suggest that from the standpoint of long-term forward planning it may be the correct one, and it is noteworthy that in my experience visitors from other countries are usually full of admiration for the general standard of care offered to all psychiatric in-patients in Britain.

You refer to the paper by Anthea M. Hailey² based on the Camberwell Register. She states that the composition of the long-stay group which she studied is changing and that the group is being replaced in part by "a large number of psycho-geriatric patients." She adds: "... elderly patients contribute half the new long-stay build-up..." Yet when Mrs. Hailey concludes by asking whether present trends of care are in the right direction you appear, in effect, to support the view that it is correct for increasing numbers of the elderly confused to be accommodated in mental hospitals. I would join issue with this implication.

At another point in her paper Mrs. Hailey states that "... hospital policies differ and the constitution of a long-stay group at any one time depends both on this and on availability of alternative services in the locality." This is indeed true and, for example, one cannot help but notice that in the general hospital psychiatric unit serving the Camberwell area³ patients are not allowed to remain in the unit more than six months, whereas, for example, in the general hospital psychiatric unit in my own area there is no restriction on the length of stay in hospital. As has so often happened in the past, it may well be that the lay public is ahead of professional personnel in its thinking on this subject and that the leader in the *Observer* of 16 May may have struck the right note when (in spite of the fact that the words "mentally handicapped" may not have been used in the customary sense it pleaded that "old people who are helpless and incontinent but not 'mental' would never be sent to institutions for the mentally handicapped.")—I am, etc.,

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¹ Jones, K., in *Trends in the Mental Health Services*, ed. H. Freeman, and J. Farndale, p. 60, Oxford, Pergamon, 1963.

² Hailey, A. M., *Psychological Medicine*, 1971, 1, 128.

³ Watson, J. P., Bennett, D. H., and Isaacs, A. D., *Lancet*, 1970, 1, 511.

Prostaglandins and Habitual Abortion

SIR,—Prostaglandins and their biophysiological properties have been extensively studied since they were first described by von Euler in 1935.¹ Our knowledge of them today, though still incomplete in many respects, is nevertheless impressive. Many have been identified, synthesized, and specific actions recognized.²

It is my view that prostaglandins may play an important role in the field of habitual abortion. I would like to propose the hypothesis that the habitual aborter (excluding those in whom other possible causes have been suspected or identified) may be the woman who is hypersensitive to any form of mechanical stimuli which are capable of causing spontaneous release of prostaglandins in pregnancy, especially early pregnancy—for example, mild trauma, such as a knock or fall of so slight a degree that it might not be recognized, remembered, or

associated as possibly significant, or the abdominal and/or vaginal/cervical stimuli of intercourse in early pregnancy, perhaps even before pregnancy had been suspected or diagnosed. Prostaglandins, too, of course, are also highly concentrated in seminal fluid.

Once suspected, it may be possible to identify such women by prostaglandin sensitivity tests, which in turn might suggest further, theoretical at least, measures for the management of early pregnancy. Furthermore, if specific prostaglandins could be identified as responsible, it may only be a matter of time before appropriate prostaglandin antagonists may be developed, which could be successfully used in suitable cases for the clinical management of habitual abortion.—I am, etc.,

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¹ Euler, U. S. von, *Klinische Wochenschrift*, 1935, 14, 1182.

² Pickles, V. R., *Nature*, 1969, 224, 221.

New Research on Cannabis

SIR,—Your leading article (8 May, p. 293) on cannabis is important. Too much emotion and prejudice, either for or against the drug, has resulted in non-medical dogmatic pronouncements about its harmlessness or otherwise.

The fat-solubility of the cannabinoids, as shown by Paton, Gill, and Pertwee at Oxford,¹ is a source of justifiable concern in relation to the toxicity of this drug to the central nervous system by its capacity for storage in fat; its fat-solubility can be compared to the chlorinated hydrocarbons. We feel that too much research has been concentrated on the psychological rather than the possible organic brain damage caused by this drug.

In a neurological outpatient department we have seen four cases aged from 17 to 23 years, who presented with primarily neurological symptoms of headache, mental impairment, and in one case epilepsy (which may or may not have been due to drug-taking). All four cases had been to some extent poly-drug takers, but in at least two cases the predominant drug had been cannabis and the other drugs had been used only infrequently, and were amphetamines and L.S.D. In all cases the drug usage had been from four to six years. Investigations on these cases showed that in all four cases there was a degree of cerebral atrophy, which is unusual in patients of this age without any obvious cause. It must be admitted that there are other causes of cerebral atrophy, but the common history of these four cases seems to us important and worthy of further work, and it would bear out the suggestions of the German workers von Zerssen, Fleige, and Wolf² in Munich, using echoencephalography. It certainly needs further work before conclusions can be drawn, and we would be grateful for the observations of other workers.

It is also of interest to us to obtain post-mortem material in cases of chronic drug takers who have committed suicide or been killed accidentally. We would like if possible to obtain this material for study in our neuropathological department. This material is obviously difficult to obtain, and we would be grateful for the co-operation of other

pathologists. Could contact be made, and suitable brains sent to: Dr. B. Brownell, Department of Neuropathology, Frenchay Hospital, Bristol?

Although work has been done on animals there appears to have been little work on the brains of chronically addicted individuals.—We are, etc.,

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J. L. G. THOMSON
M. J. WILLIAMS

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Bristol

¹ Gill, E. W., Paton, W. D. M., and Pertwee, R. G., *Nature*, 1970, 228, 134.

² Von Zerssen, D., Fleige, K., and Wolf, M., *Lancet*, 1970, 2, 313.

Cigarette Vending Machines

SIR,—In a reply to a question in the House of Lords (Parliament, 22 May, p. 478) about the banning of cigarette vending machines the Minister of State, Health and Social Security, stated that this was a matter which required legislation and that the Government could not go rushing bull-headed into it.

Why ever not? Wherever situated they enable children who are under the age at which they can legally buy tobacco products to do so with impunity—a direct incentive to law-breaking and cigarette smoking, neither of which the Government should encourage. And if the banning of vending machines were to make it more difficult for adults to obtain cigarettes, this would be no bad thing either. It might ultimately relieve the pressure on our hard-pressed chest units—I am, etc.,

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Genitourinary Tuberculosis

SIR,—Several correspondents (22 May, pp. 463 and 464) have already taken issue with the comments made in your leading article on genitourinary tuberculosis (24 April, p. 183). I should like to comment on several other aspects.

The suggestion that it is never safe to proceed (to treatment) on the evidence of a stained urinary deposit is surely erroneous. No one would contest that caution should be observed in the interpretation of the significance of acid-fast bacilli in smears of urine, but if there is clinical and radiological evidence consistent with tuberculous renal disease, a significantly positive tuberculin test, and acid-fast bacilli in the urine it is, in my opinion, unjustifiable to delay treatment until cultures are available, which may mean up to six weeks' delay. Quite apart from the possibility of important progression of the disease during this period (which your leader writer shrugs off as unimportant), why allow the patient to endure symptoms for this length of time? Furthermore, there is no need to wait for sensitivity reports in previously untreated patients, particularly as if proper chemotherapy (that is, three standard drugs) is given the risk of failure is extremely remote.

In so far as the need for surgical treatment is concerned, the comment is fairly made that experienced surgeons in Scotland, England, and Ireland do not share the view held in North America by Lattimer and his colleagues¹ that sequestered caseous tissue

need not be removed, but the implication of the succeeding comments is that Lattimer is undoubtedly wrong. This seems to be based on the assumption that caseous tuberculous tissue cannot be sterilized. What evidence has the writer for the statement that "chemotherapeutic drugs diffuse with great difficulty, if at all, into the prostate and seminal vesicles"? There is, in fact, very adequate evidence that, if proper treatment is given for a sufficiently long period, it is impossible to isolate tubercle bacilli from resected tissues.² The evidence quoted in the article in favour of nephrectomy is completely unsupported. Borthwick, for instance, states "While operations on the lungs have reduced very much in number there are still many patients who, in our opinion, require surgical treatment for their genitourinary lesions (Table VII)."³ Table VII shows that 92 nephrectomies were carried out among 407 patients in 1960-5. If my reading of the relevant table is correct, Gow reports that about 90% of patients admitted to hospital in 1967-9 have undergone surgical treatment.⁴ What were the indications for the large number of nephrectomies and other operations?

Stress is rightly placed on ensuring patency of the urinary drainage system, for obstruction of drainage at any level can threaten or destroy more renal tissue than the disease itself.⁵ It is my opinion that the writer dismisses the value of steroids too lightly. Based on experience in pulmonary disease, I use prednisolone 20 mg daily for three months where there is evidence of ureteric obstruction at any level. Since beginning this form of treatment routinely for ureteric obstruction, in a personal series of 63 cases of renal tuberculosis managed jointly with a very experienced urological surgeon, 26 (41%) patients showed evidence of ureteric obstruction and were treated with corticosteroid therapy in addition to chemotherapy. In 22 (84%) of these patients evidence of hydro-ureter and/or hydronephrosis disappeared. Three patients required subsequent surgical dilatation of the ureter and another underwent nephrectomy because, having stopped his steroid therapy on his own account, he had a gross rebound hydronephrosis and was operated on in another hospital. We have learned from subsequent experience with two patients that such a "rebound" is reversible by the reintroduction of steroids. The urine has become negative on culture for tubercle bacilli in all patients. One patient has relapsed and admitted that she had taken treatment irregularly, but has been satisfactorily retreated with chemotherapy. One patient required a diversionary operation because of gross frequency due to a very small bladder. One patient underwent nephrectomy for a destroyed kidney. I believe that our experience supports the plea made by Dr. R. Gabriel (22 May, p. 463) that physician and surgeon should collaborate closely in the management of tuberculosis of the kidney and that renography is a valuable method of assessment.

It is 15 years since thoracic surgeons largely abandoned surgical treatment for pulmonary tuberculosis because they recognized the efficacy of long-term chemotherapy. It is to be hoped that those urological surgeons who have not already done so will cease doing operations on genitourinary tuberculosis when they are not necessary, and recognize the place of steroid therapy in

the management of ureteric obstruction. As with pulmonary tuberculosis, there are, of course, a few definite indications for surgery in genitourinary tuberculosis, but I agree with Lattimer¹ when he observes that nephrectomy has become an unimportant method of treating renal tuberculosis.—I am, etc.,

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- ¹ Lattimer, J. K., Reilly, R. J., Segawa, A., Wechsler, H., Siegel, J., Girgis, A., and Gleason, D., *Journal of Urology*, 1965, 93, 735.
- ² Crofton, J., *British Medical Journal*, 1960, 2, 679.
- ³ Borthwick, W. M., *British Journal of Urology*, 1970, 42, 642.
- ⁴ Gow, J. G., *British Journal of Urology*, 1970, 42, 647.
- ⁵ Barrie, H. J., Kerr, W. K., and Gale, G. L., *Journal of Urology*, 1967, 98, 584.

Whose Purpura?

SIR,—I am disappointed to read (15 May, p. 352) for the second time this year that the names of Henoch (1874) and Schönlein (1837) have been perpetuated in the title of a leading article. Why not that of our own illustrious William Heberden (senior) who described this same popular purpura and also its association with disorder of the gut and kidney?¹ Furthermore, Robert Willan's coloured lithographs of the skin signs are magnificent.²

It would seem to be correct here to indulge ourselves with a modicum of patriotic pleasure.—I am, etc.,

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- ¹ Heberden, W., *Commentaries on the History and Cure of Diseases*, 3rd edn. London, T. Payne, 1802.
- ² Willan, R., *On Cutaneous Diseases*. London, J. Johnson, 1808.

Personality and Rheumatoid Arthritis

SIR,—The results of Dr. D. J. Ward's investigation into personality and rheumatoid arthritis (8 May, p. 297) are most interesting but they are open to further possible interpretation.

In using tests like the Eysenck Personality Inventory it is easy to forget that they are constructed to draw conclusions about an individual on the basis of his self description on a number of items. Among the questions asked that determine the degree of extraversion are the extent to which an individual enjoys being with other people, goes to parties, etc. and questions that influence the neuroticism score are partly dependent on the extent to which the individual commonly experiences various forms of physical distress. In a normal person these sorts of behaviour and complaint are likely to be very revealing about him as a person, but in a person suffering from a chronic physical disability positive answers to these questions will often predictably be due to the effects of illness. I very much agree with Dr. Ward that this artefact is a likely explanation of the lower "extraversion" score found among the arthritics. However, this same argument at first sight makes it doubly surprising that the "neuroticism" score in Dr. Ward's series is lower than average, a finding made in some other possibly psychosomatic conditions—for example, coronary thrombosis¹ and eczema.² Possible explanations of

a subnormal index of neuroticism may be that these are patients who suppress their awareness of emotional responsiveness or at a more conscious level need to present themselves to the inquirer as paragons of stability.

There is some evidence that would tend to favour the first of these hypotheses. Moos and Solomon in a series of elegant studies on rheumatoid arthritis, summarized by Solomon,³ established, among other things, that there was a significant trend for the arthritic to be unable to express hostile or other socially deprecated feelings. Solomon also reviews the considerable evidence for psychological influence on rheumatoid arthritis and immunological responsiveness.—I am, etc.,

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- ¹ Bendien, J., and Groen, J., *Journal of Psychosomatic Research*, 1963, 7, 11.
- ² Brown, D. G., *Journal of Psychosomatic Research*, 1967, 11, 27.
- ³ Solomon, G., in *Modern Trends in Psychosomatic Medicine*, Ed. O. W. Hill, London, Butterworths, 1970.

Trichomonas and Oxytetracycline

SIR,—I read Dr. Stephen Szanto's account of a 66-year-old patient with vaginitis with interest (22 May, p. 467). He wondered whether antagonism between oxytetracycline and metronidazole might explain the persistence of symptoms and positive bacteriological tests until the former drug was stopped.

An alternative explanation might be that the lady's vaginitis was mainly due to *Candida albicans*, and that this organism was not found, as sometimes happens. In these circumstances her symptoms might also diminish after stopping oxytetracycline, recognized as it is as a cause of candidal infections in the lower genital tract and elsewhere. *Trichomonas vaginalis* does not always cause symptoms, and a second course of metronidazole is quite often needed to eliminate it, especially perhaps if it has been present for a considerable time and has had the opportunity to invade extravaginal structures.—I am, etc.,

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Malaria Prophylaxis and Treatment

SIR,—In the very interesting article by Professor W. Peters (10 April, p. 95), the formulation given for Daraclor in the Table is incorrect.

Each tablet of Daraclor contains 15 mg pyrimethamine and chloroquine sulphate equivalent to 150 mg chloroquine base.—I am, etc.,

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Reticuloendothelial Activity and Cancer

SIR,—The paper by Mr. C. J. Magarey and Mr. M. Baum (15 May, p. 367) on oestrogen as a reticuloendothelial stimulant in the defence against cancer reminded me of some work that I did that is unpublished. Reticulo-