to meet the demands of an increasing number of persons in the population aged 75 years or more.

There are data that indicate the demands are likely to be extensive. The current rate of age-specific mortality is 451 per 100 population for males aged 75 years or more compared with 256 for males of all ages; the figures for females are 446 per 100 compared with 343. The older age group accounts for 20-9% of the average number of hospital beds used daily by males and 40-7% by females (excluding maternity beds and psychiatric hospitals). Community surveys (for example, that by Harris) have found that between 30 and 40% of persons aged 75 years or over are impaired physically. It is essential that co-ordinated plans are made now between the N.H.S., personal social services, and housing authorities to meet the present and foreseeable needs of the elderly.

Expenditure on housing is forecast to increase substantially in the next three years. If the problems of the N.H.S. are not to be met, the money it provides, and the increase in community care not frustrated local authorities must increase the number of dwellings provided by them that are suitable for disabled and elderly people. People who have shown that a large number of these elderly people are prepared to move house, thus releasing accommodation for others at the same time as easing some of their own physical and self-care difficulties. Your leading article, quite rightly, sounds a warning about the cut in the planned rate of increase in expenditure on the personal social services. The increase in expenditure on housing is to be welcomed, but failure here will have serious repercussions on the health and personal social services.-I am, etc.,

MICHAEL WARREN
Health Services Research Unit, University of Kent, Canterbury


Financing the Health Service

Sir,—The suddencess of major building work at Leeds, St. Mary’s, The London Hospital and no doubt in other large hospitals is indicative of a serious defect in the method by which the Department of Health and Social Security deals with the money it receives from the Treasury. It is inescapable that at departmental level, but not at regional level, there is insufficient distinction between money for capital works and that for recurrent expenditure. The two should never be confused.

An increase in recurrent expenditure caused by inflation and a sudden reduction in Government spending has been dealt with in the D.H.S.S. by a savage cut back in agricultural expenditure. This is the real cause of “Leeds Infirmary blues.” The solution is clear. The whole cost of building projects should be allocated to the appropriate authority at the time of consent to the building. Indeed it would be salutary for the authority to be given the money outright, thus providing a real sanction against last-minute expensive alteration of plans.

The Department of Trade and Industry manages its affairs much more realistically than does the D.H.S.S. A grant is made to an ailing industry and that is that. There is no question of telling the workers’ co-operative at Meriden that they can have £25,000 but after one year and the expenditure of only £1m. telling them that they can have nothing further.

Of course in the first four years of the change of policy, assuming that four years is the average time for laying foundations to completion of building, some projects would have to be postponed, but after that the progress of capital works would be sustained and the Treasury would have the realies of inflation in the N.H.S. as it does in other departments of state. It would be unable to solve its difficulties in recurrent expenditure by raiding sums allocated and agreed for capital works, as at Leeds, because these would have been paid for already.—I am, etc.,

H. B. MAY
Essex, Surrey

Unusual Diaphoretic Hazard

Sir,—We report an unusual hazard which occurred in three patients receiving diaphoretic burns during general anaesthesia. The sites of the burns in all cases were the four contact points of E.C.G. electrodes attached to Videograph E.C.G. oscilloscopes used as monitoring devices. The accidents occurred in different operating theatres using different diaphoretic machines and different oscilloscopes. In each case the indifferent electrode of the diaphoretic was a large flexible plate attached firmly to the mid thigh. The E.C.G. electrode contacts were made by metal discs 1 cm in diameter mounted on adhesive plaster (as supplied by Driscoll and Co.) and skin contact was by small adhesive blocks of E.C.G. paste. In the three cases there was prolonged use of the diaphoretic. Seemingly the burns occurred as a result of small zones of high density current passing through the E.C.G. contacts, despite apparently good surface contact of the skin with the indifferent electrode of the diaphoretic, and the excessive heat was the consequence of prolonged and intensive use of the diaphoretic. The good skin surface contact of the diaphoretic plate and its electrical continuity was confirmed by two experienced physicists. The diaphoretic machine was a modern one with an alarm system to detect failure of the continuity of the connection to the indifferent electrode plate. This suggests that the margin of safety of the flexible diaphoretic plate may not, despite visually good skin apposition, adequately guard the patient when high diaphoretic currents are used in conjunction with small E.C.G. contact discs—that is, the leakage current through these contacts may still be sufficient to cause harm. The Driscoll E.C.G. contacts are very good and for routine use they provide consistently better electrical continuity between the patient and the E.C.G. cable leads than do the more traditional large metal plates with screw-in leads. They need less E.C.G. salt paste and result in less skin irritation than do the traditional plates. They are also conveniently quick to apply. Therefore, rather than abandon the use of these electrode discs, we recommend that each lead of E.C.G. cables used with monitoring devices during anaesthesia should have a 10 kΩ resistor placed in series with the leads close to the patient end of the cable, as is already done in leads supplied by some manufacturers. This might cause some minor degradation of the E.C.G. signal, but that is a small price to pay for safety.—We are, etc.,

P. J. TOMLIN
J. A. NIEWELL
Department of Anaesthetics, University of Birmingham

E.C.G. Abnormalities Associated with Raised Intracranial Pressure

Sir,—It was with interest that we read the study by Dr. S. J. Jachuck and others (1 February, p. 242) on the effects of rising intracranial pressure on the electrocardiogram. We have shown that, though E.C.G. abnormalities are common in patients with strokes, most of these patients do have significant cardiac disease on histological examination.1 With these facts in mind it is noteworthy that the only young subject (case 5) was found to have no E.C.G. abnormality other than a notched T wave, even when his C.S.F. pressure rose to 85 mm Hg, whereas cases 1 and 2, who were middle-aged men, developed S-T changes in conjunction with tachycardia.

We suggest therefore that though the authors have made a good case for the close correlation of U-wave changes with raised intracranial pressure, the S-T changes found may be more directly related to coronary artery disease.—We are, etc.,

GERALD TOMKIN
Department of Medicine, Dudley Road Hospital, Birmingham

R. P. K. COB
West Middlesex Hospital, Epsom, Middlesex

JOHN MARSHALL
National Institute of Nervous Diseases, London W.1


Lumbar Puncture

Sir,—In your leading article on this subject (4 January, p. 3) the statement that "examples of the need to include lumbar puncture in the management of neurological diseases" include the decision to give anti-coagulants to a patient with a stroke in evolution2 implies that if blood is not present anti-coagulants may be given. Post-mortem experience of strokes shows that the absence of blood in the spinal fluid is no guarantee that a haemorrhage has not occurred.3 Indeed, it has been pointed out that in cerebral haemorrhage the spinal fluid is bloody in only 80% of cases.1 Furthermore, it was pointed out by Hurwitz that in stroke in evolution "the differential diagnosis between infarction,
cerebral haemorrhage, and a tumour is very difficult." It seems then, that your statement
must be so hedged about with reservations that its value is called into question.—I am etc.,

Tel-Aviv, Israel

G. HARRIS


Genitourinary Medicine

Sir,—The executive committee of the Renal Association at their last meeting on 20
February noted with some concern the proposal that the specialty known as "venereology" or "sexually transmitted disease" be renamed "genitourinary medicine." The executive feel that the choice of this name is unfortunate as it may lead to confusion with renal medicine and especially urology. This is particularly important when letters are advertised and we note that already an advertisement for an appointment to this specialty has appeared under "urology." We obviously have no say in what the specialty is called and I write merely to draw your attention to this possible confusion.—I am etc.,

W. R. CATTELL
Secretary, The Renal Association
London E.C.1

Barr Bodies in Cervical Smears

Sir,—During routine cervical cytological ex-
aminations on patients attending a gyna-
ocological clinic in a general hospital 10
smears from patients whose symptoms in-
cluded infertility or repeated miscarriages
were also scored for the percentage of Barr
bodies present. Four patients whose Barr-
body count was only 1-4% were subse-
quently recalled for chromosome analysis.
Three of these patients showed 46XX/45XO
mosaicism and the fourth showed 46XX/
47XXX/45XO mosaicism.

It is suggested that examination of the
Barr bodies in routine cervical smears from
patients with relevant symptoms and sub-
sequent chromosome analysis, where this is
indicated, would be of value in the clinical
evaluation of these cases. This work will be
written up more fully at a later date.—We
are etc.,

SAMUEL H. JACKSON
JEAN M. MUSKETT
DAVID YOUNG

General Hospital,
Ashdon-under-Lyne, Lancs

Psychiatric Rehabilitation Unit in Danger

Sir,—In these days of financial stringency we
can sympathize with the efforts of adminis-
trators to economize, even though this may
put new schemes or even long-established
services in jeopardy. There is, however, a
danger in doing so they may be tempted to
select targets which, however valuable, cannot command sufficient public and pro-
fessional support for prolonged resistance.
The recommendations of the Regional Team
of Officers to the West Midlands Regional
Health Authority that it close St. Wulstan's
Hospital, Malvern, is a case in point and
hard to justify even on economic grounds.

Since 1961, St. Wulstan's has served as a
highly specialized rehabilitation unit for
psychiatric patients and has achieved notable
success in this difficult field. Originally deal-
ning with institutionalized cases from neigh-
bouthing hospitals, its staff have continually
pioneered new concepts in the treatment of
the chronically mentally ill, providing a
source of dedication and expertise at a
relatively small cost and under the strictest
financial scrutiny. The closure of St. Wulstan's
will mark the scattering of these experts and
the end of an era in which advanced techniques of industrial therapy were
nicely blended with social training and
personal advancement so that even seemingly hopeless cases were able to return to
the community.

Since our published aim in psychiatry and
community care is to get patients back to
normal life and out of the hospital environ-
ment as soon as desirable, it is indeed a
triste and dolorous affair to end a venture
ideally disposed to this purpose. We can
only hope that the West Midlands R.H.A.
will not follow a course so much to the
detriment of what after all is the largest
group of patients in their care and that
doctors, nurses, and others concerned in
rehabilitation will protest strongly against
it. Community physicians in particular
might well feel that the future of St. Wulstan's
Hospital is an issue that demands their
interest and support.—I am etc.,

GODFREY O'DONELL
Worcester

Community Health Councils and the
Mental Health Act

Sir,—As a member of the Bristol (Teaching)
Community Health Council I am deeply
concerned at the failure of both central and
council governments to fully appreciate the
importance of a fully defined role for a
Community Health Council in the Mental
Health Act of 1959. Little or nothing has been
done in many areas of England and Wales to
provide facilities for the mentally ill and mentally
handicapped, and after a period of 16 years
since the Act was legislated I consider it
more than timely for pressure to be brought
to bear on the Department of Health and
Social Security and local authorities to
remedy this state of affairs.

When the community health councils were
set up it was generally considered they
would be principally concerned with the
more trivial matters of hospital administra-
tion, and that the more important issues,
such as that mentioned above, would lie
outside their functions. I do not subscribe
to this view, however, and consider that the
C.H.C.s have a most important role to play in
ensuring that those responsible for main-
taining the N.H.S. provide facilities adequate
to meet the needs of the people. It is indeed
most disturbing to find that the D.H.S.S.
has deferred financial approval for no less
than 70 projects, amounting to approxi-
mately £2 million, and it may be that if all
the 207 C.H.C.s existing at present in
England and Wales were to approach simulta-
neously the Secretary of State for Health and Social Security this would have
sufficient impact to bring about some posi-
tive action.

Furthermore, I feel strongly that the
C.H.C.s should set up forthwith both area
and national organizations representing all
the C.H.C.s in England and Wales; and that
the D.H.S.S. should have no involvement
therewith (see your leading article, 15
February, p. 355)—I am etc.,

J. P. TURLEY
Bristol

1 National Association for Mental Health, Community
Care Provision for Mentally Ill and
Handicapped Men and Women, Mind Report

Hysterectomy Hazard

Sir,—The unexplained collapse of a patient
undergoing hysterectomy when nitrous oxide
was insufflated, described by Dr. Judith A.
Hulf and others (1 March, p. 511), serves
Hto highlight a problem of using a gaseous
medium to distend the uterine cavity for this
procedure.

We have used various agents for this pur-
pur, including high-molecular-weight dextran, 5%
dextrose, and carbon dioxide, and each has
some advantages and disadvantages. While
collapse has been described when carbon
dioxide has been insufflated at an excessive
volume and pressure, I am unaware of any
such occurrence when using an
appropriate insufflating apparatus (West
Hysterosilator, Rimmer Bros., London) which
has incorporated safety devices ensuring that
the gas insufflated cannot exceed a volume
of 100 ml/min and pressure of 200 mm Hg.

—I am etc.,

IAN CRAFT
Institute of Obstetrics and Gynaecology,
Chelsea Hospital for Women,
London S.W.3

Impaired Colour Vision in Diagnosis of
Digitalis Intoxication

Sir,—We would endorse Dr. W. O. G.
Taylor's comments (1 February, p. 271) on
the uselessness of the Ishihara pseudo-
chromatic test to detect xanthopsia in
digitalis intoxication.

The precise site in the visual pathway
where digitalis acts to cause ocular distur-
bance is unclear. There are reports suggest-
ing toxic involvement of the retina, optic
nerve, and visual cortex. Though yellow
vision is usually described, red, green, blue,
brown, and white chromatopsia has also
been noted.1 We feel that while the Farns-
worth D.15 panel would be quicker and
easier to use than the 100-hue test, more
practical than either is the American Optical
H-R-R test. In fact, these three tests will
give a qualitative and quantitative evaluation
of all known colour anomalies. The H-R-R
test, in book form like the Ishihara, is now
in very short supply but copies can still be
found.

In the general ophthalmic clinics to which
may be referred patients suspected of
digitalis xanthopsia the use of a Pickford-
Nicholson anomaloscope is really not prac-
tical; many authorities consider this a purely
research instrument.—We are etc.,

HUGH WILLIAMS
JANET SILVER

Moorefield's Eye Hospital,
London E.C.1

1 Walsh, F. B., and Hoyt, W. F., Clinical Neuro-
ophthalmology, 3rd edn., p. 2543. Baltimore,
Williams and Wilkins, 1969.