

these thousands of problems together rather than separately.

These days there is a bitter competition among psychiatrists to discharge more and more long-stay patients, but very little thought has been given to the other side of the story: the community tolerance, its costs, and its limitations. Physical discharge of a patient is no substitute for cure. The criterion is that he should be happier and more useful in the community than in the hospital. I believe there is a case for moderating our enthusiasm to empty the mental hospitals with some research on discharged patients by individuals working exclusively in the community.—I am, etc.,

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REFERENCE

- ¹ Grad, J., and Sainsbury, P., *Brit. J. Psychiat.*, 1968, **114**, 265.

SIR,—While deplored the overcrowding in some mental hospitals, I cannot agree with Dr. C. Entwistle (13 April, p. 116) that chronic psychiatric patients are neglected and that "the blame for this must rest with the medical profession." While it is true, as Merry showed in 1956,¹ that some consultants, possibly because of heavy commitments, rarely visit the chronic wards, it has not been my experience to encounter neglected patients in these wards, which are usually visited daily by junior doctors who attend promptly and energetically to the needs of these patients (as evidenced by their frequently voluminous case-records). In fact chronic mental patients often appear to receive as much medical and nursing attention as many patients in acute wards.

Dr. Entwistle's conclusions would certainly have been more impressive if he had supplied breakdowns of the ages of his patients, together with follow-up details after discharge. Were none of them readmitted? From reading his letter it would seem that there are no "revolving doors" at Rubery. Furthermore, his generalization that the accomplishments at Rubery could be achieved elsewhere with modern treatments and "energetic" doctors is questionable, and I am less optimistic. During 1966 and 1967 Dr. Mabel Miller and myself intensively surveyed 116 chronic patients on our "firm" (approximately a quarter of the total chronic population, and representative of all the patients in this category at Shelton).² Sixty-nine per cent., with males and females in almost equal proportions, were over 60. After 18 months 18 patients had died, 8 went to Part III accommodation and chronic sick, 6 were transferred elsewhere, and only 2 could be discharged home; but a further 18 patients had to be admitted to these wards during this period. Thus after over 450 interviews there were only 16 fewer chronic patients on our "firm." Such figures say little for modern treatments and energetic doctors, but are more a reflection of present social trends in our society and a rising geriatric population. Mental hospitals will remain overcrowded if they continue to act as geriatric "dumping grounds," as they undoubtedly have in the past.³ Far greater selectivity is required, implying closer collaboration between psychiatrists, geriatricians, general practitioners, and local authorities. Recent figures suggest that the problem will increase⁴ until adequate faci-

lities are available nationally to deal with rising numbers of elderly patients.

Overcrowding frequently coexists with locked wards. Some mental hospitals still accommodate upwards of 100 patients, many elderly, in security wards. Our survey indicated the need for an absolute minimum of patients to be detained under lock and key⁵—only severely disturbed patients and a few Section 60 cases. At Herrison Hospital, Dorchester, in 1962 it was possible to open the male and female disturbed wards without incident, while retaining only a handful of security patients in closed sections. All disturbed patients require repeated review and should never remain under security conditions when quiescent or recovered. Also the curious traditional practice of locking up virtually all the mental hospital wards at night needs reappraisal. Frequently a shortage of nurses is blamed for the retention of the closed-ward system. But is this shortage relative, perhaps geographical, or absolute? Hospitals offering poor promotional prospects, housing, training facilities, etc., will tend to remain chronically understaffed, whereas others, particularly those that open their doors to coloured nursing applicants, can often afford to pick and choose.

The entire mental hospital administration (medical, nursing, and lay) must approach these and many related problems realistically if more doors are to be opened and overcrowding reduced.—I am, etc.,

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J. C. BARKER.

REFERENCES

- 1 Merry, J., *Brit. J. med. Psychol.*, 1956, **29**, 287.
2 Barker, J. C., and Miller, M., *Nursing Mirror*, 1968, **126**, No. 7, 21.
3 Barker, J. C., and Miller, M., in the press.
4 Robb, B., *Lancet*, 1968, **1**, 815.

Transplacental Haemorrhage in Rh-haemolytic Disease

SIR,—The Liverpool group¹ count the number of foetal cells in 50 low-power fields to determine the foetal-cell score which is used to calculate the approximate size of the transplacental haemorrhage. A score of 5 foetal cells represents approximately 0.25 ml. of blood, and a score of 60 approximately 3 ml. They indicate in their report that the diameter of the low-power field of the microscope which they use is 0.940 mm.

The area comprising one low-power field can be readily calculated from the formula πr^2 , which in the case of an objective field with a diameter of 0.940 mm. is 0.694 sq. mm. Fifty low-power fields will represent a total area of 34.7 sq. mm. The diameter of the objective field, and therefore the area scanned, varies with different microscopes. With the particular microscope which I use the low-power field (diameter 1.80 mm.) covers an area of 2.54 sq. mm.—almost four times the area of a field with a diameter of 0.940 mm. Only 13.5 low-power fields of this particular microscope would cover an area of 34.29 sq. mm. Clearly the scanning of 50 low-power fields will result in considerable differences in the actual area scanned with different microscopes, and is therefore not an acceptable convention for general use. It is highly desirable at this early stage in the routine application of this valuable procedure to adopt a convention which will be universally applicable, and to this end I recommend the adoption of 50 sq. mm. as the total area to be scanned.

Furthermore, it is essential that every published report dealing with this procedure should indicate the diameter or area of the low-power field of the microscope used to enable the appropriate correction to be applied in the interpretation of the results.

The diameter of the objective field is determined by the magnification of the objective and the diameter of the diaphragm built into the eyepiece. The necessary information to enable the diameter of the objective field to be calculated can be readily obtained from the manufacturer or supplier of the microscope, or by direct measurement with the aid of a stage micrometer.—I am, etc.,

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REFERENCE

- ¹ Woodrow, J. C., et al., *Brit. med. J.*, 1965, **1**, 279.

Rh Immunization

SIR,—Following the reports (20 January, pp. 148, 150, and 152) of failure of immunoglobulin anti-D to suppress primary sensitization by Rhesus-positive red blood cells in seven cases, we now report two further failures. During the past 11 months 250 women at risk have received between 200 and 410 µg. of immunoglobulin anti-D within 72 hours of delivery and so far two have developed antibodies.

Case 1.—A primigravida had foetal cell counts done using the Kleihauer method at 18, 22, 26, 30, 32, and 34 weeks. Up to 32 weeks these indicated that no significant transplacental haemorrhage had occurred, but at 32 and 34 weeks the count indicated bleeds of approximately 1 ml. and 3 ml. respectively. At 35 weeks she was admitted with a small antepartum haemorrhage of unknown aetiology and delivered at 36 weeks after spontaneous onset of labour by low forceps for foetal distress. The baby was ABO compatible Rhesus positive (D+ C+ E- c-). No foetal cells were seen in the maternal circulation after delivery and no antibodies were detected in the mother's serum. She received 4 ml. of gammaglobulin containing approximately 440 µg. of anti-D eight hours after delivery. Three months later her serum contained anti-D antibodies to a titre of 1 in 32 by Papain-treated-cells method.

Case 2.—A primigravida had foetal cell counts done at 32, 34, and 36 weeks' gestation. At 36 weeks the count indicated haemorrhage of approximately 1 ml. At 38 weeks she came into spontaneous labour and had an uneventful delivery of an ABO compatible Rhesus D and E positive infant. No foetal cells were found in the maternal circulation at delivery and the indirect Coombs test was negative. She received 200 µg. anti-D gammaglobulin, but six weeks later her serum contained anti-D antibodies to a titre of 1 in 32 by the Papain-treated-cells method.

It is difficult to explain these failures unless the time between probable sensitization and delivery of four weeks in one case and two weeks in the other is too long to suppress the primary immune response.—We are, etc.,

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