marks is a generalized *non-itching* rash—indeed, I saw a girl of 17 recently who was pregnant, had had a sore throat a week earlier, and had developed a non-itching generalized rash. I sent her to our V.D. department with a confident diagnosis of early secondary syphilide which was confirmed by the consultant.

I was taught that all non-itching rashes should prompt one to remember this possibility.—I am, etc.,

I. ROSE

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Particles in Spleens

SIR,—Drs. M. Tavassoli and R. Judith Ratzan (1 April, p. 48) have suggested that the unusual particles described in spleens by my colleagues and myself (18 December 1971, p. 721) were platelet lysosomes. We have been reluctant to accept this explanation because our particles are much smaller than lysosomes (Figs. 1 and 2). We agree that lysosomes have a structure which resembles some virus particles and indeed pointed this out in our original communication. We used the euphemistic term "unusual particle" because of the uncertainties shared between ourselves and others over cell organelles which mimic virus. These organelles include a range of structures quite apart from the lysosomes mentioned by Drs. Tavassoli and Ratzan. They include secretory granules of endocrine glands, the darkly staining particles of the juxta-glomerular junction, and bristle coated vesicles. Another source of difficulty, which I have not so far

found in the literature, is the pinocytosis of electron dense reticular cell cytoplasm by adjacent lymphocytes (Fig. 3). Nevertheless, my first impression and indeed, persisting impression, of these particles is their noteworthy resemblance to particles described as virus by Schwartzendruber *et al.*¹ in a mouse strain with a high leukaemic incidence, by Gross² in transmissible murine leukaemia, and by Dmochowski³ in human neoplasms.

FIG. 3—"Budding" reticular cell showing extrusion of darkly stained vesicles into cytoplasm of adjacent lymphocytes. $\times 23,125$.

Some may say why show concern over virus in the spleen.³ After all virus is ubiquitous, and even when found who can say whether it is passenger or driver. It seems better to formulate a hypothesis rather than botanize amidst the aridity of structural detail. Our working hypothesis is that a diversity of auto-destructive haematological conditions may be due to virus particles which render cell membranes auto-antigenic, and manifestations depending on which particular stem cell has been infected. Furthermore, the presence of such virus in healthy people would indicate not lack of pathogenicity on the part of the particle but tolerance on the part of the host, production of disease depending on the equilibrium between tolerance and immunity to the agent.

The conclusion drawn by myself and colleagues is not that these particles are lysosomes or cell organelles, but rather that they are sufficiently intriguing to warrant a detailed investigation.—I am, etc.,

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¹ Schwartzendruber, D. C., Ma, B.I., and Murphy, W. H., *Advances in Experimental Medicine and Biology*, 1968, 5, 203.

² Gross, L., *Acta Haematologica*, 1964, 32, 44.

³ Dmochowski, L., in *14th Annual Clinical Conference on Cancer*, 1969. New York, Year Book Medical Publishers, 1970.

Community Mental Health

SIR,—It is still frequently believed that the management and treatment of mental patients in the community has to be directed mainly from the hospital and it is disheartening that even some of our own colleagues do not seem at all well acquainted with the important contributions community psychiatrists and social workers make towards psychological medicine in general. One of the main deficiencies of the present system

appears to be the sharp division between the hospital and community mental health services and their facilities. The one is usually not responsible for the other, a system which creates tremendous difficulties especially when a patient has to be admitted and the hospital or community establishment, sometimes both, refuse to accept him with seemingly little concern for the fate of the patient.

I would like to propose the establishment of a career grade—namely, that of the community psychiatrist with the status of a consultant. His functions should include taking charge from a psychiatric point of view of all mental health facilities in the community, give advice on the welfare and needs of patients contained in them, and, equally important, counsel staff on the management of the clients under their care. This would be a most onerous task and should take the greater part of his time.

He would also advise the local authority on improvements, extensions, and new facilities required for present and future community psychiatric needs, and work closely with those responsible for planning on the hospital side. As an extension of this, he would be in close contact with colleagues in other branches of psychiatry and medicine, whether in hospital or community, in order to participate in a uniformly agreed management and placement of mental patients.

Some of his time would be set aside for research into the dynamics of psychiatric illnesses as these affect people in the community with a view to evaluating appropriate prophylactic measures and where possible suggest more suitable management and treatments. A better acquaintance with the patient's environment and a knowledge of suitable alternate placement creates for the community psychiatrist an advantageous yet impartial position from which to advise on appropriate placement, should admission to one or other establishment be refused and the patient left to the often unsatisfactory devices of his family.

To second a psychiatrist for one or two sessions a week to the community services is, in my view, of little use. The proposed appointment should allow for at least half of the sessions of a full or maximum part-time employment to be spent with the community services. It would be equally unproductive, however, if all the psychiatrist's sessions were relegated to the community at the exclusion of hospital work. The suggested ratio of commitment between community and hospital with emphasis on community work should meet the requirements of advice on psychiatric illnesses in the community. In my own area such a scheme, although not fully implemented, has been in operation for a number of years, and seems to have met with some success.

It is quite unrealistic to expect a generic social worker to undertake the very specialized and often difficult task of caring for mental patients in the community. Social work in psychiatry plays a very significant role and I can see no alternative but to amalgamate once again psychiatric social workers with psychiatrists whether engaged in the community or hospital, a suggestion which is in accord with recent recommendations of a tripartite committee on closer association between personnel working in the field of mental health.¹

Time is running out and unless some

FIG. 1—Unusual particles—virus like—in spleen from a case of ITF. $\times 23,125$.

FIG. 2—Platelet lysosomes $\times 23,125$.