have been the ideal solution to the problems of semantics which some of us have tried to resolve recently. Unfortunately, the meaning implied by this term as used by Dr. Cyriax is far too narrow to be generally acceptable, and it has seemed best to widen the concept of "rheumatology" to encompass the whole spectrum of that branch of medicine concerned with connective tissue diseases and with medical disorders of the locomotor system, including every aspect of their aetiology, diagnosis, management, and rehabilitation. At the same time the outdated and misunderstood name "physical medicine" is being honourably buried, as indicated in your recent leading article (28 October, p. 188).—I am, etc.,

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Dangers of Diazoxide

SIR,—May we comment on the plea made by Dr. M. S. Knapp and others (28 October, p. 229) for the controlled studies of the use of diazoxide in the treatment of hypertension.

We stated clearly in our relevant publications^{1,2} that our patients were selected for resistance to conventional hypotensive therapy. The question of a controlled trial does not arise under these conditions. We think it unjustifiable to add to the present knowledge of the natural history of uncontrolled malignant hypertension associated with progressive renal failure by running control groups under these circumstances.—We are, etc.,

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¹ Pohl, J. E. F., and Thurston, H., *British Medical Journal*, 1971, **4**, 142.

² Pohl, J. E. F., Thurston, H., Davis, D., and Morgan, M. Y., *British Medical Journal*, 1972, **2**, 568.

Immunological Responses in Pregnancy

SIR,—Dr. Ronald Finn and others (15 July, p. 150) suggest that the reduced T-cell activity demonstrable in pregnancy may be due to a reduction in the number of T lymphocytes. B lymphocytes can be detected by the abundant surface immunoglobulin that they carry. We therefore tried to find out whether B lymphocytes make up a greater proportion of the total lymphocyte count in pregnant women—as they should do if there is a deficiency of T lymphocytes—and also whether the total lymphocyte count is reduced. Thirty-four pregnant women, all at least in the sixth month, were studied. On each occasion that blood was collected from pregnant women it was taken at the same time of day from an equal number of healthy non-pregnant women of similar age. Of the 34 control women more than three-quarters were known not to be taking oral contraceptives.

Total leucocyte and differential counts were carefully done by conventional methods, all by the same worker with exactly the same technique. Lymphocytes were prepared by the method of Boyum.¹ The proportion of lymphocytes bearing surface immunoglobulin (B cells) was determined by the method of

	Pregnant	Control	Difference of Means ÷ S.E.	Remarks
Leucocytes/mm ³	4,360-17,880 Mean 10,600 S.D. 3,122	3,520-14,000 Mean 6,169 S.D. 2,055	6.9	Highly significant
Polymorphs/mm ³	2,485-15,630 Mean 8,220 S.D. 2,926	1,370-12,040 Mean 3,821 S.D. 1,861	7.4	Highly significant
Lymphocytes/mm ³	752-4,920 Mean 2,439 S.D. 892	1,140-3,920 Mean 2,351 S.D. 606	0.5	Not significant
Percentage fluorescent (B) lymphocytes	2-19% Mean 8.5% S.D. 4.5	1.5-23% Mean 8.0% S.D. 5.0		
Fluorescent (B) lymphocytes/mm ³	39-550 Mean 214 S.D. 143	28-900 Mean 206 S.D. 158	0.2	Not significant

Papamichail *et al.*² using the labelled Wellcome antiglobulin serum MF 01. At least 200 lymphocytes from each subject were individually examined, each one being positively identified by weak dark-ground tungsten illumination before switching to ultraviolet to look for fluorescence. Illumination was by transmitted light. The same worker did all the fluorescence tests. The Table shows the results, which suggest that there is no appreciable reduction in the number of T cells or in the total lymphocyte count in pregnancy. There is, as is already known,³ an increase in the polymorph count, and consequently in total leucocytes, in pregnant women.

The relatively insensitive method of fluorescence with transmitted ultraviolet light may not, of course, detect all the B cells in a preparation. Methods using radioisotopes⁴ give higher proportions of B cells. If there were in fact relatively more B cells in pregnancy but the mean amount of immunoglobulin on them was less results like ours might still be obtained, but since the total lymphocyte count is very similar in both groups this seems unlikely.

One of us (P.B.) was supported by a grant from the South African Medical Research Council—We are, etc.,

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¹ Böyum, A., *Scandinavian Journal of Clinical and Laboratory Investigation*, 1968, **21**, Supplement 97, p. 77.

² Papamichail, M., Brown, J. C., and Holborow, E. J., *Lancet*, 1971, **2**, 850.

³ Wintrobe, M. M., *Clinical Hematology*, 3rd edn., p. 202. Philadelphia, Lea & Febiger, 1951.

⁴ Wilson, J. D., and Nossal, G. J. V., *Lancet*, 1971, **2**, 788.

Community Care in Perspective

SIR,—Evidence of an increasing population of homeless single people, particularly in London, is increasing.¹⁻³ The number of homeless single people has risen in the last seven years from 30,000 to 50,000. This includes those in common lodging houses, hostels, reception centres, and those sleeping rough. Of the latter, 10,000 is a conservative estimate for London alone. This population is a floating one circulating back and forth among our hospitals, hostels, and prisons. The number of patients in psychiatric hospitals has dropped from 131,000 to 109,000 between 1964 and 1971—a drop of 22,000 which closely approximates the rise in the number of homeless single people in the community over the same period.

Some 185,000 people are discharged from psychiatric hospitals and units each year, and the number with inadequate personalities is rising steadily as the longstay mental hospitals are being phased out. Sixty per cent become homeless after their first hospital admission. Owing to the lack of facilities for resettlement and rehabilitation these handicapped people make up some 50-75% of the residents of common lodging houses, Salvation Army hostels, and the like as well as 30-50% of the prison population in England and Wales. It is to be regretted that no one central government department is responsible for this state of affairs. Local authorities are empowered to provide residential accommodation for the homeless and to give financial aid to lodging houses, but these powers have not been implemented in the absence of a legal obligation. Research in this field is virtually left to voluntary agencies with their limited resources. Prison medical, including psychiatric, treatment is financed by the Home Office and is thus divorced from the National Health Service.

The problem takes on gigantic proportions in London, where plans to redevelop certain areas involve demolition of no less than 40% of the registered common lodging houses. In the whole of London the number of beds has fallen from 6,000 to 4,000 since 1961. All this reduces community care to mere disposal overwhelmed by the rapid discharge rate, the loosening of family ties, and the increasing pressures the outside world imposes on inadequate people handicapped by personality disorders.

Further surveys are needed to define the size of the problem, but some recommendations can be made in the light of available data. Responsibility and legal obligation must be clearly delegated to the local authorities, and services (medical, social, resettlement, and rehabilitation) must be extended within the community with their full complement of staffing. Grants must be extended to voluntary bodies for research as well as to psychiatric aftercare hostels to upgrade the services they provide. Hostels that are closing down need to be replaced by adequate accommodation to meet the increasing demand. All community facilities must be closely integrated in order to provide proper care for the destitute. Until such time as these recommendations can be implemented hospital psychiatrists ought to review their policy of early discharge of certain types of patients who need more support in the community.—We are, etc.,

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