will survive 600 mg. of the drug but will be destroyed by 2 g. Thus the dosage of metronidazole usually employed for trichomoniasis does not appear to be treponemicidal. However, until more investigations have been carried out it would be wise for the venereologist to withhold metronidazole from patients who may be incubating or in the early phase of syphilis, until that diagnosis has been confirmed.

More Retroperitoneal Fibrosis

Though first described over 60 years ago, interest in retroperitoneal fibrosis has grown since its reported association with the drug methysergide.[1-3] There are now reports of over 200 cases, and the evidence suggests that it is being increasingly recognized. For example, in a recent series of 14 patients encountered in as many years in Birmingham,[4] no fewer than ten were seen after 1963. This may be due to better awareness of the protean manifestations of a curious disease or to the increased activity of some aetiological agent as yet unknown.

There is no general agreement on what constitutes the syndrome of retroperitoneal fibrosis, and some authorities would exclude localized plaques of fibrosis. But it might be defined as a chronic fibrosing process which usually starts in the pelvis or lumbar region, and in the majority of cases spreads to the ureters. The disease attacks their walls though patency is maintained. Mediastinal fibrosis[5] can also occur, and discrete fibrous masses may be found at the hilum of the lung and even in the lung parenchyma. Arteries, veins, and lymphatic channels may be compressed by fibrosis, so that a wide variety of ischaemic and obstructive lesions result. The usual history is of vague abdominal pain and backache, often radiating into the groins, with sooner or later signs of impaired renal function and hypertension. Epididymal swelling, hydrocele, and leg oedema may result from obstruction of veins in the pelvis, and in some patients the arterial supply to the lower limbs may be jeopardized. Less commonly, mediastinal fibrosis may have such diverse consequences as facial oedema, coronary ischaemia, pericarditis, and pleurisy. In addition there are such indications of the generalized nature of the disease[6] as loss of weight, anaemia, a raised erythrocyte sedimentation rate, and increased levels of γ-globulin in the serum. While no doubt most patients will be seen by genitourinary surgeons or by physicians concerned with renal disease and hypertension, it is clear that no one, whatever his specialty, can afford to ignore the syndrome, and this is borne out by the fact that two of the patients in the Birmingham series presented as orthopaedic problems.

Retroperitoneal fibrosis may be a self-limiting condition,[7] and spontaneous remission has been recorded.[8] But in some cases it is progressive and fatal. Recognition is all the more important because, once the condition is thought of, diagnosis in the average case is not difficult and treatment is often rewarding. Hypertension with a history of abdominal pain, a raised blood urea and erythrocyte sedimentation rate, and abnormalities in the plasma proteins, especially if there are other seemingly bizarre clinical features, should suggest the need for pyelography, especially by the retrograde route. The features are characteristic[4]: delayed excretion of dye, with hydronephrosis and hydroureter above an obstruction, which is commonly in the mid-lumbar region or at the pelvic brim, and medial deviation and irregularity of the ureter at the site of obstruction. In difficult cases lymphangiography may also be valuable. Operation to free the ureters is often strikingly successful, though further obstruction may occur, and in some patients an affected segment of ureter has had to be resected.

What is the nature of retroperitoneal fibrosis? Histological examination of excised tissue has shown a wide variety of cell types, and in some cases vasculitis has been a prominent feature. There seems little doubt that an immunological reaction to a variety of sensitizing agents is the likely mechanism, and in some cases an autoimmune type of response is probable.[9] The association with methysergide suggests a drug sensitivity, but so far no other drug has been implicated. Sometimes the condition appears to have been initiated by local infection or by haemorrhage in association with blood diseases.[4] In a few cases the fibrosis represents an intense fibrotic response to malignant disease.[10] But most must still be labelled "idiopathic," and they represent a challenge which will no doubt be met by careful clinical appraisal of new cases and by the efforts of immunologists.

Mental Handicap and the Family

Most undergraduate and postgraduate teaching on mental subnormality concentrates on diagnosis and phenomenology and gives little time to the study of the families of subnormal children and the stresses to which they are exposed. However, the interested doctor is aware that despite the common sense and compassion he brings to bear on the family's situation he needs to be better informed. He feels the lack of a broader background of knowledge and of guidance when he seeks to alleviate the stresses inevitable within a family confronted by the tragedy of mental handicap. He needs to know how the handicapped child should be assessed and educated, how the services available are organized, and how to make use of them. Further, he should be aware of current opinion on how these services could be developed and improved. A number of recent publications[1 2] have dealt with these matters, but what the practitioner requires is a succinct but comprehensive presentation of the information. A working party convened by the National Society for Mentally Handicapped Children has recently produced a short report which goes a long way to meeting these requirements.[3]

In 1958 F. L. Masland and his colleagues[4] came to the broad conclusion that many mentally subnormal children do better at home than in institutions, especially in the early years. Later J. Tizard and J. C. Grad suggested that, unless there were strong contraindications, "parents should be encouraged and helped" to care for mentally handicapped babies themselves. The working party accepted these views as a premise, but it was no doubt aware that beyond a certain point the burden of looking after a mentally handicapped child may threaten the well-being of the family, and in these cases institutional care may be the only answer. "For parents of older children the choice remains theirs. It is unfortunate

[1] Utz, D. C., Rooke, E. D., Spittell, J. A., and Bartholomew, L. G., *J. Amer. med. Ass.*, 1965, **191**, 983.
[2] Graham, J. R., Suby, H. I., LeCompte, P. R., and Sadowsky, N. L., *New Engl. J. Med.*, 1966, **274**, 359.
[3] *Brit. med. J.*, 1966, **1**, 755.
[4] Webb, A. J., and Dawson-Edwards, P., *Brit. J. Surg.*, 1967, **54**, 508.
[5] Barrett, N. R., ibid., 1958, **46**, 207.
[6] Kay, R. G., *Brit. J. Urol.*, 1963, **35**, 284.
[7] Ormond, J. K., *J. Urol. (Baltimore)*, 1965, **94**, 385.
[8] Benfield, J. R., Harrison, R. W., Moulder, P. V., Lyon, E. S., and Graff P. W., *J. Amer. med. Ass.*, 1962, **182**, 579.
[9] Que, G. S., and Mandema, E., *Amer. J. Med.*, 1964, **36**, 320.
[10] Webb, A. J., and Dawson-Edwards, P., *Brit. J. Surg.*, 1967, **54**, 505.

that, today, the parents who bring up a subnormal baby themselves are likely to have a hard time of it."[3]

The report examines the procedure whereby the school medical officer, acting on behalf of the local education authority, assesses children who may be subnormal at the age of about 5. It points out that no matter how skilfully this assessment is made the objective is primarily administrative and is directed at excluding the child from school rather than at making a constructive educational or therapeutic recommendation. The report also emphasizes the inadequacy of a single assessment at a single point in time. Child psychiatry has long recognized the value of the multidisciplinary team approach for the diagnosis, assessment, and management of childhood disorders. This important concept is adopted and extended by the working party. Its view is that the assessments should be undertaken by such a team working in a co-ordinating centre planned and staffed jointly by the local authority and the National Health Service. The staff of such a centre should include medical specialists, educationalists, psychologists, social workers, and possibly parents. The team should work in co-operation with general practitioners and hand on information to them. Such an arrangement would give a family access to a centre where they could obtain authoritative diagnosis and assessment of subnormality and other handicaps, and under the same roof the accumulated knowledge of social and personal problems could be applied for the benefit of individual cases.

The report describes how provisions for the care and management of handicapped children vary from area to area throughout Britain. Greater co-operation between local authorities, hospital authorities, and voluntary societies is necessary before services can be integrated and rationalized so that more effective use is made of existing resources. Essential services such as pre-school facilities for subnormal children, training centres, and accommodation for short-term residential care to cover holidays or family crises are missing or inadequate in some parts. Planning for the future should ensure that these gaps are filled.

However, comprehensive outside services of this kind supply only part of the help that families need. The report goes on to indicate what needs to be done nearer home to relieve the burden of those who have handicapped children. They need help in getting suitable housing. Financial assistance, when applicable, should include increased grants from the National Assistance Board, income tax relief, grants for laundry or home nursing, and subsidized holiday care. In addition to short-stay residential units, crèches and day nurseries should be widespread.

Counselling is of crucial importance. In the hands of the uninformed it may tend only to increase distress. Disclosure is a painful and delicate task, and, however carefully conducted, it may lead to an unfavourable reaction in the parents. It has been shown that a proportion of parents are critical not only of the way in which the disclosure was conducted but of the subsequent advice and help they had received.[5,6] Parents need a patient and sympathetic hearing and well-informed answers to their questions. They need genetic counselling and advice about family planning. They will wish to know how they can help with play activities; they will want advice about education, speech development, and training in social behaviour. The family will also need help with its own adjustment to handicap, with its own attitudes and reactions. If the counsellor has both the training and judgement to know not only when but how to explain the child's condition and is also capable of offering informed advice on the problems outlined above, the family will be the more likely to accept the situation realistically and to deal with it effectively, while adverse reactions such as rejection, over-compensation, or overwhelming feelings of guilt and conflict within the family may be avoided or attenuated.

[1] Tizard, J., *Community Services for the Mentally Handicapped*. London, 1964.
[2] —— and Grad, J. C., *The Mentally Handicapped and their Families*. London, 1961.
[3] *Stress in Families with a Mentally Handicapped Child*. Report of a working party set up by the National Society for Mentally Handicapped Children. London, 1967
[4] Masland, R. L., Sarason, S. B., and Gladwin, T., *Mental Subnormality: Biological, Psychological and Cultural Factors*. New York, 1958.
[5] Koch, R., Graliker, B. V., Sands, R., and Parmelee, A. H. Sr., *Pediatrics*, 1959, **23**, 582.
[6] Jensen, R. A., *Amer. J. Psychiat.*, 1950, **106**, 830.

Visible Alternatives

What is the best treatment for the ailing Health Service? Should it be radical, symptomatic, or both? What other ways are there of finding money and administering the Service? Taking up Mr. Enoch Powell's contention that "what is necessary is a visible alternative,"[1] the *B.M.J.* has recently examined some of the possibilities. Experts in economics and related fields have discussed, among other solutions, a nationalized health corporation, decentralizing administration, a Parliamentary Committee on the Health Service, and the prospects for private health insurance. All the articles in this series, together with a medical summing up by Sir Robert Aitken, have now been collected into a booklet, which was published this week.[2]

Most of the contributors conclude that for various reasons the National Health Service cannot now be abandoned. Nevertheless, as Sir Robert Aitken points out in his thoughtful and provocative concluding essay, "some large and important practical improvements . . . lie to hand." The first of these should be a serious attempt to lessen central control over hospital boards. Boards should be given considerable responsibility for the design and construction of buildings and allowed to spend their recurrent grants as they wish. Sir Robert's second main proposal is for a Health Service Ombudsman, possibly associated with a Select Parliamentary Committee on Health, through which valuable and unbiased evidence would flow to Parliament. Sir Robert argues that the creation of an Ombudsman would take away the strain of the petty Parliamentary Question without lessening the standards and accountability inherent in a public service. Thirdly, experiments should be made in ending the tripartite structure of the Service—for example, by associating general practice with hospital practice. In this way "urban general practice would come alive again." Finally, he argues, more value must be got out of the same amount of money, both by sensible economies and by greater efficiency.

Unlike some of the alternatives proposed, this last suggestion would cost nothing and could be put into practice more or less immediately. Nevertheless, it is only one of several important changes that must be made if our Health Service is to compare with those in many other countries. All who are striving to improve the Service will find much useful guidance in this booklet.

[1] Powell, J. E., *A New Look at Medicine and Politics*, 1966. London.
[2] *Is There an Alternative?*, 1967, B.M.A., Tavistock House, Tavistock Square, London W.C.1 Obtainable from the Publishing Manager, *B.M.J.*, price (including postage) 7s. 6d.