has upset the pregnant women in their charge, might do harm if it fell into the hands of small boys, and so on. One complainant includes among those whom he criticizes the B.M.A. Board of Science.

Two points arise. Firstly, the Board had nothing to do with the leaflet. We would no more have expected to receive advice from the Board about an instrument of publicity than we would expect to give advice about, for instance, the design of midwifery forceps.

Secondly, very few of the doctors who complained are likely to be smokers and even fewer, I feel sure, are pregnant. With all respect to them, therefore, what they think about our naked woman matters very little. What does matter is whether she does her job. Most pregnant smokers, our research tells us, are young women in the lower socioeconomic groups. They are exposed (as, indeed, are the rest of us) to blasts of strident advertising, among the most assiduous practitioners of which are the cigarette makers. The only way to get at these young women is to use material of a kind no less arresting than the cigarette advertising. The best of several alternatives tested is the one we have chosen. A lot of research established quite clearly that the naked woman not only would not give offence; she would also bring home the simple medical points that our leaflet makes far more effectively than would an anatomical diagram. All the evidence so far is that the research is correct.—I am, etc.,

A. C. L. MACKIE

Director General,
Health Educational Council

London W.C.1

Old People's Nutrition

SIR,—Your leading article (9 February, p. 212) refers to the value of meals-on-wheels services to the elderly, but there is little evidence available of the nutritive value of these meals.

In our survey of 200 meals delivered in Portsmouth^{1,3} we found the following energy and nutritive intakes: energy, mean 760 kcal, range 190–1,170 kcal; protein, mean 28 g, range 8–58 g; potassium, mean 28 mEq (1.1 g), range 10.3–48.5 mEq (0.4–1.9 g); vitamin C (by analysis), mean 9 mg, range 0–37 mg. The enormous range in nutrients consumed means that despite satisfactory average values, except for vitamin C, some individuals were eating inadequate meals. If such a wide variation occurs in 200 meals in one city, supplied from one kitchen, there is clearly a need for more widespread investigation.

One of the causes of inadequate meals is that there is no central source of advice on menu planning, portion control, and nutrient content of such meals. Apart from the delivered meals, the weighed weekly food intake of 100 persons in Portsmouth showed a relatively low intake of energy, potassium, and vitamin C but an adequate protein intake.

With regard to the education of people visiting the elderly, and indeed the elderly themselves, this unit is attempting to help in this direction by a conference next September advising on large-scale catering to residential homes, luncheon clubs, and the

meals-on-wheels service. As well as this we are producing sets of simple cartoon slides teaching the rudiments of nutrition and have published a paperback called *Easy Cooking for One or Two*. There is a demonstrated demand for such advice.—We are, etc.,

LOUISE DAVIES
ARNOLD BENDER
M. D. HOLDSWORTH

Geriatric Nutrition Unit,
Queen Elizabeth College,
London W.8

- ¹ Davies, L., Hastrop, K., and Bender, A. E., *Modern Geriatrics*, 1973, 3, 385.
- ² Davies, L., Hastrop, K., and Bender, A. E., *Modern Geriatrics*, 1973, 3, 390.
- ³ Davies, L., Hastrop, K., and Bender, A. E., *Modern Geriatrics*, 1973, 3, 482.

Misdiagnosis in Still's Disease

SIR,—Your leading article (9 March, p. 406) points out that juvenile rheumatoid arthritis tends to be diagnosed too readily on too little evidence. The review of misdiagnosed cases from the John Hopkins Hospital to which you refer included patients with lymphosarcoma and leukaemia.¹

Neuroblastoma, which is one of the commonest malignant tumours of childhood, may also present with bone and joint pains which can be mistaken for juvenile rheumatoid arthritis. We have had several patients with advanced neuroblastoma admitted to this hospital in whom an initial diagnosis of juvenile rheumatoid arthritis had been made. Recently we admitted a girl of 8 years who had been treated for three months previously for increasing bone and joint pains and a limp. She had been given prednisone on the presumptive diagnosis of juvenile rheumatoid arthritis. During this period her urinary excretion of vanilmandelic acid had been measured and on each occasion it had been grossly abnormal. However, the significance of this finding had not been appreciated and no further relevant investigations were done at that time. On admission a full skeletal survey revealed multiple bone lesions due to metastatic deposits, and bone marrow biopsy showed infiltration with malignant cells, thus confirming the initial diagnosis of neuroblastoma.

The vanilmandelic acid estimation is a useful screening test since it will be positive in up to 80% of children with neuroblastoma, whether or not they have metastatic disease. Any child with unexplained bone pain requires a full skeletal survey to reveal all lesions, since not every metastatic deposit produces symptoms. A bone marrow biopsy may also confirm the diagnosis of leukaemia or metastatic malignant disease, (neuroblastoma, lymphosarcoma, or other sarcomas), any of which may present with bone or joint pain, fever, anaemia, raised E.S.R., weight loss, etc. which can be mistaken for juvenile rheumatoid arthritis. The bone marrow biopsy may well be positive in the absence of any identifiable bone lesions on x-ray.—I am, etc.,

JANE V. BOND

Department of Paediatric Oncology,
Hospital for Sick Children,
Great Ormond Street,
London W.C.1

- ¹ Sills, E. M., *John Hopkins Medical Journal*, 1973, 133, 88.

Mental or Criminal?

SIR,—Your leading article (24 November, p. 438) dealing with the annual report on the work of the Prison Department refers to "the assumption by the prison medical service of a positive therapeutic rather than custodial role in the handling of the mentally abnormal offender." An example that it is indeed possible to treat people while in prison can be seen in experiences with a recent experimental therapeutic community set up at Wormwood Scrubs Prison comprising alcoholics, drug addicts, and compulsive gamblers. Of course, all such addicts are essentially sick people, and not primarily "criminals," who do not really belong in prison. All possible attempts should be made to find suitable alternatives to prison and non-custodial treatment, but nevertheless there will always be addicts who end up in prison for offences directly or indirectly connected with their addiction. Rather than wasting this period, one should try to make use of the enforced abstinence and lack of access to the dependence-producing agent to initiate—if possible—the long-term rehabilitation process and to induce the motivation which is usually lacking initially.

Having tried for about 10 years to "treat" such people in prison I felt frustrated because the little that could be attempted in individual or group therapy sessions once or twice weekly seemed to become lost during the 24-hour day in a custodial, non-therapeutic atmosphere. This environment often engendered in these people—often of the "immature and inadequate" personality make-up referred to in your article—reactions of tension, depression, and frustration, with continual demand for tranquilizers and similar drugs. Our group sessions had, however, indicated that it was possible for compulsive drinkers, drug takers, gamblers, smokers, etc. to "identify" with each other, even while in prison, and it certainly seemed worth while to explore the possibility of the formation of a therapeutic community in prison.^{1,2} The opportunity to set up an "addiction unit" came a year ago. Owing to administrative problems this unit formed part of a larger unit comprising also other types of psychiatric patient-offenders, the various types being under the care of three different psychiatrists.

During the period between 1 December 1972 and 4 September 1973 the highest number of all patients at any one time was 27 and of the "addicts" among them 20. The majority of "addicts" were youngish poly-drug abusers; their total number was 25, varying in age from 21 to 30 years. There were seven alcoholics (aged 21–47 years) and two gamblers. The staff comprised seven hospital officers and two disciplinary officers. All the hospital officers had volunteered for the work in the unit and had previously spent a brief special training period in Grendon Prison and in the St. Bernard's Hospital Addiction Unit. The treatment programme centred on daily group therapy sessions, each officer looking after his own group of patients. The atmosphere was clearly non-custodial and therapeutic, with emphasis on the development of initiative and responsibility among the patients, who chose their own group leader and published their own magazine. There was an ongoing dialogue between