

corded. Post-cerebral malaria (? oedema) residua have been non-existent (by psychological and intelligence testing). We have used the drug as a life-saving measure in spite of its reported ability to exacerbate dormant amoebiasis and tuberculosis. Its effect on melioidosis is unknown.

We are taking our study one step further. It is a clinical impression that if an absolute contraindication to a short course of steroids (three days) does not exist, dexamethasone in doses of 4-6 mg. intravenously every 4-6 hours decreases the morbidity of the disease. Severe haemolysis (except in G.6-P.D. deficiency), cerebral malaria, renal and pulmonary complications may be prevented or rapidly reversed. We have been disseminating this information verbally. A protocol is being followed, and when significant case numbers are accumulated a report with positive results undoubtedly will be recorded. This brief letter may initially make physicians aware of what may be a significant advance in a disease that is still a world-wide problem.—I am, etc.,

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SIR,—Recently a Spanish sailor of 50 was admitted to a Liverpool hospital. He was transferred from his ship, which had just returned from the west coast of Africa via the Canaries, having been found unconscious in his cabin. Six days previously he had been seen on arrival in Bristol and given a course of tetracycline for a pyrexia which had started six days earlier, accompanied by headache and chest signs.

On admission he was deeply unconscious with no focal neurological abnormalities and was apyrexial. As his cabin locker had contained large quantities of proprietary medicines he was initially considered to have taken an overdose of drugs. Examination of the blood and urine, however, failed to confirm this, and later the same day he developed a fever of 100° F. (38° C.). A lumbar puncture was entirely normal, but blood films revealed infection with *P. falciparum* (malignant tertian malaria). The parasitaemia was 9%. Mature forms including schizonts were found in the peripheral blood. He was treated with parenteral chloroquine, and within 72 hours the blood was clear of parasites. Corticosteroids in the form of hydrocortisone hemisuccinate were given in high dosage, initially 200 mg. four-hourly, without any observable effect on the course of the illness. He remained comatose for five days after admission, and during this time showed evidence of a left hemiparesis and suffered a generalized epileptic attack. However, he then rapidly regained consciousness and made a full recovery with no residual neurological sequelae.

In this patient diagnosis was delayed several hours because the temperature was normal on admission. The importance of blood-film examination in any unconscious patient who has recently returned from a malaria endemic area cannot be too strongly emphasized. In fact the diagnosis might well have been made when the patient first presented six days earlier with fever and headache. Blood-film examination at that time would have averted a severe illness and what could have been a fatal outcome. With successful treatment of the infection prolonged coma is unusual in cerebral malaria, but this case not only confirms that it does occur but also demonstrates the possibility of

complete recovery even after five days' deep coma, and fully justifies persisting with strenuous efforts to support the patient until consciousness returns.

Falciparum malaria in the non-immune justly deserves the prefix "malignant," and in view of its increasing occurrence in Britain must be recognized promptly and treated efficiently if we are to avoid fatal or near fatal results.—We are, etc.,

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Intraperitoneal Blood Transfusion

SIR,—The paper by Dr. J. M. Fowler and others (27 July, p. 220) certainly demonstrated the effectiveness of intraperitoneal blood transfusion in the adult, but as an aid to the treatment of severe anaemia there is a much simpler method.

If a short-acting diuretic is given during intravenous transfusion there follows a brisk diuresis which prevents circulatory overload. Fisher *et al.*,¹ using frusemide, have shown this method to be successful, while Ledingham² has transfused patients initially in congestive heart failure by adding ethacrynic acid to the transfused blood. Blood transfusions undertaken in this hospital on children with thalassaemia are always aided by a diuresis from frusemide, and over the past two years there have been no complications.

The technique is simplicity itself. The intravenous transfusion is started and 20 mg. of frusemide given intramuscularly. This dose is repeated if the urine output falls below the level of the fluid intake. This method has wide application for all severe anaemias, unless associated with renal disease; does not require the apparatus for exchange techniques, and retains an intact peritoneum.—I am, etc.,

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REFERENCES

- ¹ Fisher, J. A., Gibbon, J. E., Netscher, M., and Bradford, D. E., *Lancet*, 1966, 2, 545.
² Ledingham, J. G. G., *Lancet*, 1964, 1, 952.

Doctor or Social Worker ?

SIR,—I found your leading article (3 August, p. 265) on the Seebohm Committee's report¹ very pertinent and the remarks of Dr. J. D. Kershaw (24 August, p. 497) equally apt. I believe a few other points are also worth consideration.

Firstly, the expansion of community care programmes under medically qualified personnel capable of evaluating the service and the needs of the individual within the service would inevitably be stopped. Indeed, it seems certain that existing provisions would be curtailed. Many hospital consultants now recognize the value of comprehensive analysis of intertwining social and medical factors both within and without the hospital setting, and appreciate that, for the individual, the service should be fully co-ordinated. This is surely better done by administrators trained in medicine and sociology (i.e., social medicine consultants) and field workers with a

base in medicine and social work (i.e., health visitors).

Secondly, if workers dealing with the social factors of illness are entirely separated from the medical services a profoundly disturbing situation could arise. Patients referred for social difficulties with a medical causation—e.g., physical and mental long-term handicap—could be "treated" by social workers with little or no medical insight. This, I feel, is extremely likely to occur if those workers (e.g., psychiatric social workers) connected with the disabled are incorporated in the social work department. To some extent this already happens. Anyone in the profession must surely regard the development of a second-rate medical consultative service for the poor and socially vulnerable as highly undesirable.

Thirdly, the social factors concerned with the epidemiology would be much more difficult to elicit. This is because very few existing departments keep centralized records and are unlikely to develop them in the near future.

However, it is absolutely certain that social work should be organized in a single social work department. Indeed, the possibility of social workers being stationed in the field in the health centre working alongside general practitioners is an exciting one. Moreover, some may argue that the Seebohm Report's recommendations are based on the jealousy of a very new profession for the skill, power, and position of a very old profession. This, I feel, is not true. However, initially, before responsibilities are delineated, it is important to ascertain the true sociological role of the new social work department and to realize that a wrong analysis of the situation resulting in ill-trained staff in charge of the large resources governing medical services could cause inefficiency, lack of co-ordination, and the prevention of progressive developments.—I am, etc.,

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REFERENCE

- ¹ Report of the Committee on the Local Authority and Allied Personal Social Services, 1968, Cmnd. 3703. H.M.S.O., London.

Purgatives and the Colon

SIR,—As the manufacturers of standardised senna (Senokot) we have been greatly interested in the studies of Dr. F. Avery Jones¹ and Dr. Barbara Smith² on the "cathartic colon" and especially in your assessment of their work (13 July, p. 74) "Purgatives and the Colon."

The histopathology described by Dr. Smith clearly provides valuable objective evidence of the cellular damage caused by prolonged purging, but whether the effects described are specific to a particular drug or drugs, or whether they are the non-specific effects of excessive purging, is open to question. Dr. Smith favours the idea of a specific causation, because, as she puts it, "it is almost impossible to wear out a physiological reflex in the presence of normal neurones." An alternative and, we think, a more likely possibility is to be found in the atrophy which results from disuse of all muscle tissue. In the case of the colon, motility mechanisms are easily disrupted, and we suggest that atony leading to atrophy of its