Making Hospital Geriatrics Work

Sir,—It is interesting to read that one of the consequences of Drs. H. M. Hodkinson and P. M. Jeffery's approach to "Making Hospital Geriatrics Work" (2 December, p. 536) is the maintenance of the morale and professional satisfaction of "ancillary staff." May I, as a physiotherapist working in this particular area, put a different point of view? Paramedical staff involved in the geriatric service frequently experience feelings of impotence and frustration. This is one of the major causes for poor recruitment and field of medicine and I do not believe that the situation can be remedied by increasing patient turnover.

Rehabilitation of the elderly patient is a lengthy and detailed procedure. Generally it is not so much the acute medical problems that concern the therapist but, to quote Drs. Hodkinson and Jeffery's, "the unavoidable [case load] of patients with greater disability." If such patients are to return once again as viable members of their community and maintain optimum independence there, then much time needs to be given by those involved to the rehabilitation process. In these situations, the therapist will need medical support over a long period rather than medical "pressure" to carry out such a programme effectively. Drs. Hodkinson and Jeffery's may be able to concede "less than complete therapeutic results," but in rehabilitation of older patients there should be no such compromise. The process cannot be hurried. The rate of turnover may be slowed down in consequence, but the alternative for the patient is breakdown at home and eventual hospital readmission, and for the therapist the knowledge that one has been prevented from giving one's professional best.

After three months in hospital, in Drs. Hodkinson and Jeffery's view, discharge becomes very much harder because of "institutionalization" and "the withering of the patient's ties with the community." One might venture to suggest that perhaps it is those with the greatest disability who tend to have the longest stay in hospital. If a patient has adequate incentive and his reablement programme is both realistic and appropriate, it has not been my experience that "institutionalization" occurs, however prolonged his hospital stay may be. Moreover—and this is essential—if relatives, friends and any supporting social service personnel are involved from the beginning, need there be this inevitable "withering" of community ties? Rehabilitation after all, is an exercise in vivo and not in vitro.—I am, etc.,

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Sickle-cell Anaemia

Sir,—Sickle-cell anaemia was unknown to medicine until 1905, when James B. Herrick of Chicago, an experienced haematologist in a large negro population, seems to have got the shock of his life on seeing the sickling phenomenon in the blood film of a negro with severe anaemia.1 I have been informed by a haematologist that of course sickle-cell anaemia was well known before 1905. However, at the beginning of the century there were numerous books on haematology with coloured illustrations of the bloods of all known anaemics, and at least in British, American, French, and German books there is no mention of sickle-cell anaemia or thalassaemia, with its almost equally arresting blood picture. These two words seem to have been unknown to the medical profession in those countries. Can anyone refer me to any evidence in black and white in any language that these two diseases were known to exist before 1905?—I am, etc.,

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Anthrax

Sir,—Dr. Robert Lamb's article on anthrax (2 January, p. 157) was most valuable for doctors working in the U.K. but did not cover the full spectrum of the disease as seen elsewhere.

During my service a good many years ago as a pathologist in the Gold Coast (now Ghana) it was not very uncommon to encounter anthrax in the necropsy room, although a malignant pustule was never seen. The story was usually that the body had been found under a tree, supplemented occasionally by evidence that the deceased was one of many people who had eaten the meat of a cow which had been killed when moribund. The ratio of reported fatalities to incidents was usually unity, and it seemed likely that the common mode of infection was by ingestion and that the infectivity of the organism by this route was very low.

Soon after my arrival at the Accra laboratory I was taught, by Dr. George Robinson, that it was a good plan to remove the skull-cap before opening the trunk when doing a necropsy. A bulging purple dura with haemorrhagic meningitis was suggestive of anthrax, which could be confirmed by puncturing the membranes and withdrawing a drop of cerebrospinal fluid for examination; in this way further opening of an infected body could be avoided. My curiosity once more led me to do a full necropsy on one of these patients, in whom large masses of mesenteric lymph nodes, which looked like ripe Victoria plums, convinced me that the gut had indeed been the portal of entry of the infection. On one occasion only was I able to diag-

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1 Herrick, J. B., Archives of Internal Medicine, 1910, 4, 517.