deficiency is present in about one-third of all patients who require admission to hospital—that is, these patients have reduced serum folate levels and raised urinary folate excretion on oral histidine loading. However, very few of them have reduced red-cell folate levels, and the reduced red-cell folate level in one-third of the rheumatoid group suggests an important degree of folate deficiency. Nevertheless, this folate deficiency leads to a megaloblastic anaemia in only about three out of every 1,000 patients.

Though Omer and Mowat found early marrow changes in 8 out of 37 patients, an earlier study from the same unit failed to find any evidence of megaloblastic change in the marrows of 64 rheumatoid patients.

M. E. Carter and colleagues in London failed to find a significant difference between the serum folate levels of some 92 rheumatoid patients and matched controls. There are suggestions that there are differences in the folate status of the population in different parts of the country, and this may well be related to variation in dietary intake of folate. This suggestion is based on the variation noted in the frequency of megaloblastic anaemia in pregnancy and in the frequency with which evidence of folate deficiency is encountered in the older population. Folate deficiency associated with rheumatoid arthritis is also likely to be influenced to a large extent by the dietary folate intake, which may vary significantly in different centres.

“Totting”

Most local authorities do not allow their dustmen to separate and salvage articles from domestic refuse. Few of these salvaged rags, metals, and other objects have any commercial value, and this process of “totting” is time-consuming. Far more important, however, are the health hazards of salvaging articles. Rags are collected and bulked, the clean with the filthy and often infected and verminous objects. Though the Public Health Acts make it an offence to trade in filthy or verminous articles, control is difficult and the definition of filthy or verminous is often a matter of opinion. Many a bargain hunter has to his cost introduced bed bugs, fleas, and woodworm into his home by purchasing a piece of second-hand furniture—a detailed and critical appraisal for cleanliness is as important as that for intrinsic merit. The chances of the dustman salvage some valuable article are so rare that it cannot be used to justify the continuance of this filthy practice in modern society. There are no major health hazards to the dustmen themselves, as local authorities provide good bathing facilities and protective clothing.

Today we are living in an era of expendable domestic appliances, and householders often find it difficult to dispose of old wireless or television sets, refrigerators, cooking stoves, and the like which have no real value. Though most local authorities will collect such articles, they usually make a small charge for this service. Perhaps the time has now come when this should be a free municipal service, available on request but separate from regular refuse collection.

Another refuse disposal problem which is becoming increasingly important is the hygienic disposal of “medical” refuse. As the open fire becomes less common there is obviously a need to find a new method for the safe disposal of soiled dressings, bulky incontinence pads, and other infected disposable articles which were formerly burnt. The orthodox advice is that these articles should be put in a stout plastic bag, which should be sealed securely and put in the dustbin; but, except for small quantities, this is scarcely a satisfactory method. Recently quantities of disposable plastic syringes put into dustbins and dumped on refuse tips have been found in the possession of schoolchildren. Some of these syringes were bloodstained, and their dangers to children playing with them are all too apparent. All plastic syringes should have the end broken off after use, and if many are used they should be destroyed by incineration. Most local authorities will co-operate in this, and will prefer to arrange to collect and dispose of such dangerous medical articles rather than to have them included in ordinary domestic refuse—with the additional hazard to the natural curiosity of children and the acquisitiveness of amateur “totters.” Any hospital, clinic, or indeed any doctor with this problem should get in touch with the local medical officer of health.

Cyclophosphamide for Nephrotic Syndrome in Children

Probably about 30% of children with the nephrotic syndrome that initially responds to corticosteroid therapy will relapse frequently enough to pose serious problems of management. With conventional treatment many children who still have active nephrosis five years after it began will probably die during the following five years. Moreover, for some patients prolonged remission is bought only at the price of considerable steroid toxicity—with hypertension, osteoporosis, and failure of growth. To these risks must be added the hazard of collapse or even death occurring from adrenal cortical suppression during withdrawal of treatment.

Thus the ultimate recovery rate from childhood nephrosis is unlikely to be much more than 70%. This is the conclusion reached by M. W. Moncrieff and his colleagues in an article at p. 666 of this week’s B.M.J., in which they describe an alternative treatment with cyclophosphamide for patients whose response to steroid therapy was considered unsatisfactory. The patients on whom they report are a homogeneous group, mostly showing highly selective proteinuria and so-called “minimal” histological changes in renal biopsy specimens. All but three of the 46 children were initially steroid-responsive but exhibited steroid dependence—that is, they required continuous maintenance therapy to control their proteinuria. Subsequently seven of these children became steroid resistant. The average duration of illness was five years, and many patients showed considerable steroid toxicity.

After treatment with cyclophosphamide steroid therapy was completely withdrawn in 83% of these children. Five needed a second course of treatment and only one of