Improving the Psychiatric Services

SIR,—Being very interested in and committed to the task of trying to plan and provide suitable hospital services for elderly people, I think that Dr. H. Jacobs's letter (16 December, p. 681) calls for some comment.

I refer to the very popular notion of "x weeks in and x weeks out geriatric service." Such service is not necessarily the sort of panacea that many people seek. It is very difficult indeed to keep to any such timetable. One knows that shuttling the elderly from here to there will in itself very often affect them adversely and one had found that at the end of the allocated stay in hospital the patient is much worse than at the time of admission. Although one is keen to help the relatives and benefactors of frail elderly people by giving them respite, and is able to do this in selected cases, I have come after many years to believe that the primary task of the geriatrician is to treat vigorously whichever patients have tractable diseases, tempering such treatment with, one hopes, humanity and common sense.

As for day hospitals, I am completely sold on their virtues and efficacy. I am beginning to think that these, paralleled by local authority day centres, might very well reduce dramatically the expense of providing in future for the needs of the elderly.—I am, etc.,

St. Edmund's Hospital, Northampton. J. H. RAPHAEL.

Tetanus Prophylaxis

SIR,—I was very interested to read your leading article on tetanus prophylaxis (16 December, p. 635). I was pleased to see that you made it very clear that prophylaxis in the non-immune wounded patient for practical purposes rests between antibiotics and antitetanus serum. Neither of these has been proved to be 100% effective, but nevertheless clearly must be largely effective, for, as you state, the number of tetanus cases in this country is quite small.

I do wish, however, that you had made it very clear that tetanus toxoid has no practical value in the immediate prophylaxis of tetanus. We see a number of patients in this hospital who have had their initial treatment of wounds at a neighbouring hospital where the staff seem to be convinced that either tetanus toxoid alone, or tetanus toxoid plus one injection of penicillin, is adequate prophylaxis. At the recent symposium on tetanus held in Leeds in April,¹ which is referred to in your leading article, both Mr. Sharrard and I emphasized that a course of antibiotics was necessary for adequate prophylaxis. This point you have brought out in your leading article. Recently, however, my colleague Dr. J. J. L. Ablett lectured on the treatment of tetanus to a society some 40 miles from here. As a matter of interest, at the end of the lecture he inquired from all those present what method of prophylaxis they themselves used in the patient at risk. The majority of those present stated that they gave tetanus toxoid and one injection of penicillin. I am sure that Mr. Sharrard will join with me in condemning this as inadequate and in stressing once more that tetanus toxoid is of no immediate prophylactic value.

All except one of our last 10 patients undergoing treatment in our tetanus unit had

been given this form of prophylaxis, emphasizing its inadequacy from a different point of view.—I am, etc.,

Tetanus Unit,
General Infirmary,
Leeds.

M. ELLIS.

REFERENCE

- ¹ Sharrard, W. J. W., in *Proceedings of a Symposium on Tetanus in Great Britain*, Leeds, 1967, ed. M. Ellis.

Low Back Pain

SIR,—I was interested in Dr. W. I. D. Scott's comments on back troubles in industrial and general practice (9 December, p. 618). I would agree with him that strict bed rest in simple lumbago is impractical. Indeed, I would suggest that it may be harmful in some patients by providing yet another somatic outlet for their psychological stresses.

After all, the acute prolapsed disc is rarely seen in general practice, and most cases of lumbago-sciatica fall into the category of musculo-ligamentous strains.

These cases respond admirably, in my experience, to infiltration with local anaesthetic solutions, with or without hydrocortisone, together with manipulation and early mobilization.—I am, etc.,

Elgin,
Morayshire.

A. M. BLAIN.

Bromism

SIR,—We should like to point out once more the dangers of the long-term administration of carbromal, especially as the amount prescribed may go somewhat unnoticed when it is combined with a hypnotic such as pentobarbitone as in Carbrital (carbromal 250 mg., pentobarbitone 100 mg.). The danger lies in the fact that bromide (to which most of the carbromal is metabolized) is much more slowly excreted from the body than pentobarbitone and therefore has a cumulative effect. A recent case illustrates this.

A 75-year-old man who had been taking Carbrital as a hypnotic for many years, and who possibly took more than his usual dose of two capsules four days prior to admission, was admitted in a very confused state with nystagmus, marked ataxia, and generalized diminution of sensation. His serum bromide level at this time

was 60 mg./100 ml. Without treatment this had fallen to 40 mg./100 ml. in five days and the above symptoms and signs had disappeared.

In the past nine years he has had five admissions to mental hospitals with episodes of confusion, delusions, and hallucinations. On each occasion these settled down without any specific treatment within a few days of admission. A number of psychiatric diagnoses were suggested, but none were consistent with the transient nature of the symptoms.

As the serum bromide was not recorded during these admissions we have no definite proof that they were due to bromism, but in view of his recent illness and the well-documented evidence of psychiatric symptoms in bromide intoxication,^{1,2} we consider that these were manifestations of a toxic level of bromide.

We would like to thank Dr. J. E. G. Pearson for his permission to report on this case.

—We are, etc.,

Bristol Royal Hospital,
Bristol.

A. F. BOYLES.
D. J. MARTIN.

REFERENCES

- ¹ Andrews, S., *Med. J. Aust.*, 1965, 1, 646.
² Wuth, O., *J. Amer. med. Ass.*, 1927, 88, 2013.

Cause of Death

SIR,—Why in the obituary notices of doctors published in the *British Medical Journal* is the cause of death never stated? In the *Journal of the American Medical Association* it invariably is.

The American practice is, I suggest, more seemly. After all, the *British Medical Journal* is written by doctors for doctors, and deals mainly with disease and death; and it would be easy to make provision for that very small minority of deaths in which a public statement of the cause might distress relatives. Certainly a changed practice in this respect would have the incidental advantage of reminding us in a most direct way that we too are mortal. And lastly, one task of medicine is to discover and to set forth the truth, and reticence of the kind in question would seem to be at variance with it.—I am, etc.,

Little Missenden,
Amersham, Bucks.

S. BRADSHAW.

Hospital Management

SIR,—In your leading article (28 October, p. 187) you draw attention to the report on *The Shape of Hospital Management in 1980* by the King Edward's Hospital Fund.¹ The report of the joint working party set up by the Joint Consultants Committee and the Ministry of Health on the "Organization of Medical Work in Hospital"² has also just been published (4 November, p. 252). These two documents form an interesting comparison and deserve careful study by members of the medical profession who work in hospitals.

Considerable attention has rightly been given to the question of remuneration and to hospital buildings, but the administration of hospitals has tended to be considered of less importance. This, I think, is a mistake. Given a reasonable standard of remuneration and freedom from financial worry most doctors can put up with considerable difficulties as

regards their buildings, provided that the administration of the hospital satisfies them. In my view one of the causes of frustration and the so-called "brain drain" is the administration of hospitals. Members of the medical staff have difficulty in getting their views made plain and in getting their needs carried out efficiently, quickly, and economically. Although the consultant medical staff are not trained administrators they do have to make many decisions quickly and under difficult circumstances. It therefore causes them irritation when they see what appears to be quite a minor decision being shelved or wrongly made. Committee structure and multiplicity is often wrongly blamed for this when the trouble is the shortage of trained administrators of adequate calibre. Decisions are put off and shelter taken behind committee procedure.³ I would like at this point