Geriatric Accommodation in Acute Illness

SIR,—I feel I cannot let Dr. J. A. Fraiss's letter (18 November, p. 424) go without comment.

The difficulty in obtaining geriatric admissions is basically due to a shortage of beds for the elderly, especially in certain sectors, largely for those needing long-term psychiatric and welfare home care. The reason for the difficulty in obtaining admission of the elderly to ordinary medical wards and to geriatric wards is that it is so difficult to get them out when they are found to fall into one of these two categories.

The introduction of short-stay reception centres would only produce a geriatric "ghetto" which would probably rapidly "silt up" with a lot of inadequately supervised elderly people with varying types of social, psychiatric, and other problems.—I am, etc.,

D. E. SHARLAND

Whittington Hospital,
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Attitudes to Renal Transplantation

SIR,—In this area cadaveric organs are often used for renal transplantation. Relatives of some of the donors have told me of their gratitude that some benefit had been recovered from what would otherwise have been for them a total disaster. This attitude should not be forgotten when considering the reactions of the profession and the public to the use of cadaveric organs in transplantation.—I am, etc.,

G. A. GRESHAM

Addenbrooke's Hospital,
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Children in Hospital in Wales

SIR,—I should be grateful if you would give me the opportunity of correcting your inaccurate and misleading comments under the heading of "Medical News" (18 November, p. 439) on the recently published report on "Children in Hospital in Wales."¹

The report, as is stated in the foreword, is probably the first of its kind in Britain and sets out over 150 detailed recommendations for the future of hospital services for children in Wales in the context of the child health service as a whole. Its central theme is "that any policy for children in hospital must rest upon a recognition of the special needs of children as children," and all other considerations in the report flow from this basic concept. Your comment that the central theme of the report is that children should be separated from adult patients while in hospital and that children admitted by E.N.T. and eye surgeons should be nursed in a children's unit is unfortunate, since it is both misleading and inaccurate.

The recommendation that children should not be nursed in adult wards and wherever possible should be gathered into a children's unit available to any member of the medical staff first appeared in the Platt report,² and its reiteration by the working party highlights only one facet of its report.

In the case of E.N.T. children the working party recognized that many E.N.T. surgeons would wish to continue to nurse these children in E.N.T. wards, but expressed the hope that in the future more of them would find it possible to treat their children in a children's unit, particularly if an E.N.T.

clinical treatment area was provided within the unit.

In considering children admitted by ophthalmic surgeons the working party accepted the need for children who had undergone intraocular surgery or had been admitted with other serious conditions or injuries to be nursed in an ophthalmic unit. Since the great majority of children in the specialty were admitted for squint operations, the working party saw an advantage in these children being nursed in the children's unit if it were convenient for them to be taken to the ophthalmic department for the necessary treatment and assessment.

Your final comment that "the working party acknowledges that its proposals [that is to nurse children in a children's unit where their general welfare would be the concern of a paediatrician] would lead to divided clinical responsibilities" is entirely opposed to the recommendation of the working party, which, in defining the manner in which the consultant paediatrician would exercise a general concern and responsibility for the welfare of children in all hospital departments, emphasized that the (non-paediatric) specialist would retain full clinical responsibility for child patients admitted under his care. The role of the paediatrician was seen as an advisory one, with concern for the adequate provision of mothers-in units and other facilities for parents, for play and teaching facilities, and for the review of abandoned or near-abandoned children. He would also generally act as spokesman for all children in hospital on advisory committees and at administrative levels.—I am, etc.,

EDWARD LYONS

Member,

Working Party on Children in Hospital in Wales

Abergele,
Denbighshire

¹ Working Party on Children in Hospital in Wales. *Children in Hospital in Wales*. Final report of Working Party. Cardiff, Welsh Hospital Board, 1972.

² Ministry of Health. Central Health Services Council. *The Welfare of Children in Hospital*. Report of the Committee. London, H.M.S.O., 1959.

Climate and Chest Disorders

SIR,—The observations of Dr. K. J. Cullen (14 October, p. 65) on climate and chest illness come as no surprise to a physician currently practising in Saskatchewan. This region of the world enjoys a continental climate with drastic variations in temperature between winter and summer, the thermometer falling to 40°F below zero (-40°C) occasionally in winter and going up to 100°F (37.8°C) in summer. It is a prairie region and the predominant vegetation is grass, willow, aspen, and other small deciduous trees. Having practised for many years in Essex, where there was a moderate amount of allergic chest illness, the most significant change I noticed on coming to this part of the world was the incredible frequency of atopic eczemas and asthma and eczema syndromes, which are daily occurrences in one's office. The experience of people moving to Australia and New Zealand therefore is no great surprise. I feel certain that there is a very significant incidence of allergic or irritative disease due to dry climates with a high incidence of dust and allergic pollens.

We recommend a change to wetter climates rather than warmer climates to help those who suffer from chronic allergic asthma in Saskatchewan, where the other factor that

has significant effect on triggering chest illness is the extremely low humidity, particularly in winter.—I am, etc.,

J. D. BURY

Saskatoon, Saskatchewan,
Canada

Apple Allergy

SIR,—The ancient adage "an apple a day keeps the doctor away" is due for revision. The purpose of this note is to report two cases of eczema in elderly people who had faithfully followed that adage all their lives, developed eczema, and were dramatically cured when the apple a day was stopped.

About 15 years ago Dr. J. W. Pickup, who was Medical Officer of Health for Worcestershire, described to me how his father, at the age of about 65, had been cured of severe and long-standing eczema when he was admitted to Manchester Eye Hospital for cataract operation. His love for apples was great and he took a large supply with him, but his pride and independence were even greater. In those days, after an operation for cataract, it was a strict rule that the patient should move as little as possible. When he wasn't allowed to reach for his apples he refused to ask the nurse to hand one to him. During the rest of the time in bed he discovered a remarkable improvement in his eczematous condition, which had caused him much inconvenience over the past 10 years. Thereafter, by avoiding raw or cooked apples, he remained free of eczema until his death at 80 years of age.

The second patient is my own wife. About two years ago she developed irritation and slight hyperaemia of the back of her neck. Local applications did no good. A rash developed, spread to her trunk, and became frankly eczematous. When the usual treatment only made it worse, we began to search for an allergen. In course of time cosmetics and various items of diet were ruled out. Then the account of the experience of Dr. Pickup's father came to mind. Her apple a day was stopped and the eczema cleared in a matter of days. It has recurred only once, when roast pork and apple sauce was served at a hotel meal. Apple in any form has been carefully avoided ever since.

I admit that two cases in an uncontrolled series do not amount to statistical significance, but Dr. Pickup and I hope the sheer drama of the two cases will impress other observers and lead to the discovery of further cases and the prevention of severe physical suffering.—I am, etc.,

I. LLOYD JOHNSTONE

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Family Planning Payments

SIR,—A few interesting facts have come to our notice which merit further publicity. The Family Planning Association (F.P.A.) has recently increased its fee to members to £3.80 per year. In addition to this further charges may be made for fitting appliances—for example, £5 for the fitting of an intrauterine device. It is apparently the practice of some local authorities, including Lancashire County Council, to pay a fee to the F.P.A. on the patient's behalf in the following circumstances: (1) within 12 months of the birth of a child; (2) where the husband is unemployed; (3) where family incomes supplement is being claimed; and (4) at the