marks is a generalized non-itching rash—indeed, I saw a girl of 17 recently who was pregnant, had had a sore throat a week earlier, and had developed a non-itching generalized rash. I sent her to our V.D. department with a confident diagnosis of early secondary syphilide which was confirmed by the consultant.

I was taught that all non-itching rashes should prompt one to remember this possibility.—I am, etc.,

Leeds

I. Rose

Particles in Spleens

Sir,—Drs. M. Tavassoli and R. Judith Ratzan (1 April, p. 48) have suggested that the unusual particles described in spleens by my colleagues and myself (18 December 1971, p. 721) were platelet lysosomes. We have been reluctant to accept this explanation because our particles are much smaller than lysosomes (Figs. 1 and 2). We agree that lysosomes have a structure which resembles some virus particles and indeed pointed this out in our original communication. We used the euphemistic term “unusual particle” because of the uncertainties shared between ourselves and others over cell organelles which mimic virus. These organelles include a range of structures quite apart from the lysosomes mentioned by Drs. Tavassoli and Ratzan. They include secretory granules of endocrine glands, the darkly staining particles of the juxta-glomerular junction, and bristle coated vesicles. Another source of difficulty, which I have not so far found in the literature, is the pinocytosis of electron dense reticular cell cytoplasm by adjacent lymphocytes (Fig. 3). Nevertheless, my first impression and indeed, persisting impression, of these particles is their noteworthy resemblance to particles described as virus by Schwartzendruber et al. in a mouse strain with a high leukaemic incidence, by Gross in transmissible murine leukaemia, and by Dmochowska in human neoplasms.

Some may say why show concern over virus in the spleen. After all virus is ubiquitous, and even when found who can say whether it is passenger or driver. It seems better to formulate a hypothesis rather than botanize amidst the aridity of structural detail. Our working hypothesis is that a diversity of auto-destructive haematological conditions may be due to virus particles which render cell membranes auto-antigenic, and manifestations depending on which particular stem cell has been infected. Furthermore, the presence of such virus in healthy people would indicate not lack of pathogenicity on the part of the particle but tolerance on the part of the host, production of disease depending on the equilibrium between tolerance and immunity to the agent.

The conclusion drawn by myself and colleagues is not that these particles are lysosomes or cell organelles, but rather that they are sufficiently intriguing to warrant a detailed investigation.—I am, etc.,

Angus Stuart

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1 Schwartzendruber, D. G., Ma, B. J., and Murphy, W. H., Advances in Experimental Medicine and Biology, 1968, 5, 201.

Community Mental Health

Sir,—It is still frequently believed that the management and care of mental patients in the community has to be directed mainly from the hospital and it is disheartening that even some of our own colleagues do not seem at all well acquainted with the important contributions community psychiatrists and social workers make towards psychological medicine in general. One of the main deficiencies of the present system appears to be the sharp division between the hospital and community mental health services and their facilities. The one is usually not responsible for the other, a system which creates tremendous difficulties especially when a patient has to be admitted and the hospital or community establishment, sometimes both, refuse to accept him with seemingly little concern for the fate of the patient.

I would like to propose the establishment of a career grade—namely, that of the community psychiatrist with the status of a consultant. His functions should include, but not be limited to, taking charge from a psychiatric point of view of all mental health facilities in the community, give advice on the welfare and needs of patients contained in them, and, equally important, work as a consultant to the group of his family practitioners. This would be a most onerous task and should take the greater part of his time.

He would also advise the local authority on improvements, extensions, and new facilities required for present and future community psychiatric needs, and work closely with those responsible for planning on the hospital side. In effect, he would be in close contact with colleagues in other branches of psychiatry and medicine, whether in hospital or community, in order to participate in a uniformly agreed management of mental patients.

Some of his time would be set aside for research into the dynamics of psychiatric illnesses as these affect people in the community with a view to evaluating appropriate care and new treatments. This might possibly suggest more suitable management and treatments. A better acquaintance with the patient’s environment and a knowledge of suitable alternate placements creates for the community psychiatrist an advantageous yet impartial position from which to advise on appropriate placement, should admission to one or other establishment be refused and the patient left to the often unsatisfactory device of family members.

To second a psychiatrist for one or two sessions a week to the community services is, in my view, of little use. The proposed appointment should allow for at least half of the sessions of a full or maximum time employment to be spent with the community services. It would be equally unproductive, however, if all the psychiatrist’s sessions were relegated to the community at the exclusion of hospital staff. The suggested ratio of commitment between community and hospital with emphasis on community work should meet the requirements of advice on psychiatric illnesses in the community. In my view, such a scheme, although not fully implemented, has been in operation for a number of years, and seems to have met with some success.

It is not unrealistic to expect a generic social worker to undertake the very specialized and often difficult task of caring for mental patients in the community. Social work in psychiatry plays a very significant role and I can see no alternative but to amalgamate once again psychiatric social workers with psychiatrists whether engaged in the community or hospital, a suggestion which is in accord with recent recommendations of a tripartite committee on the closer association between personnel working in the field of mental health.

Time is running out and unless some
agreement can soon be found, 1974 might well see an even greater disintegration of the mental health services than occurred after the implementation of the Local Authority Social Services Act of 1970 whereby medical and social services have become further separated than ever before. It would be a grave mistake to reduce psychiatric hospital accommodation before an adequate and well-integrated community psychiatric service has been established.

The views expressed are my own and do not necessarily reflect those of my employing authorities.

— I am, etc.,

London N.W.6

U. P. SEIDEL

Cold Drink and Syncope

Sir,—A case is reported of a man who had a syncope attack on drinking a glass of cold beer.

A 41-year-old Royal Air Force N.C.O., serving in the sultanate of Oman, was drinking a glass of cold beer after a warm afternoon's work. On taking an initial large mouthful he swallowed, experienced a very severe pain of a "bursting" nature in the lower retrosternal region, and collapsed pulseless to the floor. This was witnessed by a trained nurse. Almost immediately he recovered and felt perfectly fit and well. On further questioning it appeared that he had suffered similar episodes on three occasions since the age of 17 years and always when drinking cold liquids quickly.

On each of the five minutes his colour was good, and no abnormality was detected. His temperature was 98.4°F (36-9°C); pulse 80/minute, regular, and good volume; blood pressure 125/80; no cardiovascular abnormalities detected and the fundi were normal. Routine investigations were all normal.

Usually syncope is due to an extreme fall in blood pressure, or a slowing or standstill of the heart. The precipitation causing a syncope in some cases.

It is suggested that in this case the mechanism of collapse was as follows. The drinking of the cold fluid led to an acute spasm of the cardia and dilatation of the esophagus. This caused an increase in intrathoracic vascular tone, thus slowing the heart and producing a sharp fall in cardiac output, sufficient to cause syncope.

The history of drinking cold fluids, followed immediately by a "bursting" lower retrosternal pain, suggests that spasm of the cardia leading to oesophageal distension initiated vagal stimulation. Weiss and Ferries described a case in which a patient with an oesophageal traction diverticulum experienced fainting and cardiac standstill when swallowing. This was reproduced by oesophageal distension and prevented by atropine. In this case there was no evidence of oesophageal diverticulum on barium studies. The history and circumstances make a diagnosis of intermittent heart block unlikely, particularly as the symptoms had only occurred three times in the previous years, and only on rapid ingestion of cold fluids. Also the electrocardiogram was normal, with no QT prolongation as in the cases reported by Gale.

Although ingestion of cold fluids has been shown to delay repolarization of the posterior heart wall as demonstrated by E.C.G. changes in normal and abnormal hearts, there is no evidence that this is deleterious to the subject. In that series maximal electrocardiographic changes occurred within five minutes of drinking iced water, and subsided completely within minutes. In the case described here there were no T wave changes to suggest a direct action of the cold beer on the myocardium.—I am, etc.,

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1 Weiss, S., and Ferries, E. B., Archives of Internal Medicine, 1970, 112, 505.

Facial Palsy in Tetanus

Sir,—Palsy of skeletal muscles in tetanus is unusual. An unusual case of tetanus presenting with facial palsy is reported here. A male aged 42 years fell from a bicycle and abraded the skin. Eight days later he developed lock-jaw and was admitted to Darbhanga Medical College Hospital where a diagnosis of tetanus was made. The next day he developed stiffness of the neck and the recti abdominis, showed some ophthamoplegia, and a mild numbness was evident on the left side of the face. Apart from the frontal belly of the occipito-frontalis the right side of his face was paralysed. The patient could not close the right eye. No other neurological abnormality was detected. The pulse rate was 120/min, but no other abnormalities were found.

For about a week there was no change in the patient's condition, and he had no muscle spasms. Gradually he began to improve and three weeks after the accident the rigidity of the neck and recti abdominis had disappeared, and the heart rate had returned to normal. Ten days later the facial palsy had regressed.

Local tetanus is a well-recognized entity but facial palsy as one of its manifestations is certainly unusual. The condition is mentioned by Park but not by Kloetzke in his study of 84 cases of severe tetanus. The explanation of this condition is difficult. Wright et al. believe that the toxin is absorbed by the motor end plates and spreads up in the space between the nerve fibres. The toxin then excites the anterior horn cells and later diffuses to involve the whole of the central nervous system. This explanation is adequate to explain rilsan sardonicos but not the facial palsy. The lesion is supposed to be on the facial nucleus (the cranial homologue of anterior horn cells) the frontal belly of the occipito-frontalis has been involved.

It is assumed that the toxin acts on the motor end plates the present case should be easy to explain. It is possible that the toxin ascended up the nerve fibres to reach the C.N.S. and excite various muscles. In the