thin atmosphere of their mountains; the sound of the bagpipes provoked the disease in Scots soldiers serving as mercenaries abroad. But both early and late its prime cause was always recognised[3] as "a strong, emotionally charged desire to return home"; and the cure was to send the patient home. Naturally, soldiers and sailors were especially prone to it.

Vanished diseases are not very common. Chlorosis, encephalitis lethargica, and very soon smallpox are three of the few examples. Nostalgia as a clinical diagnosis has all but gone from the scene this century in spite of two great wars and their aftermath,[4] "a swirling tide of human movement." It may have disappeared from medical literature, and in particular from the titles of military medicine of the last six years, but it continues as an influence in three guises: as a near-universal experience in migrants whether forced (refugees) or voluntary (immigrants, migrant workers); it is one of the many factors probably responsible for the higher incidence of neurosis in migrants than in native populations[5] ("I cannot live in this country, it is affecting my soul"); and it is possibly a factor causing psychotic illness to be commoner in them too.

There is, indeed, abundant evidence that psychoses, or at least some types of psychosis, particularly schizophrenia, are commoner in immigrants. This evidence dates from the classic paper of Ødergård[6] on Norwegian immigrants to Minnesota compared with both native Americans in Minnesota and Norwegians in Norway. Since then this finding has been repeatedly observed: for example, in migrants from other States into New York State;[7] Europeans into Australia;[8] immigrants into Birmingham;[9] immigrants into Camberwell;[10] the Irish into Camberwell;[11] migrant workers into Yugoslavia;[12] and the West Indians in England have a higher incidence than their compatriots at home.[13]

There is still controversy about the reasons. Are emigrants self-selected by restlessness, instability, lack of success in their native lands, prepsychosis, or even, in a small proportion, psychotic symptoms before they move[6-8 14-16]—the drift theory? Are immigrants at risk of psychotic breakdown because of the stress, including nostalgia, they encounter in their adopted country, so-called reactive psychosis? Or are the figures for migrants inflated only because, as they often live alone, it is more difficult for them when ill to stay out of hospital?[7] Indeed, it is not entirely clear whether, if first admission figures are standardised for age, much of the difference in admission rates does not melt away.

With the neuroses there is a closer approach to unanimity.

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Not all authors agree,[17] but to most people it seems axiomatic that stress precipitates neurotic illnesses and that these are commoner in immigrants than in native populations. Among all the forms of stress that immigrants are subject to—language barrier perhaps, problems of housing and employment, adaptation to an alien culture and possibly a hostile population—nostalgia probably does not rate very high. A few published papers mention it specifically, some from abroad (displaced persons and immigrants in Montreal,[18] French immigrants to Canada,[19] migrant workers in West Germany,[20] German labour camp inmates)[21] and some from Britain. Among these there is nothing about au pair girls, but Frost[22] studied homesickness in Austrian and German domestic servants, a curious echo of Jaspers (but no arson), and a broadsheet by Bertram[23] on West Indian immigrants mentions the many who were disillusioned by homesickness, unemployment, and cold. Then there are the comprehensive reports[5 14] of Mezey on the 20 000 Hungarians who came to Britain in 1956-7, and Rawnsley and Loudon's account[24] of the exodus of the total population of Tristan da Cunha in 1961.

These last were almost all eager to return home when their island was pronounced safe, and all except 14 returned in 1963. But they are a special case. Repatriation, the traditional remedy for nostalgia, can never before have happened on this scale. Figures are scarce. By 1957 2000 of the West Indian immigrants to Britain had returned home;[23] 2000, again, of the 132 000 Greeks who emigrated to Australia between 1959 and 1970 came back to Europe.[25] Presumably the rest, like migrants, refugees, and foreign workers elsewhere, surmounted their immediate difficulties in some fashion, overcame their nostalgia and idealisation of the past, and either continued to live in their rather separate ethnic groups or became assimilated to the culture of their countries of adoption.

Nor is repatriation the panacea it may seem to be. Presumably it cures nostalgia, but Ødergård was only the first to find that immigrants who returned had high rates of psychotic breakdown. In each of the last two years the Supplementary Benefits Commission has repatriated about 80 adults, mostly to the West Indies. Many of these were mentally ill, and Burke has remarked on the handicaps and poor outlook of such a group returning to Jamaica,[26] self-esteem gone and stigmatised by the resident people.

To demote nostalgia from a disease to a doubtful cause of psychosis, accepted by Scandinavian psychiatrists but not by many others, or even to a rather low-ranking precipitating factor in neurosis may seem to be flying in the face of all human experience. Long before Hofer the psalmist wrote:

By the waters of Babylon we sat down and wept:
When we remembered thee, O Sion.

But the obvious is not always true.

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The apartheid screw

During the 25 years since it was founded in 1951 the University of Natal Medical School at Durban has provided the training for most of South Africa's non-White doctors. A few were admitted to the medical schools of Cape Town and Witwatersrand, though subject by statute since 1961 to greater control than before that time. The province of Natal has a substantial population of Indian origin, and the medical students at Durban were drawn mainly from them as well as from the African population. The South African government has now made plans to open a new medical school near Pretoria to admit African students. The new school, we are told in a statement published in our news columns this week, will have "the most modern facilities for the training of 200 final year medical students."

The statement from which this quotation is taken has an odd history. It was sent to the Medical Association of South Africa and is largely an attempted refutation of a letter that appeared a few weeks ago in the *BMJ*.[1] A week later two letters making virtually the same charges against the South African government as had appeared in the *BMJ* were published in the *South African Medical Journal*. One was signed by 17 professors of the Natal medical faculty,[2] the other by a retired emeritus professor of the same faculty.[3] From all this correspondence it may be taken that the South African government is planning to open, at some future date, a medical school for African students and to phase African students out of the Durban medical school, while the future education of medical students from the Indian community is at present undecided.

Having had a key role in the education of non-White students for a quarter of a century, and built up a fine tradition of racial tolerance in a country rather short of that quality, the staff at Durban are understandably worried about the future of the medical school there. But the issue goes deeper than that. Is the proposed building of the new medical school near Pretoria to be another turn of the apartheid screw? Are White students, Black students, and Brown students to be segregated into separate medical schools? This is already partly the case. Is it to be pushed to the final conclusion? If so the policy will cause great disquiet in South Africa itself as well as being a travesty of everything that medicine stands for.

The South African government's statement accuses our correspondent of "attempting to make a political issue of the matter." But in fact it *is* a political issue and it should be one of grave concern to the medical profession in that country. Yet again the Medical Association of South Africa is having to face government plans that could have a deeply disruptive influence

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