affected bowel was resected. The patient was given massive doses of steroids, antibiotics, and fluid replacement for septicaemic shock and gradually recovered. Clinical features of myxoedema were then apparent and this was confirmed by iodine studies. The patient's appearance and bowel habit returned to normal with thyroxine. Histologically, the resected bowel showed features of acute ischaemic colitis.

Constipation and abdominal distension are well-recognized features of hypothyroidism. Gross colonic dilatation in this patient was followed by mucosal ischaemia and necrosis, allowing the development of septicaemic shock secondary to invasive infection. The usually fatal outcome in this condition was avoided by prompt excision of the diseased bowel and intensive therapy for septicaemic shock.—We are, etc.,

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- 1 Chadda, J. S., Ashby, D. W., and Cowan, W. K., *British Medical Journal*, 1969, 3, 398.
- 2 Liechty, R. D., Miller, R. F., and Cohen, W. N., *Surgical Clinics of North America*, 1970, 50, 1087.
- 3 Marston, A., et al., *Gut*, 1966, 7, 1.

Conversations on the Social Services

SIR,—I certainly sympathize with some of your special correspondent's criticisms of local authority social services departments (22 June, p. 659) but am glad he appreciates some of our difficulties. Time will doubtless heal the wounds and disabilities inflicted by all the recent reorganization, not least of which are this year's local government and N.H.S. restructurings. However, as we all strive to practise the flexible community-oriented care which the 1972 N.H.S. White Paper outlined "to provide for the population of a given area of a comprehensible size the best health service that the money and skills available can provide,"¹ we realize only too clearly that much of the work of a social services department does indeed present in the general practitioner's surgery.

While social workers do understand the "threat" they and their rapidly developing bureaucracies pose to the single-handed practitioner and the frustration this ever-changing personnel and structures can cause, they equally feel threatened by those doctors who remain on their "professional pedestals." One of the major problems can be lack of accurate and perceptive communication between us when we employ fundamentally different jargon and philosophies, doctors being accused of being unnecessarily brusque and social workers as being hopelessly long-winded.

It is essential that we talk purposefully together. While the case conference offers a valuable avenue, it can be abused when utilized in the way your correspondent describes, and both professions are guilty of that. It should be used only where appropriate and in the enhancement of increasingly necessary interdisciplinary teamwork, both within and outside the hospital. Until the principle of linking social workers in social services departments with group practices is fully accepted by both doctors and social services administrators alike the most functional type of communication must be individual contact, preferably face-to-face, as the needs arise. In that

way we can, it is to be hoped, get to know each other better.

In our patients' best interests, therefore, we can do our jobs realistically only by mutual collaboration. That means remembering that it was our own Seeborn Report which exhorted social services departments to "make a determined effort to collaborate with local general practitioners," and similarly that the authors hoped that "the doctors will also exert themselves."² It was, after all, that very report which reminded us that G.P.s see "a higher proportion of those who are in difficulties than any other of the social services" and they accordingly need "the full support of them all."³

Incidentally, some of my best friends are G.P.s—I am, etc.,

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- 1 *National Health Service Reorganization: England*, p. vi, Cmnd. 5055. London, H.M.S.O., 1972.
- 2 Committee on Local Authority and Allied Personal Social Services, Report, para. 700, Cmnd. 3703. London H.M.S.O., 1968.
- 3 Committee on Local Authority and Allied Personal Social Services, Report, para. 692, Cmnd. 3703. London, H.M.S.O., 1968.

SIR,—As a health visitor may I comment on "Conversations on the Social Services" (15 June, p. 595). There is indeed some overlap between social workers and health visitors since both may be supporting the same client. However, the health visitor is primarily concerned with prevention and early detection of illness, both physical and social, and works with normal families to a greater extent than the social worker.

I should not like your readers to gain the impression that the health visitor is to be regarded as a second-best social worker. Before Seeborn we had in fact several duties that have now been ascribed to the social services departments. Those of us attached to general practices often act as a liaison between the practice and the statutory and voluntary social services in the area. I would also remind your readers that all health visitors hold the S.R.N. and health visitor certificates, as well as having some training in midwifery. The majority of social workers still have no professional qualification.—I am, etc.,

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Medicine in China

SIR,—Dr. I. Gordon (22 June, p. 674) has questioned the epidemiological sense of the concurrent observations that at the present time cervical cancer is common in China while premarital intercourse, venereal disease, and early marriage are reported to be very rare and frowned upon. This confusion ignores the obvious latent or incubation period between cervical cancer and the antecedent sexual behaviour. Dr. Valerie Beral¹ has most elegantly and convincingly demonstrated that the mortality rate for cervical cancer for an age group mirrors the reported incidence of gonococcal venereal disease for the period during which that age group was about 20 years old, based on data for the British Isles. Thus cases of cervical cancer identified today would reflect the sexual activity of 15-20 or more years ago, and reports of cervical cancer deaths today would reflect sexual activity at an even earlier time.

All reports from China today that indicate the low incidence of premarital intercourse, venereal disease, and early marriage make the point that these observations are in contradistinction to the situation prevailing a few decades ago. Thus the concurrent observations are not contradictory, but rather they hold out the possibility that the incidence of cervical cancer in China may be seen to fall markedly in succeeding decades.—I am, etc.,

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- 1 Beral, V., *Lancet*, 1974, 1, 1037.

Jaundice in Acute Pustular Psoriasis

SIR,—With regard to the case presented by Dr. D. J. Warren and others (25 May, p. 406), I should like to report a case of pustular psoriasis sharing one feature—namely, jaundice—with theirs.

A woman of 62 who had a three-year history of psoriasis with arthropathy treated with various drugs, including systemic methotrexate, was admitted with generalized pustular psoriasis. Pulses of intravenous methotrexate were given every 14 days and she remained stable for six weeks, when she developed a spike of temperature. She was started on fusidic acid and clindamycin (because of the report by McFadyen and Lyell¹ that antistaphylococcal treatment induces remissions of pustular psoriasis) and blood cultures were taken, which later proved sterile. No other evidence of infection was found. She had had no methotrexate for the previous 10 days.

Three days later she developed jaundice accompanied by marked leucocytosis. The jaundice was unusual in that it was unaccompanied by malaise; that the serum bilirubin was virtually all conjugated (to a maximum of 11.0 out of 12.2 mg/100 ml); that the bilirubin levels fell two days after her antibiotics were stopped and had returned almost to normal before any abnormality in the transaminases and alkaline phosphatase was noted; and finally that the leucocytosis reached very high levels (55,000/mm³), rising and falling in parallel with the bilirubin level. Thrombocytopenia prevented liver biopsy at this time. She died six weeks later and at necropsy there was a small, pale liver, histological examination showing moderately acute hepatitis with mixed cell infiltration of the portal tracts and severe fatty degeneration sparing the periportal areas.

The type of jaundice was difficult to classify, the conjugated bilirubin making it closest to, but much more severe than, the Dubin-Johnson type of congenital hyperbilirubinaemia. The subsequent rise in transaminases and alkaline phosphatase and the postmortem histology also make this diagnosis unlikely. It seems unlikely that the jaundice was due solely to oligaemia, pustular psoriasis, or methotrexate treatment. It seems possible, in view of the temporal relationship, that the giving of antibiotics and the jaundice were related. Both antibiotics concerned are excreted by the liver, and fusidic acid can compete with bromsulphalein for its excretory pathway, suggesting that an acquired intracellular transport defect could have developed.

However, it also seems possible that the liver in pustular psoriasis is predisposed to damage by the factors mentioned above, and it might be prudent to avoid drugs excreted by the liver in patients with generalized pustular psoriasis.—I am, etc.,

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- 1 McFadyen, T., and Lyell, A., *British Journal of Dermatology*, 1971, 85, 274.