The principal role of the consultant psychiatrist must be to bestow therapeutic skill on other workers (including general practitioners, social workers, health visitors, and ward nurses). This is not only dictated by arithmetic—it also offers the only hope for prevention. Mr. Bury is right to insist that psychiatry become more effective, but he should be warned not to expect (or psychiatrists) to become popular; for it deals with the most unpopular of human feelings.

—I am, etc.,

Department of Child and Family Psychiatry,
United Sheffield Hospitals

Sir,—What kind of world does Mr. M. Kopelman (10 March, p. 609) think he is living in? Who does he think cares for mentally subnormal people in hospitals? Psychologists and educationalists visit the wards perhaps once or twice a week in the more progressive establishments, but in other hospitals these visits are even more infrequent.

Patients' training and education programmes are formulated in many cases without prior consultation with senior nurses, but it is these nurses who will eventually have to put these programmes into practice. Education and training for mentally subnormal people is a continuous process and must therefore be carried out constantly. At present this work is being carried out mainly by nurses of the mentally handicapped with remarkable success, and surely by the application of their considerable expertise they are filling the gap referred to in your leading article (24 February, p. 435).

We are, etc.,

Peter Birchennall
Paul Tuddenham
Nurse Tutor Students
Royal College of Nursing
London W.1

Dyslexia versus Illiteracy

Sir,—In commenting on the paper by Dr. M. G. Barker and myself on dyslexia as a cause of psychiatric disorder in adults (30 December, p. 759), Mrs. Bev Hornsby states that she disagrees "as to the differential diagnosis between dyslexia and illiteracy" (24 February, p. 487).

I do not wish to become involved in a semantic argument, but I feel I must point out that she has defined "specific developmental dyslexia" and not "dyslexia." These terms were defined separately by the research group on developmental dyslexia of the World Federation of Neurology. It is also not correct to say that the patients referred to in the paper were of dull average intelligence or below on testing. "Average" refers to the I.Q. range 90-110, and four of the patients scored well within this range while the other three had a considerable discrepancy between verbal and performance scores. In the paper we discussed the difficulties these patients had in a test situation and the likelihood of underestimating their abilities.

We have in fact had considerable correspondence supporting our findings from other workers.—I am, etc.,

W. A. Saunders
Bristol Royal Hospital for Sick Children, Bristol

Care of Elderly People with Dementia

Sir,—Your leading article (24 February, p. 434) was welcome, for the important statement of Government policy1 to which it refers has so far received strangely little attention.

In the space available you give a fair summary of what the circular says, but on one important point it is surely misleading. You write that "though it notes that psychiatrists with special responsibility for psychiatric services to the aged have been appointed in some areas, the memorandum makes no specific recommendation to create a specialist "psychogeriatrician." On the contrary, what the memorandum actually says is that "experience in some areas has shown that it may be advantageous to appoint a psychiatrist with special responsibility for psychiatric services for the aged." Many of us with a particular interest in this field have long argued that the only way to begin to make sense of the escalating problem of the psychiatric care of the elderly is for particular psychiatrists in each district to take special responsibility for this component of the psychiatric service, and for this the new memorandum gives important official encouragement.

To say this is not to argue for the creation of "specialist psychogeriatricians."

JANE BATE
O. H. B. GYDE
Department of Geriatrics, East Birmingham Hospital

Rifampicin and Folate and Vitamin B12 Assays

Sir,—We have observed apparent low serum folate and vitamin B12 levels in patients receiving rifampicin as a part of antituberculosis therapy. As this drug is a broad-spectrum antibiotic it was considered likely that this was due to in vitro inhibition of the microbiological assay. A small investigation was therefore undertaken with the active co-operation of the public health laboratory (Dr. J. G. P. Hutchison) and the isotope department (Dr. R. A. Carter) at this hospital.

Whole blood was taken from 17 patients taking rifampicin (450 mg daily by mouth), from 10 patients receiving other antituberculosis drugs, and from 10 healthy volunteers. Serum folate and B12 levels were estimated with Lactobacillus casei and L. leichmannii from stock cultures and after with strains of the same organisms in which resistance to rifampicin had been induced. This was done by exposing the organisms in serial subculture to increasing sublethal concentrations of rifampicin and determining the minimum inhibitory concentration greater than 100 μg/ml was established. Serum B12 levels were further estimated by a method employing 12Co-labelled cyanocobalamin.1 Red cell folate levels were estimated by the method of Spray2 after washing in saline to eliminate rifampicin present in the serum. Serum folate levels were measured by a standard method.

The mean results obtained with the stock and resistant organisms in the rifampicin and combined control groups are shown in the table. By comparison with the values obtained with the resistant organisms in the stock, organisms gave low folate and B12 levels in 12 patients—in some of these cases there was no growth at all in the assay tubes. All these 12 patients had serum folate levels of more than 2 μg/ml. The washed red cell folate levels were normal in all patients. The folate and B12 levels measured with resistant organisms were normal except for one patient who was found to have a low B12 level. This result was confirmed when the 17 sera were assayed for B12 by the radioisotope technique and a Dicopac test showed the patient to have malabsorption of B12.

In vivo inhibition by therapeutic levels of rifampicin of the standard assays for serum B12 and folate has thus been demonstrated. If serum B12 or folate assay is requested in patients whose treatment cannot be stopped, then it is necessary to use a rifampicin-resistant organism. Alternatively, it might be sufficient to withdraw blood from the patient just before the daily dose of rifampicin is due, when serum levels can be expected to be below 2 μg/ml. However, as it has been recommended that rifampicin be given on an empty stomach two hours before breakfast, one dose would have to be omitted. Failing this, estimation of red cell folate is a suitable alternative to that of the serum level, while an isotope method for the assay of serum B12 may be used if facilities are available.—We are, etc.,

A. J. L. COLE
JANE BATE
Department of Haematology, East Birmingham Hospital

Mean Values (±S.E. of Mean) Obtained with Stock and Rifampicin-resistant Organisms in 17 Patients taking Rifampicin and 20 Controls

<table>
<thead>
<tr>
<th>Serum Folate (ng/ml)</th>
<th>Serum Vitamin B12 (μg/ml)</th>
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<tbody>
<tr>
<td>Stock Organism</td>
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<tr>
<td>Stock Organism</td>
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<tr>
<td>Patients</td>
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<td>I ± 0.5</td>
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<tr>
<td>Controls</td>
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<tr>
<td>5 ± 1.0</td>
<td>&lt;0.01</td>
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