high incidence of amenorrhoea. In most cases the menses spontaneously recur within a few months unless some other factor such as malnutrition is also operating.¹ Fear of being pregnant commonly delays the onset of menstruation, but less often a desperate desire for pregnancy or a phantasy of love relationship may lead to a pseudocyesis or phantom pregnancy. The woman is convinced that she has conceived and develops many signs and symptoms of maternity. Amenorrhoea is common, but not invariable. Abdominal swelling, usually accompanied by lumbar lordosis, the experience of fetal movements, breast soreness, swelling and secretion, and morning sickness complete the picture. But on examination no fetal parts can be felt, the fetal heart not heard, and rectal examination discloses a uterus of normal size. Though there is often evidence of a hysterical personality and low intelligence, this is not always so.

In anorexia nervosa amenorrhoea is a constant feature and may precede the abnormal attitudes to eating and body weight. The uniformity of some aspects of the syndrome is striking and lends support to the view that it is a specific endocrine disorder. G. F. M. Russell⁵ has added biochemical evidence in support of this. However, in terms of clinical management anorexia nervosa is best regarded as a chronic, recurrent, and often severe neurotic disorder in which physical and psychological methods of treatment need to be combined.

The relationship between the neuroendocrine system and emotion is complex, and despite advances in understanding further basic research needs to be done. Meanwhile much can be done to help women live with their cyclical changes.

¹ Tonks, C. M., British Journal of Hospital Medicine, 1968, 1, 383.

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**Proposal for an Academy**

In our columns this week a group of distinguished signatories to a letter (page 737) examine the role of the royal colleges and allied bodies in relation to Britain's entry into the European Economic Community and propose the creation of a British academy of medicine. Since about 1950 the colleges have increasingly taken on the function of advancing education in the branches of medicine represented in them. As the letter puts it, a college represents the interests of its discipline and not that of individual practitioners. This is a notable and recent shift of emphasis. What is now proposed therefore is that the distinctive contributions which each college makes in its sphere should be brought together in an academy, in which all the existing colleges and faculties in Great Britain and Ireland would be represented.

As well as being a valuable source of information and advice to the E.E.C. countries on the British way of medical life such a body might help the constituent colleges themselves by providing a forum for the discussion of common problems. The generality of medicine, say the authors of this letter, cries out for a unifying, co-ordinating force, and this general aspiration undoubtedly reflects the particularities of practice and research. Clinical work is increasingly a matter for a team rather than an individual, and research is thought to be hardly worthy of the name unless it is multidisciplinary or at least interdisciplinary. So that we see the paradox of increasing collaboration at ground level, yet increasing dispersal in the sky. The B.M.A. itself is familiar enough with this situation. Could an academy succeed among such contentious people as doctors show themselves to be in public debate?

The sponsors of the new venture are not wedded to the title academy, and it would probably prevent confusion if they adopted another. An academy is usually thought of as an educational institution or a society devoted to the pursuit of learning. But what Sir Thomas Holmes Selbers and his colleagues seem to have in mind is a co-ordinating committee. Nothing could be worse than the creation of a pseudo-academy embellished with the mummery of gold chains, maces, gavels of exotic wood, and hypnotic after-dinner speeches. If it is judged by its declared object of providing an opportunity for the colleges and faculties to profit from each other's experience and to present a clear and united opinion on matters of major policy, then the proposed new body will find itself among several others with similarly unitary but in various ways differently directed aims. Among them are the B.M.A., the (presumably reconstituted) G.M.C., and (with only slight broadening of its representation) the Joint Consultants Committee. In addition, as the letter itself mentions, medical education finds expert expression in the Conference of Postgraduate Deans. Yet when all that is said, the present proposal does offer something different. It therefore deserves examination and debate. But if the sponsors really believe it "would require no substantial funds," the reader must be forgiven for wondering how seriously they have thought about the academy's role in today's expensive world. The G.M.C. is one comparable body that could offer advice on that.

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**Serum Cholesterol in Children**

Prospective studies in adults have now shown that a high serum cholesterol concentration is one of the most readily identifiable risk factors in the development of coronary heart disease.¹ It is not yet known with certainty whether lowering the serum cholesterol will prevent or delay the onset of this disease, but the results of a recent dietary trial in Finland² are promising. Because there is considerable evidence that atherosclerosis may originate in childhood³ it would seem desirable that risk factors should be identified as early in life as possible, so that preventive measures can be introduced at a stage when they are most likely to influence the underlying pathological process.

At present it is not clear whether serum lipid levels in adults can be predicted from estimations made during infancy and childhood. Familial hyperbetalipoproteinemia is probably the most common of the genetically determined hyperlipidaemias and can usually be diagnosed in childhood, at least after the first year of life.⁴ But exact information on
its incidence or prevalence is still lacking, and it is unlikely to affect more than a small proportion of persons liable to develop a high serum cholesterol in adult life. Population studies are therefore required to determine the range of serum cholesterol concentration in childhood and its association with levels in adult life, and with the subsequent development of coronary artery disease. Results from prospective studies will not be available for many years, but meanwhile much can already be learnt from careful short-term observations.

Such a study has recently been reported by R. C. Godfrey and his colleagues5 from Busselton in Western Australia. In 1967, as part of a population study, the serum cholesterol concentration of 1,292 school children was estimated. A gradual rise in the medium value throughout school life was found in the boys and girls, with a preadolescent rise comparable to that reported in other studies.6 In 1969 the cholesterol concentrations of the children whose levels had been in the highest, middle, and lowest 5% in 1967 were determined again. A highly significant correlation was found between the two sets of values, thus indicating that a single cholesterol estimation had predictive value, at least over a two-year period.

With regard to the actual concentrations, the median value at six years of age was 160mg/100 ml and at 17 years had risen to 183/100 ml. But the authors emphasize that at each age the range was wide. In 173 children the concentration was greater than 200mg/100 ml; 32 of these had levels above 238mg/100ml, and 7 had levels above 270mg/100 ml. These “cut-off” points were chosen because they were the limiting values for the upper two quartiles in the prospective study of London busmen by J. N. Morris and colleagues,7 who had shown an increased number of attacks of coronary heart disease in these two groups. Godfrey and his colleagues, on the basis of the findings in the Busselton study, speculate that a level of 200mg/100 ml in a 6-year-old boy may represent a risk equivalent to that predicted by a value of 238mg/100 ml in an adult, and calculate that 79 children in their group (6%) would carry such an increased risk.

In 929 of the Busselton children serum cholesterol concentrations were compared with those of their parents. A highly significant correlation was found throughout the whole range of concentrations. It was not possible to determine the extent to which dietary or genetic factors or both together were responsible for the correlation of cholesterol levels in these families. In the children with levels greater than 250mg/100 ml genetic factors were considered more important. This association of serum cholesterol concentration in the parents and the children has also been found by S. Deutscher and his colleagues8 in Tecumseh, Michigan, and by A. Drash9 and his group in Pittsburgh. Furthermore, the Michigan workers showed a relationship between increased risk factors in children and increased mortality in their parents from coronary heart disease; and Drash found the incidence of vascular disease to be much higher in the parents in his “high-cholesterol” families (200-230mg/100 ml) than in the parents of a group of insulin-independent diabetic children.

Further epidemiological studies are required before limits can be set or advice given about preventive measures on a population basis. Cholesterol estimations should certainly be undertaken in children when there is a clear history of early coronary artery disease or familial hyperlipoproteinaemia, but the time has not yet come for routine estimation of serum cholesterol in children.

Malaria Risk to Travellers

The risk of contracting exotic diseases in tropical and subtropical countries is greater than many travellers realize.1-7 A stop of only a few hours in a malarial place has more than once resulted in death from the malignant tertian disease, which has a high fatality rate. Yet writers of holiday articles in the press and agencies that organize tours to the warm countries habitually fail to mention in their glowing descriptions that tropical diseases, and especially malaria, present the visitor with a real risk.

A recent report of the World Health Organization6 indicates that the total number of notified cases of malaria in 25 European countries rose from 2,966 in 1969 to 3,412 in 1970 and to 4,987 in 1971. Nearly 90% of these cases were reported from Portugal. Clearly this is related to military operations in Portuguese territories in Africa. But other countries showing a substantial increase of cases of malaria are the United Kingdom, the Federal Republic of Germany, Greece, Italy, and the Netherlands. The number of cases reported in 1971 from England and Wales was 269, and the addition of cases in Scotland brings the total to 294, the highest annual figure recorded over the past 15 years.

Some 92% of all cases of malaria seen in Europe during the years 1969-71 originated in Africa, and though only one-quarter of these cases were due to the malignant tertian type (Plasmodium falciparum) they had a fatality rate close to 2%. In England and Wales in 1971 no fewer than 138 of the 269 cases of malaria (52%) were due to P. falciparum, and there were eight deaths. Death is usually due to missed diagnosis or to delay in the treatment of the P. falciparum infection, which in a nonimmune person may develop with dramatic suddenness and severity. The pattern of these sad episodes is similar in most of the European countries.4-7

Travellers exposed to the disease in tropical or subtropical countries are often careless about the preventive measures, including chemoprophylaxis.3 On their return from overseas febrile symptoms combined with other complaints are often diagnosed as "influenza" or "gastroenteritis" and they are given palliative treatment, if any. Within a day or two the patient may suddenly show signs of the central nervous system being affected, or hyperpyrexia, or renal failure. An emergency admission to hospital may lead to the correct diagnosis, but even prompt treatment may fail if the P. falciparum infection is severe.4

To improve the general knowledge of the malaria risk in