leading conditions which may be associated with cerebral oedema.

Another paediatric condition in which raised intracranial pressure has recently been recognized is galactosaemia. P. R. Huttenlocher and his colleagues at Yale reported three newborn infants with galactosaemia who presented with a bulging fontanelle and jaundice. Meningitis was suspected in one case and sepsis in another until the true diagnosis was recognized. The optic discs are mentioned in only one case and are reported to have been normal. Rapid clinical improvement on a galactose-free diet was accompanied by return of the fontanelle tension to normal. The authors suggest that cerebral oedema in galactosaemia may be related to accumulation in the brain of dulcitol, the sugar alcohol derived from galactose, since animal experiments have shown this to accumulate in the lens of the eye in certain conditions.

The pathogenesis of raised intracranial pressure in the various clinical conditions mentioned is obscure in many cases and must clearly vary. Cases related to infections are less frequent than before, and more diverse causes are being recognized, among them medical treatment. Reports of further causes of it seem likely to come.

World Medical Assembly

The World Medical Association recently held its twenty-fourth Assembly in Oslo, with the Norwegian Medical Association as host. Among the delegates from 27 national member associations were those from the United Kingdom and the Irish Republic, from Australia, Canada, Ghana, India, and Pakistan within the Commonwealth, and from South Africa. A report of the meeting appears at page 581 of this week's B.M.J.

It is no disparagement of the W.M.A.'s indefatigable secretariat, still less of the wonderfully hospitable host association, to say that the yield from the six days' discussion and debate was disappointingly small. There was a good exchange of information on malpractice claims and the ways these are dealt with in different parts of the world. A two-day debate on the general practitioner's future produced a useful session on his education: it should begin well before the student's entry to the wards, where first acquaintance with the intellectual allurements of hospital practice are apt to blind him to alternatives. And, lastly, after some hesitation the Assembly committed itself to a first statement on therapeutic abortion. Admittedly not perfect, perhaps, the statement seeks to safeguard the rights of the doctor within society as well as those of his patients, and so is welcome. There was also the customary conference of editors.

Naturally much else goes on at a large international congress than ever appears in its recorded proceedings. People meet their opposite numbers, delegations exchange views privately and discuss their difficulties, and so on. These things alone could be held to justify the W.M.A.'s Assemblies. Nevertheless these meetings are costly, and member associations look to them to be as productive as possible. The W.M.A. is dedicated to raising standards of medical education, ethics, and practice and to improving health care throughout the world. Its potential for advancing these high aims is real. It would therefore be unfortunate if a reputation for inconclusive debating were to lead to less support of its work.

Much of the trouble at Oslo was procedural. For instance, a cumbersome reference committee system impeded discussion. Too often debates were diffuse, too late, or even occasionally duplicated. The sheer weight of documentation tended to cloud the important issues, and when agreement was reached delegates were sometimes left wondering what would follow. These are matters in which it may be hoped the W.M.A.'s council will turn its attention. The Assembly is the focal point of the year's activities. Inevitably, too, it catches the public eye. For both these reasons its streamlining is urgent.

Overcrowded Broadmoor

Founded in 1863 as a Criminal Lunatic Asylum, Broadmoor is an institution for the treatment under conditions of special security of patients of dangerous, violent, or criminal propensities to which intellectual subnormality as such does not contribute. It has undergone various changes in the hundred years of its history. For example, it has adopted the name of Broadmoor Hospital, added to its complement of inmates, and added a few feet to the height of its outer walls. Last week the Health Department announced that another institution of the same kind is to be put up in west Lancashire. Intended to accommodate 410 male patients, it will help to relieve "gross overcrowding" at Broadmoor.

The Mental Health Act 1959 transferred the emphasis for the care of mentally abnormal offenders from the prison service to the mental hospitals and so increased the demand for admissions to Broadmoor. But because of its limited accommodation only the very worst of such patients could be crammed in, thus leaving the rest to be managed in conventional mental hospitals, all ill-equipped for the task. The pressure is further heightened as a result of Section 72 of the Act, which replaced previous equivalent legislation. Under this section prisoners deemed to be suffering from mental disorder during their sentence can be transferred from prison to a mental hospital, which in the case of the highly dangerous can only mean to Broadmoor. P. McGrath,1 his physician superintendent, has reported that in 1965 22% of 157 admissions were so admitted. A more recent example of the use of Section 72 is seen in the return to Broadmoor of Martin Victor Frape,2 one of the Parkhurst Prison rioters, after their much-publicized trial.

The very nature of the work at Broadmoor and the pressures to which it is subjected, both internal and external, make it, despite its sylvan setting, a difficult institution to staff adequately. Yet it has an incomparable tradition of service to itself and to the community at large. Its record of escapes is by no means the most important criterion, yet since 1880 the list is limited to only 17 people. One was a child murderer who within hours of his cunningly planned escape killed another small girl. His deed serves as a constant reminder that in this hospital security must come first.

It is in the context of security that the present rumbles of

5 British Medical Journal, 1968, 1, 783.

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discontent among the nursing staff could be evaluated. The national press carried reports of two events at Broadmoor which are seemingly linked. The first was of an attempt at a mass break-out, foiled by the nurses. The second was of the proposed implementation of the scheme in the Salmon report by which the off-duty hours of senior officers in the evenings and at week-ends would be brought into line with those of office workers, thus depriving the hospital at these times of its most experienced staff. The danger of an actual break-out may have been exaggerated. And, as to staffing, some administrative adjustment in the number, training, and payment of senior officers could fill the gap even if the new scheme were introduced. But if the overcrowding at Broadmoor had not caused anxiety in the staff it would be surprising. The report of the Commons Estimates Committee published in 1968 reflected a grave situation. The main conclusion drawn from it in these columns was that the bad conditions had been allowed to drag on for far too long. Since the new hospital is not expected to be finished before 1974-5, the remedying of those conditions may fairly be described as somewhat lethargic.

Brave New Hospital

The opening of a lavishly equipped hospital and research centre is inevitably an occasion for congratulations. But when economy and retrenchment are on everybody's lips the apparent sparing of the new medical complex at Northwick Park from the worst of the cuts is particularly welcome. The Clinical Research Centre and the district hospital, still being built on the bunkers and greens of a former golf course, are far from the traditional academic ivory towers. Throughout the planning stages there has been a strong emphasis that, as well as being at the forefront of medical research and undertaking a "national" function, Northwick Park should have close links with the community. The hospital will provide a full range of district hospital services for the surrounding area, and members of the community will serve on its board of management. Local general practitioners will be brought into the hospital from the start as clinical assistants and in the postgraduate education programmes. Finally, an independent research team from the nearby Brunel University is already planning to assess how the hospital and the Research Centre are working from the community's point of view.

Amid so many plans the patient's needs have not been forgotten. Not only are his physical needs met in the way to be expected in a new hospital, but any experiments in which he consents to take part will have to follow a strict ethical code. As the Centre's Director, Professor G. M. Bull, told our Special Correspondent (page 576), all research on patients will be scrutinized by an ethics committee, and the procedure for obtaining informed consent has been strictly defined. With these safeguards one will look forward to the results of the research programmes which the Centre has planned. Distinguished workers in medicine and the sciences will be able to meet and exchange ideas in a centre specially built for their needs, yet they will have no formal teaching commitments. These conditions, which are claimed to be unique, should augur well for their results.

Sensitivity Tests in Tuberculosis

In treating tuberculosis it is better to have no sensitivity tests at all than to have inaccurate tests or faulty interpretations of them. Both can harm the patient.

An inaccurate report of isoniazid resistance on a culture made before treatment begins may lead to the choice of more toxic or expensive drugs than are needed. Faulty interpretation of a culture obtained during treatment can, for instance, lead to the mistaken conclusion that treatment has failed when in fact "transitional resistance" has arisen—that is, a culture with only a few colonies usually appearing just before the total disappearance of tubercle bacilli. This has no adverse prognostic significance.

But the value of sensitivity tests in treating individual patients has been exaggerated. They have an important role in research and in epidemiological studies, but only a minor one in clinical practice. Their role has been defined by G. Canetti and others. The tests are difficult to carry out, requiring far more care and precision than most routine bacteriological procedures. They are better done only in specialized laboratories where a well-trained and experienced staff can maintain a high standard. Even in Great Britain, with all its facilities, the general standard of sensitivity tests has been criticized. In 1965, for instance, J. Marks reported gross discrepancies between the results on cultures examined at the Tuberculosis Reference Laboratory and on the same cultures at many general bacteriological laboratories in the country. He concluded that "in most parts of the country the diagnosis of resistance in a recent case of tuberculosis is more often wrong than right." As a result of this report certain laboratories of the Public Health Laboratory Service in different parts of the country were designated to carry out sensitivity tests with uniform techniques and reporting methods.

In technically advanced countries it is considered best to carry out sensitivity tests on pretreatment cultures in all newly diagnosed cases. The object is to detect patients with initially resistant cultures and fit the chemotherapy regimen to the sensitivity patterns. Canetti and his colleagues suggest that this is unnecessary in countries where the level of primary resistance to drugs is known to be low. This may seem a revolutionary doctrine, but there is good evidence to support it. In Britain, for instance, the prevalence of primary resistance is low. Resistance to only one of the three drugs—streptomycin, isoniazid, and para-aminosalicylic acid (P.A.S.)—can be expected in only 3% of newly diagnosed patients. With the standard triple-drug regimen few, if any, of such patients will fail to become sputum-negative. It is only among those with resistance to two or three drugs that failure is probable, and these form only about 1% of the total. To apply routine tests to all patients is hardly an economical procedure.

When treatment is failing, the fact can often be detected by simple examination of the sputum by microscopy every month. A clear fall and rise in the quantity of bacilli in the sputum smear indicates bacteriological "escape" and the

5 Poppe de Figueiredo, F., Tubercle, 1969, 50, 335.