remain the arbiters of how widely confidences expressed to their doctor or social worker may be shared. Most of them will readily agree to the co-option of a colleague to a situation, or to a confidential second opinion. But few will seek help from an organization where they themselves, the patients, forfeit control of who does and who does not have access to their private affairs. This is one of the causes of present underuse of some social service departments. Future improvement of medical care by co-operation between general practitioners and social workers will depend largely on genuine attachment of suitably trained social workers to general practices, and freedom from hierarchical involvement in case detail and case management. I suggest that it is only in this way that the large area of personal care, which is indivisibly both medical and social, can be fruitfully approached.—I am, etc.,

SHOLTO FORMAN.

Barnstaple, Devon.

SIR,—As medical and psychiatric social workers in a hospital setting, we are concerned to see that the recommendations of the Seebohm Committee¹ in your leading article (3 August, p. 265) are seen as presenting the public with a choice between doctor and social workers. We suggest that the implementation of the report would provide the public with an increased opportunity to be helped by the special skills of both professions.

No one doubts that most family doctors have "insight and understanding" and that they "help patients better to understand their situation," but the training of the two professions results in a difference of emphasis. The doctor is able to give insight into the effect of the illness on the patient, the course it is likely to take, and the medical help available, and it is essential for the patient and his family to receive such information from the doctor himself. But we as social workers maintain that the doctor has neither the time nor has his training been directed towards giving him the skill to enable him to help the patient and his family adjust to the implications of illness—for instance, to the idea of a permanent disability, to a change of employment, to a functioning at a different or possibly lower level, or to bereavement. Help of this description often involves hours of patient, sensitive listening, the ability to recognize helpful and unhelpful emotional reactions and developments in personal and family relationships, together with the time and skill to handle these. It is necessary, too, to have a wide knowledge and experience of social resources and the ability to enable patients to use these and yet keep their sense of independence and autonomy. We suggest that it is unrealistic to expect family doctors to fulfil this function.

Your article also supports the notion that health and welfare departments should amalgamate under the direction of the medical officer of health. We would point out that many families have social problems far beyond the sphere of these departments. These difficulties may involve education, housing, child care, or delinquency. It would therefore seem that a department of

social service under a professional social worker/administrator working in close collaboration with specialists in the field of medicine, education, housing, etc., would be the rational form of organization to give the public the maximum benefit of professional skills in each of these related spheres.—We are, etc.,

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REFERENCE

¹ *Report of the Committee on the Local Authority and Allied Personal Social Services*, 1968, Cmnd. 3703. H.M.S.O., London.

SIR,—I read your leading article on the Seebohm Committee (3 August, p. 265) with puzzled interest. The bland assumption that a doctor could be the only person to cope with the personal problems of individuals seems to be a little far fetched. Since 1945 there has been a series of Acts of Parliament—for example, 1948 and 1963 Children's Acts—which have been passed to help individuals in need, and they affect the medical profession only slightly. Coupled with this has been a tremendous growth of social work training courses at all academic levels. There is now a realization that all social problems do not necessarily have a medical origin. Accordingly, a new emerging group (profession) has come about to cope with the new approach to the problems of the community.

To return to your detailed comments, particularly the one concerning confidentiality. This is a difficult one for everybody helping individuals in need, but the fact must be faced that there has to be an exchange of information—for example, the probation officer to the court, the child care officer to his committee, the psychiatrist to the child care officer on decisions of returning or removing children from their families, and so on. Some of these confidential exchanges are enforced by law or by local regulation and some occur because the best well-being of the individual concerned can only be achieved by this exchange. The best methods—that is, the ones with the highest regard for the individual being helped—on how these confidential exchanges can take place are, I feel, still open to further discussion. Another detail in your article which is rather dogmatic is the assumption that "when in trouble patients turn first to their doctor; and they look to him to sort things out." This may be true in a number of cases, but there is a high degree of evidence in various social work departments that the majority of case referrals come from other sources. This is certainly true of this experimental centre, which is conducting research into referrals among other topics.

My own feeling as a qualified social worker is that the time has come when persons in the helping capacity within the community must look to each other as members of a team and yet acknowledge the specialization each person brings, and accordingly the specialists must be given freedom to run their organizations.—I am, etc.,

GRAHAM LYTHER.

Craigmillar Health, Welfare,
and Advice Centre,
Edinburgh 9.

Measles Inoculation

SIR,—I am prompted by Mr. D. P. Choyce's letter (27 July, p. 254) to report another unfortunate personal experience with the new live attenuated measles vaccine.

Thirteen days after his inoculation my 4-year-old son developed a generalized blotchy rash, a fever up to 102° F. (39° C.), and much malaise and anorexia. The illness lasted a full week and included transient puffiness of the eyes and a slight dry cough. Our family doctor prescribed a course of antibiotics. After the acute illness my son was anorexic and easily tired for a further 10 to 14 days. In effect this was a case of iatrogenic measles. Previously he had been exceptionally healthy for a full year, so I doubt the significance of the fact that his 6-year-old sister, inoculated simultaneously, suffered no ill-effects.

One wonders how many more of these very distressing episodes are occurring, and whether the authorities realize what is going on. My wife and I would never have permitted this vaccination to be done if we had known that it can cause reactions of this severity. I would support Mr. Choyce's suggestion that when a new vaccine is introduced a built-in early warning system is included.—I am, etc.,

Henleaze,
Bristol.

K. W. HEATON.

Guinea-worm Arthritis of Knee Joint

SIR,—We have read with considerable interest the excellent presentation by Professor C. R. R. M. Reddy and Professor M. Sivaramappa of four cases of guinea-worm arthritis of the knee joint (20 January, p. 155) and the subsequent letters in the correspondence column by Dr. B. M. Greenwood and Mrs. Margaret F. Johnson (3 February, p. 314).

In a series of 250 cases of guinea-worm infection seen in the last 12 months and another 100 cases seen by one of us (M. L. K.) in the preceding four years, we have come across seven cases of acute arthritis of the knee joint. Only one knee joint was affected in these cases and presented with acute inflammation and effusion in the joint without constitutional symptoms. In all cases the guinea-worm was seen in the vicinity of the knee joint. Five cases were treated with one or two aspirations followed by a compression bandage and institution of physiotherapy. All cases regained full function within four weeks. The aspirate in these cases was a thick straw-coloured fluid (specific gravity 1020–1024) exhibiting fibrinous threads on the side of the test tube. The protein content was 4.2–4.5 g./100 ml. with albumin/globulin ratio 1:3. A fair amount of fibrinogen was present. Microscopic examination of the aspirate showed a large number of monocytes and lymphocytes. There were no eosinophils and guinea-worm larvae were not seen in any of the aspirates. Bacteriological culture was negative in all cases. Two cases of acute arthritis were treated with nifedazole and showed complete recovery within 1–3 weeks without local intervention. The effectiveness of nifedazole has been documented.^{1–3}

We agree with Dr. Greenwood that there is a group of patients who develop arthritis

of various joints, specially the knee joint, without the guineaworm being inside the joint cavity, and in these the larvae play no role. Fairley and Glen Liston (quoted by Manson Bahr 1966⁴) failed to induce any local or general reaction by subcutaneous injection of guineaworm larvae. It is therefore likely that it is a toxin liberated by the adult worm that causes the arthritic lesion irrespective of its actual location.—We are, etc.,

M. L. KOTHARI.

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Penicillin-induced Haemolytic Anaemia

SIR,—We read with interest your leading article and the paper by Dr. J. M. White and others (6 July, pp. 4 and 26) and feel that, in view of the small number of reported cases in Great Britain, it would be of value to report another case of penicillin-induced haemolytic anaemia.

On 12 April 1968 a 32-year-old woman was admitted to hospital for the investigation of abdominal pain accompanied by rigors. Seven years previously she had undergone mitral valvotomy for rheumatic heart disease. Penicillin had been administered on many occasions.

Optimum Size of Books

SIR,—The review entitled "Paediatrics," by Professor D. Hubble (13 July, p. 110) prompts me to write about an attitude which has for long irritated me. Professor Hubble says the book is not only better but also bigger, and then raises the point "to what size should the textbook be allowed to grow and what should be omitted from it to keep it within its allotted span?"

I believe that reviewers (and this seems to be a common attitude; I am not referring specifically to Professor Hubble) adopt the wrong criterion when, as they often do, they praise second editions for not exceeding the size of the previous one while incorporating new material. Should not the criterion for judging a book be its completeness rather than its size? Will the reader who refers to a textbook find in it what he by right expects to find? Why should there be an "allotted span" for textbooks and who

allots it? Does a new discovery in medicine which must be described in a textbook mean that something else known long before is necessarily no longer true or useful and must be thrown out to make way for the new arrival?

Sellar and Yeatman in their humorous classic *1066 and All That*¹ quoted a possibly fictitious review of their book from *Punch* consisting of the three words; "This slim volume." They were being funny; others seem to make a fetish of a limited size in books in all seriousness. Of course one is against prolixity and turgidity, but shall we be bullied, consciously or otherwise, by commercial interests into praising the smaller at the expense of the more complete? Will the day ever come when we will be judging authors or medical consultants by the criteria by which beauty queens are chosen?—I am, etc.,

EMANUEL AGIUS.

St. Julian's,
Malta G.C.

REFERENCE

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Aphthous Ulceration

SIR,—Your correspondent Dr. A. J. Moore (25 May, p. 494) stresses trauma as a cause of aphthous ulcers, and asks if his observations have been borne out by experience in other practices.

Recently I had a female patient, aged 48 years, with a crop of aphthous ulcers on the buccal surface of her upper lip. The ulcers were resistant to mouth washes, mouth paints, and the administration of hydrocortisone sodium succinate pellets (2.5 mg.). After reading Dr. Moore's letter I examined her toothbrush, to find that it was practically bald in the centre and the bristles curved gracefully outwards from the middle line. The use of a new toothbrush was quickly followed by the disappearance of the ulcers.—I am, etc.,

Gwelo, Rhodesia.

J. C. COMLINE.

Addiction to Methedrine

SIR,—A patient of mine who has recently ceased to take intravenous methylamphetamine in a dose of ten ampoules or so a day told me how he got it from general practitioners. In the waiting room he used to think himself into the part of a deprived addict, walk in weak and pale, slump into a chair, and throw his head back. Breathing with difficulty, he would announce that he was a Methedrine addict and urgently needed the drug. The doctor would look grave and say, "I'm sorry but I never prescribe to addicts." Thereupon the patient would intensify his symptomatology, making the doctor feel very anxious. Eventually the doctor would, as like as not, say, "Well, very well, then, I'll give you a prescription for five ampoules, but you understand that that's the last you get from me."

It must be pointed out that although there are many points of similarity between narcotic addiction and methylamphetamine addiction there are also very great differences. One of these is that the former produces a physiological dependence, whereas the latter does not. Consequently the Methedrine

On this admission a diagnosis of subacute bacterial endocarditis was made and she was treated with benzyl penicillin in increasing dosage, culminating in the intravenous administration of 20 mega units a day for eight days. At the start of therapy the results of haematological investigations were as follows: haemoglobin 12.9 g./100 ml., white cell count 6,700/cu.mm. Film appearances normal. Subsequent haematological investigations demonstrated a falling haemoglobin with increasing evidence of haemolysis. Sixteen days after the beginning of therapy the haemoglobin had fallen to 7.0 g./100 ml., the reticulocyte count was 26%, the nucleated cell count was 11,500 cu.mm., and spherocytes and normoblasts were seen in the peripheral blood film. At this time the direct antiglobulin test was positive with an optimum A.H.G. dilution of 1-64 using a broad-spectrum antiglobulin

reagent, and also positive using an anti-IgG reagent. Penicillin antibodies were demonstrated in the serum by the standard passive haemagglutination technique of de Weck.¹ The major antibody was shown to be IgG, but we were also able to demonstrate a small IgM component.

Penicillin therapy was discontinued on the sixteenth day, and no other treatment for the anaemia was instituted. During the next seventeen days the haemoglobin rose to 10.2 g./100 ml. with a fall in the reticulocyte count to 4%. When seen two months after

We are grateful to Dr. L. Martin for permission to publish the case history of this patient.

—We are, etc.,

H. E. AMOS.

A. N. R. BISHOP.

MURIEL J. SEAMAN.

JOAN TROWELL.

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REFERENCE

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