May 1971 over 100 cases have occurred among workers in shipyards on the Clyde and other industrial concerns in the west of Scotland. The peak of the outbreak was reached at the end of June and beginning of July, and a decreasing number of cases are still being notified. Those mainly involved are shipyard personnel working on the open decks of ships under construction, and only a few non-industrial workers have been affected. As in previous outbreaks in the Clyde Valley in 1956, 1967, and 1968, adenovirus type 12 was the causal virus.1,2

While we agree that medical personnel are frequently the cause of the passage of the virus from patient to patient, spread also takes place outside the hospital or shipyard ambulance room, probably as a result of such procedures as amateur first aid for foreign bodies. In the present Clyde-side outbreak many of the patients presented with the condition at the ambulance room and had not been to a clinic with another condition. Furthermore, spread within families was a feature of the 1967 outbreak (Taylor, personal communication). However, an inquiry1 into an outbreak which had shown that only 6 of 103 patients questioned specifically on this point had another family member suffering from conjunctivitis. This curtailment of family spread may well be due to propaganda given at the ambulance rooms and clinics since the earlier outbreaks to ensure that the patients are punctilious about hand washing, use of personal towels, etc. Autococulonization by contaminated fingers is probably the reason for some of the cases we have encountered among doctors, nurses, or ambulance-room attendants. The importance of hand washing is illustrated by Wegman and his colleagues in an outbreak in an American hospital, which ceased after the institution of thorough washing of hands and instruments with soap and water.4 We suggest that this measure should be added to the recommendations given by the Bristol workers.—

We are, etc,

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Pregnancy Testing

Sir,—Mr. A. D. Thurst (25 September, p. 769) and Dr. F. W. Winton (30 October, p. 296) draw attention to the “free” pregnancy testing facilities available through National Health Service laboratories. We also, like Dr. Winton, are disturbed over the increasing numbers of these tests. It must be realized, however, that the increasing demand for laboratory examinations is by no means confined to pregnancy tests. This laboratory covers the disciplines of bacteriology, haematology, clinical biochemistry, and toxicology. In 1960, a gross total of 67,018 specimens (not tests) of all kinds were received, of which 1,978 (2.9%) were pregnancy tests. In 1970 the gross total had risen to 134,433, of which 6,221 (4.6%) were for pregnancy testing. According to the 1961 Census, it is calculated that there will be more pregnancy tests performed in this laboratory during 1972 than there will be births in the whole of R. ELLIS, M. D.

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Care of Chronic Psychotics

Sir,—We find it necessary to challenge some of the claims made by Drs. M. Z. Hussain and A. C. Taylor (18 September, p. 703) about psychiatric services in Saskatchewan. It is true that Saskatchewan once had the highest ratio of patients in mental institutions in Canada, and also probably one of the worst mental hospitals in the world.1 Also, it is true that during the sixties the Saskatchewan Hospital, Weyburn, showed the sharpest decline in population of any hospital in the western world. However, despite the repeated and numerous claims emanating from Saskatchewan we cannot agree that the effectiveness of so-called community care in that Province has been subverted.1 The big discharge began in 1964, and by early 1966 there had been complaints concerning the rate of discharge and the standards and conditions in homes in which the patients were being placed. An ad hoc committee investigated these complaints, and in June 1966 suggested tighter laws and improved standards for placement homes. However, complaints continued about the early discharge of patients who were still symptomatic and also about the standards in approved homes. When a former patient murdered nine people, the concern became so widespread that another inquiry was instituted under Professor Shervert H. Frazier at the end of 1967. The following extracts from the Frazier report2 are of interest:

"Another common theme was that the Weyburn Hospital (Main Building) had adopted a policy of discharging patients no matter what the situation, the patient's condition, etc. Several mentioned that a 'statistical approach' had replaced an individual psychiatric evaluation in cases..."

"Recommendation 11: We suggest that the practice of early discharge be brought in line with the principles that discharge is determined by bed counts, ‘statistics,’ or attempts to satisfy institutional goals, but by the needs of the patient, his family, and his community."

"Recommendation 23: Outpatient care and especially home-placement should be enriched more therapeutic by the addition of such as many of the following programs as feasible: sheltered workshops, half-way houses, day treatment centers, vocational rehabilitation programs, additional recreation, social clubs, exercise classes, nutritional guidance, and classes in personal hygiene."

It can be seen very little change since 1967, although the hard core of presumably non-dischargeable patients has resulted in a leveling off in the residual mental hospital population. We find it incomprehensible that a hospital which has discharged in population from 2,600 to less than 400 beds should still retain a ward with over 100 patients. We are by no means in favour of the continued existence of such a large mental hospital, but we are concerned at their being phased out without any adequate planning for alternative methods of care.

Drs. Hussain and Khan mention that the readmission rate has dropped dramatically for the Prince Albert unit. As 1970 was the first full year of operation we question the validity of this statement. Reference to the Yaroslav Report, which became the Royal Commission on Mental Hygiene in 1964, shows that a readmission rate of less than 40% in the first year gradually rises to over 70%, together with an average length of stay of 27.5 days by 1969, both of these figures being the highest for any facility in the Province. It seems likely that Prince Albert will reveal a similar trend over the next few years.

Finally, we view with increasing suspicion all publications which show an obsessive preoccupation with statistics such as beds per 1,000 population, while revealing nothing about what is really happening to the patients contained in these statistics.—

We are, etc.

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Neurofibromatosis and Childhood Leukaemia

Sir,—Drs. W. M. McEvoy and Jillian R. Mann (11 September, p. 641) describe the association of neurofibromatosis with acute myeloblastic leukaemia in a 5-year-old boy,


Weyburn, Saskatchewan, Canada