A. K. Thouless points out in his paper on page 1089 of this week’s B.M.J., myocardial infarction is often painless in old age. But the sudden development of heart failure in a patient with previously good exercise tolerance should always strongly suggest myocardial infarction if there is no disturbance of the rhythm of the heart and no evidence of pulmonary embolism. The pathological diagnosis of ischaemic heart disease as the cause of heart failure may also be difficult if there is no large infarct, since there is no clear relation between the severity of coronary atheroma and the presence or absence of heart failure in old people. The importance of small fibrotic myocardial lesions is also not clear; Pomerance believes that they contribute little to heart failure.

The certain diagnosis of heart failure due to hypertension is also difficult in the elderly. In “normal” old age there is a wide range of blood-pressure, so that systolic pressures of up to 210 mm Hg and diastolic pressures of up to 110 mm Hg are acceptable as normal. Moreover, when the heart begins to fail the blood-pressure may either fall or, perhaps more commonly, rise. If a known previous sustained very high pressure is the diagnostic criterion, hypertension may contribute to heart failure in perhaps one-third of elderly patients.

Causes of heart failure other than those mentioned are rare, though recently attention has been given to massive calcification of the annulus of the mitral valve and to senile cardiac amyloidosis, both of which are virtually confined to old age. Calcification of the mitral annulus may produce mitral incompetence and occasionally obstruction, and is recognized by the characteristic radiological appearances. Senile cardiac amyloidosis is found in as many as 10% of necropsies of patients over the age of 80, the amyloid material being deposited in the endocardium, especially of the atria, and around the myocardial fibres. If severe, it may certainly result in heart failure, but its clinical and electrocardiographic features are not yet sufficiently well defined to allow diagnosis in life. Its cause is quite unknown, but it may be a variant of primary amyloidosis.

One of the basic features of geriatric medicine is that patients commonly have more than one pathological condition. Thus rheumatic and ischaemic heart disease may co-exist, and thyrotoxicosis precipitates heart failure in patients with all forms of organic heart disease. Pomerance concludes that in as many as two-thirds of cases there is more than one cause for failure of the heart in elderly patients, and that there are very few, if any, patients in whom no cause can be found. This should sharpen our diagnostic acuity, and help to dispel the undoubted naivety of the old cardiologist who dismisses as a sign of senile myocardial degeneration, which often appears on the death certificates of elderly patients.

Origins of Homosexuality

It is commonly estimated that about one in twenty of our male population is a practising homosexual. His opportunities for establishing lasting relationships with homosexuals or with normal people are severely restricted by the current legal, moral, and social attitudes of our society. Of all males who acquire venereal disease perhaps 30% do so by homosexual contact, and this promiscuity may derive from these attitudes. Male prostitutes, particularly the mincing effeminate type so frequently caricatured, are often bisexual or people with severely disordered personalities whose drift into homosexuality is part of a more serious failure in adaptation. The effeminate homosexual is as often despised by other homosexuals as by heterosexual individuals. Despite their vulnerability the majority of homosexuals live useful lives and are effective members of society.

Contrary to popular opinion the majority of practising homosexuals are not interested in prepubertal boys. The paedophiliac presents a distinct and largely unrelated problem showing more common ground with the exhibitionist than with the homosexual. The role of boarding-schools and of childhood seduction in the genesis of homosexuality appears to have been exaggerated. Nor indeed is there much evidence of emotional disturbance in the assaulted child, while there is increasing evidence to suggest that seduction in either sex is often a manifestation rather than a cause of disturbance in behaviour. The crime of the homosexual is usually that which occurs between “consenting adults.” Here the ratio of criminal acts to known offences is thought to be at least 2,500 to 1 and if Kinsey’s estimates are accepted may be as high as 30,000 to 1 in some age groups.

Female homosexuality is less frequent and less subject to sanctions. Many regard the excess of male deviants as evidence of the operation of a biological factor, and E. Slater’s observation that affected persons are of late birth rank and commonly born to older mothers would appear to support this. Other workers point to the universal identification of the young child with its mother. In the female the mother model remains of prime importance, but the male child must turn towards his father as a model for later behaviour. Genetic studies have been inconclusive, for while F. J. Kallman observed a 100% concordance rate for homosexuality between monozygotic twins others have cast doubts on his observations. Chromosomal sex always corresponds to anatomical sex and in fact no abnormalities of the chromosomes have been detected in this condition. At present no clear-cut genetic
hypothesis is tenable, and it seems unlikely that inborn errors can ever provide a complete explanation of this disorder.

Several studies have emphasized the more frequent defective parent–child relationships among homosexuals than in other groups.18-22 Their mothers, with whom they often have an unusually intense relationship, have been variously described as demanding, over-protective, domineering, seductive, and inhibiting. Fathers are usually described in negative terms such as weak, indifferent, absent, or hostile. Two recent studies23-24 have emphasized the frequency of a poor relationship with a father who is ineffective as a parent or a male prototype. While the developing child’s need for a warm and continuous relationship with his mother is generally recognized, the importance of the father’s part in the development of personality has been less extensively investigated. There are, however, some suggestions of an association between “father deprivation” and a variety of disorders of behaviour.25-37

Changing patterns of employment, marriage, and child rearing in our society which blur distinct parental roles may also confuse the child about his developing sexual identity, while patterns of prepubertal dating as seen in the United States may increase the boy’s sense of sexual inadequacy and inhibit normal development. Smaller families and increasing geographical mobility may mean that the alternative father figures that were provided formerly by the larger family are now no longer available. Two additional factors frequently noted in the early life history of homosexuals are within the family a rigid puritanical suppression of all things concerned with sex and the frequent encouragement of the young child to dress and play like the opposite sex.

The child’s needs for effective and affectionate models of both sexes can be met in part outside the family. For the established homosexual, however, treatment is frequently ineffective. Intensive psychotherapy is expensive, time-consuming, and uncertain in outcome. Recently various behaviour-therapy techniques have attracted considerable attention and might improve as many as one-half of patients if they were widely available.28-39 These techniques are not yet fully established and are not without danger.30 Psychiatric treatment is more often concerned with the management of problems arising from the homosexual situation than the deviation itself.

Whatever means of treatment or prevention are employed, the majority of homosexuals will remain in the community. Changes in the law, increasing public education, and a gradual improvement in public attitudes might result in better protection of the interests of young people rather than the reverse and in removing some of the disabilities affecting those whose life is marred by sexual inversion.

### Influenza Prospects

In recent years the incidence of influenza in different regions of the world has varied considerably. Nevertheless no serious pandemics have been observed since those which followed the emergence of the A2 (Asian) antigenic subtype. In Britain no large epidemics have been reported since 1959, though the incidence of the disease was relatively high in 1961 caused by the A2 strain and 1962 caused by the B strain. Since then there has been only a small or moderate incidence of influenza A or B or both, the outbreaks being local or sporadic. This pattern has not been seen in other countries. Russia and some eastern and northern European countries had extensive epidemics of influenza A2 last winter. Severe epidemics with high death rates were also observed in Papua and New Guinea.1 The virus responsible for these epidemics was characterized as influenza A2, though its antigenic composition differs somewhat from the original strains isolated in 1957. This new antigenic variant of A2 had been previously recorded in England in 1961, but it was not associated with any large-scale epidemics. Thus the antigenic variations observed so far among the A2 strains are not by themselves sufficiently large to account for the large epidemics of last winter. Several antigenic variants have also been observed in recent years among influenza B strains. As usual with this type, however, each new variant has shown clear antigenic relationships with preceding strains, and as in the case of influenza A2, the emergence of antigenic variants of influenza B has not been associated with major epidemics.

The purely virological data, therefore, do not at present point to severe outbreaks of influenza this winter. But this prospect must be balanced against the possibility that the low incidence of influenza over the past few years in Britain may have resulted in a reduction in the level of immunity, leading to increased susceptibility of the population as a whole. Thus at present it is impossible to predict with confidence the amount of influenza to be expected. But unless a new antigenic subtype of the virus appears we should expect only small or moderate epidemics at the most. Under these conditions there seems to be no indication for a widespread vaccination programme. The influenza vaccines available at present will probably confer some protection against current strains, and they may suitably be offered to high risk subjects. Oil adjuvant vaccines, however, occasionally give rise to troublesome local complications (see “Any Questions?” p. 1107).

### Risks of Synthetic Foods

Synthetic foods are rarely, if ever, of exactly the same composition as the original. Various food factors may be omitted, but this is seldom of vital importance if the food is given with a mixed diet. But in infants fed solely on a synthetic milk these omissions may be serious. There are now a number of reports on deficiency states in infants fed on such milks.

The first instance of this was the recognition of fits due to deficiency of pyridoxine in infants who had been fed since birth on a particular synthetic milk.1 2 This condition was reported in over 50 infants, all between the ages of 5 weeks and 4 months. When the manufacturers ensured that there was an adequate content of pyridoxine in this synthetic milk there was no further trouble.

The next reports were of extensive skin eruptions in infants with phenylketonuria fed on a particular food with a low phenylalanine content.3 4 K. M. Wilson and B. E. Clayton5 investigated three of these foods, and showed that two of