I have received many kindnesses and help from many colleagues who have done their various bests to help me cope with the problems of stroke illness, with a lot of success, and I am very grateful to them. The problem of pain management in the hemiplegic limb and trunk is a depressing cross to bear long term, and this, together with the management of trophic problems in the limb, seems to need a therapeutic synergy that medicine has not yet succeeded in providing in any specialty that I have come across.

Pathological emotionalism is probably present in many more stroke victims than is realised. (Men are not allowed to cry publicly in our culture.) But this seems partially to heal itself in time. I can now usually survive the relatively non-emotional experience of the reception of the Eucharist without tears. But if I want to listen to *La Bohème* then alone in my study is the only way.

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Blythburgh Hospital

SIR,—What a pleasure it was to some of us in Suffolk to see the painting of Blythburgh Hospital by Anne Bruce adorning the front cover of your excellent Christmas number. Blythburgh is much honoured. That old hospital has been a vital part of the active geriatric department in east Suffolk for just 30 years. It was built as a "house of industry" and so were some dozen others in Suffolk as a result of individual acts of parliament, and it was opened on 13 October 1766. (This was before the general act of 1782 which permitted such large establishments and which led on to the Victorian "unions.") The story still circulates that the local villagers, not liking the thought of such a "prison" near them, each night pulled down the work of the bricklayers —until the militia was called out and the Riot Act was read to them, threatening deportation. A prison it almost was, and the plight of the inmates was sad. Nevertheless, it helped form the basis of a geriatric service nearly 200 years later, so Suffolk was unwittingly pioneering.

After the war we were able, thanks to public opinion, benign authorities, and a touch or two of opportunism, quickly to upgrade it into a bright, spacious, cheerful, and colourful longer stay unit with every normal amenity. It has the bonus of quiet rural surroundings and views of a splendid Suffolk estuary. If the need arose I would be content to be nursed there or to have any member of my family nursed there sine die, such are the virtues of Blythburgh and its devoted staff. On places like this have many of Britain's geriatric departments been founded for later development. We were not alone in this, but we were lucky that the embryo NHS took over this formidable old place in 1948, and we are still proud of our hospital in 1987, its 222nd year.

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Points

Impact of a handicapped child on mental health of parents

Dr J NEWCOMBE (Mental Handicap Services Unit, Meanwood Park Hospital, Leeds LS6 4QD) writes: Dr Sarah Romans-Clarkson and others (29 November, p 1395) appear to accept that the parents of mentally handicapped children were less able and successful than the parents of non-handicapped children. This, surely, would be correct only if you included the subcultural group where nothing has gone wrong and the children are simply chips off the old block. If we take the more handicapped group, including children with Down's syndrome, we find no difference between the two groups of parents. Severe mental handicap is no respecter of wealth and success in the parents. The authors seemed surprised that mothers rather than fathers show the greatest strain from looking after a severely mentally handicapped child in the family. This is not surprising; the mother looks after the child by day and by night. The father, however, can go out to work by day and retire to the pub or club at night. The article made no mention of a group which is seldom mentioned but which is most affected by the presence of a severely mentally handicapped child in the house: the normal brothers and sisters. They suffer because the handicapped child gets most of the attention and they are left to fend for themselves and because normal children do not like to invite their friends to their house and they themselves are not invited to other children's houses. Those who press for severely mentally handicapped children to remain at home should remember that they are robbing the normal brothers and sisters of their childhood.

Coffee, cholesterol, and colon cancer

Drs M N CLIFFORD, R WALKER, and J WRIGHT (Department of Biochemistry, University of Surrey, Guildford GU2 5XH) write: Dr Bjamek Jacobsen and Professor Dag S Thelle suggested that there may be a positive relation between coffee consumption and serum total cholesterol concentration and a reduced risk for cancer of the colon (3 January, p 4). They point out that they are not aware of any data in man on the effect of coffee consumption on bile acid and neutral sterol excretion from the liver. We are not aware of any definite studies on this either, although we have indicated the need.[1] We wish, however, to draw your attention to a substantial collection of data which seems to have passed unnoticed. A drink of coffee supplies appreciable quantities of chlorogenic acids—for example, a 200 ml cup prepared from 2 g of instant coffee as available in the UK could supply between 70 mg and 200 mg, and 200 ml of a beverage prepared from roast and ground coffee could supply over 600 mg.[2-4] There is evidence from clinical studies that chlorogenic acids (500-1500 mg/day) can increase the elimination of bile acids by a factor of three[5] as well as reducing serum concentrations of total cholesterol (−13 to −31%), β lipoprotein (−12 to −28%), the β:α lipoprotein ratio, triglycerides (−11 to −30%), free fatty acids (−29%), and glycerol (−24%).[6-12] We agree with the authors that there is a very good case for examining in man the interrelation between coffee (brewed in different ways), bile excretion, and cholesterol metabolism, but in any such study the composition of the coffee must be controlled and the chlorogenic acid content defined.

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Contact tracing in pelvic inflammatory disease

Mr JULIAN PAMPIGLIONE (Department of Obstetrics and Gynaecology, King's College School of Medicine and Dentistry, London SE5 8RX) writes: Mr M J Hare (8 November, p 1225) provides a concise and accurate account of how pelvic inflammatory disease should be managed. A major treatment failure in the UK is that of contact tracing and examination of the partner. Twenty five contacts of 42 women clinically diagnosed as having pelvic inflammatory disease at the Whitechapel Clinic (London Hospital) over six months were examined. Of these, six had gonococcal infections, 15 had non-specific urethritis, and three had both gonorrhoea and post-gonococcal urethritis. While these figures are uncontrolled and there may be a bias towards sexually transmitted disease, many partners of patients with pelvic inflammatory disease may well be infected. Many patients are treated by general practitioners, casualty officers, and junior gynaecological staff as outpatients. There are usually no formal contact tracing facilities available. Unless these can be provided in the form of available contact tracing cards, routine reporting of cases to genito-urinary clinics, and follow up and counselling then there is a good case for treating the partner, if traceable, immediately and empirically. If this is not done reinfection may well result. Treatment should be the same for both male and female partners. Some early recurrence of pelvic inflammatory disease is no doubt due to reinfection resulting from failure of initial contact tracing and treatment.

Contraception

Dr RICHARD PAISEY (Medical Centre, Torbay Hospital, Torquay TQ2 7AA) writes: "Fertility awareness" and "natural methods of family planning" are mentioned briefly by Mr Alia Kubba and Mr John Guillebaud (6 December, p 1491) with an accurate description of the symptoms diagnostic of the post-ovulatory infertile phase. Unfortunately they suggest in their flow diagram that women with irregular cycles cannot use this method and that a preovulatory infertile phase can never be relied on. With proper teaching, women in the premenopause, those breast feeding, and those with irregular cycle lengths can use these methods, and in many a preovulatory infertile phase is perceptible. The main problem for couples wishing to adopt natural methods of contraception is accessibility to trained teachers, as the vast majority of Family Planning Association doctors and nurses are not properly qualified to teach these methods. It is hoped that this situation will change in the future; in the mean time couples may be referred to the Natural Family Planning Centre, Birmingham Maternity Hospital, for the address of their nearest teacher.

Saint Who's?

Dr TERENCE MORRIS (Prince Charles Hospital, Merthyr Tydfil C47 9DT) writes: May I add another saint to Sir John Dewhurst's list? St Tydfil's Hospital is the oldest in Merthyr Tydfil and recently reopened after modernisation. St Tydfil (Tudvyl) was a Celtic Christian, daughter of a local Welsh chieftain, Brychan Brycheiniog. She and her family are believed to have been killed by a group of marauding Picts some time between AD 450 and 480. Tydfil is believed to have knelt in prayer before her death and this is the origin of the tradition of her martyrdom.