have been the ideal solution to the problems of semantics which some of us have tried to resolve recently. Unfortunately, the meaning implied by this term as used by Dr. Cyriax is far too narrow to be generally acceptable, and it has seemed best to widen the concept of "rheumatology" to encompass the whole spectrum of that branch of medicine concerned with connective tissue diseases and with medical disorders of the locomotor system, including every aspect of their aetiology, diagnosis, management, and rehabilitation. At the same time the outdated and misunderstood name "physical medicine" is being honourably buried, as indicated in your recent leading article (28 October, p. 188).—I am, etc.,

D. R. L. NEWTON

Rheumatology Unit,
Middlesbrough General Hospital,
Teesside

Dangers of Diazoxide

SIR,—May we comment on the plea made by Dr. M. S. Knapp and others (28 October, p. 229) for the controlled studies of the use of diazoxide in the treatment of hypertension.

We stated clearly in our relevant publications^{1,2} that our patients were selected for resistance to conventional hypotensive therapy. The question of a controlled trial does not arise under these conditions. We think it unjustifiable to add to the present knowledge of the natural history of uncontrolled malignant hypertension associated with progressive renal failure by running control groups under these circumstances.—We are, etc.,

J. E. F. POHL
H. THURSTON

Royal Infirmary,
Manchester

¹ Pohl, J. E. F., and Thurston, H., *British Medical Journal*, 1971, **4**, 142.

² Pohl, J. E. F., Thurston, H., Davis, D., and Morgan, M. Y., *British Medical Journal*, 1972, **2**, 568.

Immunological Responses in Pregnancy

SIR,—Dr. Ronald Finn and others (15 July, p. 150) suggest that the reduced T-cell activity demonstrable in pregnancy may be due to a reduction in the number of T lymphocytes. B lymphocytes can be detected by the abundant surface immunoglobulin that they carry. We therefore tried to find out whether B lymphocytes make up a greater proportion of the total lymphocyte count in pregnant women—as they should do if there is a deficiency of T lymphocytes—and also whether the total lymphocyte count is reduced. Thirty-four pregnant women, all at least in the sixth month, were studied. On each occasion that blood was collected from pregnant women it was taken at the same time of day from an equal number of healthy non-pregnant women of similar age. Of the 34 control women more than three-quarters were known not to be taking oral contraceptives.

Total leucocyte and differential counts were carefully done by conventional methods, all by the same worker with exactly the same technique. Lymphocytes were prepared by the method of Boyum.¹ The proportion of lymphocytes bearing surface immunoglobulin (B cells) was determined by the method of

	Pregnant	Control	Difference of Means ÷ S.E.	Remarks
Leucocytes/mm ³	4,360-17,880 Mean 10,600 S.D. 3,122	3,520-14,000 Mean 6,169 S.D. 2,055	6.9	Highly significant
Polymorphs/mm ³	2,485-15,630 Mean 8,220 S.D. 2,926	1,370-12,040 Mean 3,821 S.D. 1,861	7.4	Highly significant
Lymphocytes/mm ³	752-4,920 Mean 2,439 S.D. 892	1,140-3,920 Mean 2,351 S.D. 606	0.5	Not significant
Percentage fluorescent (B) lymphocytes	2-19% Mean 8.5% S.D. 4.5	1.5-23% Mean 8.0% S.D. 5.0		
Fluorescent (B) lymphocytes/mm ³	39-550 Mean 214 S.D. 143	28-900 Mean 206 S.D. 158	0.2	Not significant

Papamichail *et al.*² using the labelled Wellcome antiglobulin serum MF 01. At least 200 lymphocytes from each subject were individually examined, each one being positively identified by weak dark-ground tungsten illumination before switching to ultraviolet to look for fluorescence. Illumination was by transmitted light. The same worker did all the fluorescence tests. The Table shows the results, which suggest that there is no appreciable reduction in the number of T cells or in the total lymphocyte count in pregnancy. There is, as is already known,³ an increase in the polymorph count, and consequently in total leucocytes, in pregnant women.

The relatively insensitive method of fluorescence with transmitted ultraviolet light may not, of course, detect all the B cells in a preparation. Methods using radioisotopes⁴ give higher proportions of B cells. If there were in fact relatively more B cells in pregnancy but the mean amount of immunoglobulin on them was less results like ours might still be obtained, but since the total lymphocyte count is very similar in both groups this seems unlikely.

One of us (P.B.) was supported by a grant from the South African Medical Research Council—We are, etc.,

P. BRAIN
R. H. MARSTON
JUNE GORDON

The Natal Institute of Immunology,
Durban, South Africa

¹ Böyum, A., *Scandinavian Journal of Clinical and Laboratory Investigation*, 1968, **21**, Supplement 97, p. 77.

² Papamichail, M., Brown, J. C., and Holborow, E. J., *Lancet*, 1971, **2**, 850.

³ Wintrobe, M. M., *Clinical Hematology*, 3rd edn., p. 202. Philadelphia, Lea & Febiger, 1951.

⁴ Wilson, J. D., and Nossal, G. J. V., *Lancet*, 1971, **2**, 788.

Community Care in Perspective

SIR,—Evidence of an increasing population of homeless single people, particularly in London, is increasing.¹⁻³ The number of homeless single people has risen in the last seven years from 30,000 to 50,000. This includes those in common lodging houses, hostels, reception centres, and those sleeping rough. Of the latter, 10,000 is a conservative estimate for London alone. This population is a floating one circulating back and forth among our hospitals, hostels, and prisons. The number of patients in psychiatric hospitals has dropped from 131,000 to 109,000 between 1964 and 1971—a drop of 22,000 which closely approximates the rise in the number of homeless single people in the community over the same period.

Some 185,000 people are discharged from psychiatric hospitals and units each year, and the number with inadequate personalities is rising steadily as the longstay mental hospitals are being phased out. Sixty per cent become homeless after their first hospital admission. Owing to the lack of facilities for resettlement and rehabilitation these handicapped people make up some 50-75% of the residents of common lodging houses, Salvation Army hostels, and the like as well as 30-50% of the prison population in England and Wales. It is to be regretted that no one central government department is responsible for this state of affairs. Local authorities are empowered to provide residential accommodation for the homeless and to give financial aid to lodging houses, but these powers have not been implemented in the absence of a legal obligation. Research in this field is virtually left to voluntary agencies with their limited resources. Prison medical, including psychiatric, treatment is financed by the Home Office and is thus divorced from the National Health Service.

The problem takes on gigantic proportions in London, where plans to redevelop certain areas involve demolition of no less than 40% of the registered common lodging houses. In the whole of London the number of beds has fallen from 6,000 to 4,000 since 1961. All this reduces community care to mere disposal overwhelmed by the rapid discharge rate, the loosening of family ties, and the increasing pressures the outside world imposes on inadequate people handicapped by personality disorders.

Further surveys are needed to define the size of the problem, but some recommendations can be made in the light of available data. Responsibility and legal obligation must be clearly delegated to the local authorities, and services (medical, social, resettlement, and rehabilitation) must be extended within the community with their full complement of staffing. Grants must be extended to voluntary bodies for research as well as to psychiatric aftercare hostels to upgrade the services they provide. Hostels that are closing down need to be replaced by adequate accommodation to meet the increasing demand. All community facilities must be closely integrated in order to provide proper care for the destitute. Until such time as these recommendations can be implemented hospital psychiatrists ought to review their policy of early discharge of certain types of patients who need more support in the community.—We are, etc.,

M. F. SALAMA
B. L. HUDSON

Guy's Hospital,
London S.E.1

- ¹ Tidmarsh, D., Woode, Susanne, King, J. K., Report on Research at Camberwell Reception Centre, 1972.
- ² House of Commons. Parliamentary Debates (Hansard), *Single Homeless People*, August 2nd, 1972, p. 639. London, H.M.S.O.
- ³ National Association for Mental Health. Mind Report No. 7, *Hospital, Prison or Pad*. London, N.A.M.H., 1972.

Geriatric Practice

SIR,—Dr. Graham M. Hunter and others (28 October, p. 224) are to be congratulated on the succinct way in which they presented a number of important aspects of the practice of geriatric medicine. I would make two comments.

(1) There may be some advantages in the clinical management of cases if the pre-admission home assessment visit is paid by a physician in the geriatric unit. One basic principle in geriatric medicine is the need to make a diagnosis, and he is perhaps the best skilled person to assess the medical component of the multiple disorders (physical, mental, social and economic) which may be present and so estimate the degree of urgency for hospital admission. Early assessment by the medical social worker is also essential so that the patient's discharge from hospital can be anticipated even before hospital admission is arranged, but the details of the help that may be required cannot be arranged until the patient is nearing "peak performance" after investigation, treatment, and rehabilitation.

(2) Perhaps one should be cautious about putting steroids into weight-bearing joints. The relief of pain may allow the patient to over-exercise the joint and there is a risk of the development of a Charcot-like joint. —I am, etc.,

C. COHEN

Stracathro Hospital,
Brechin, Angus.

Hereditary Nephritis

SIR,—Your leading article on hereditary nephritis (12 August, p. 367) states that "though the urinary abnormalities are present equally in affected males and females, the prognosis differs enormously between the sexes," and that "this pattern of the disease is consistent in the majority of families, but rarely there is a more benign disorder [in men] or more serious lesions in females." Indeed such peculiarities of the typical pattern of the disease were until recently only exceptionally reported in the literature, and the severity in female patients

□ male ○ female
● nephropathy
■ uraemia
†(20) dead (age at death)
• perceptible deafness
△ ocular (lens) lesion

was usually attributed to intercurrent pregnancies, though some observations contradicted this concept.^{1,2} Our own experience with 12 Greek families seven of which have been published³ is consistent with the recent suggestion that "prognosis appears to differ not only between sexes but also among kindreds."^{4,5} One such family, in which the disease was severe in the female patients, is shown in the figure. Out of four sisters in the third generation three were dead from uraemia at the ages of 43, 24, and 24 respectively. The fourth, now 40 years old, is already uraemic.—We are, etc.,

ALEXANDER SYMBOULIDIS

SONIA VOUDICLARIS

DORA MAYOPOULOU-SYMYVOULIDIS

ANTONIOS KATIRTSGLOU

Renal Unit,
2nd Department of Internal Medicine,
University of Athens,
Hippocraton Hospital,
Athens

¹ Buchem, F. S. P., Van Beetsstra, A., *Acta Medica Scandinavica*, 1966, **179**, 319.

² Purriel, P., *American Journal of Medicine*, 1970, **49**, 753.

³ Symbooulidis, A., Voudiclaris, S., Mayooulou-Symbooulidis, D., Oreopoulos, D., and Yatzidis, H., *Nosokomiaca Chronica*, 1968, **30**, 491.

⁴ Chazan, J. A., Jacks, J., Cohen, J. J., and Garcia, S., *American Journal of Medicine*, 1971, **50**, 764.

⁵ Ferguson, A. C., and Rance, C. P., *American Journal of Diseases of Children*, 1972, **124**, 84.

Hypothyroidism in the Elderly

SIR,—Dr. Graham M. Hunter and others (28 October, p. 224) are to be congratulated on their charming tale of two sisters, which tells how the diagnosis and treatment of their multiple maladies led to the preservation of the integrity of their home. Hypothyroidism is indeed one of the diseases of insidious onset which is easily missed by the unwary, especially if the sufferer has already been classified in the doctor's mind as "senile."

I often think the medical profession should cultivate that persistent and astonished inquiry epitomized so well by Father William's son in *Alice in Wonderland*,

You are old, said the youth, and your jaws
are too weak
For anything tougher than suet;
Yet you finished the goose, with the bones
and the beak—
Pray how did you manage to do it?

It is unsafe to assume that age, dementia, and incompetence go hand in hand without making diligent inquiry. Fortunately patients seldom react to this as Father William eventually did.

But there is another aspect of this condition which deserves notice. I have twice been asked to admit a patient because she had become too much for her daughter or he for his wife to manage. In one case the proposed patient was not suffering from any noteworthy disorder or incompetence, but to shake the daughter's hand was enough to reveal her coarse, dry, cold skin and to recognize that it was myxoedema in the daughter aged 60 not disease in her mother aged 84 which was the root cause of the trouble.

In another case, though the husband was confined to his bedroom by osteoarthritis and pain (which proved to be due to myelomatosis), it was apparent on visiting the house that hypothyroidism developing in his wife was partly responsible for her impaired capacity to care for him.

Dr. Hunter and his colleagues describe how their patients' problem was solved by investigation within the hospital. I would like to stress, though not for their benefit, the value of home visiting and domiciliary consultation by the physician. Consideration of the patient's social setting and the influence of disease on it affords much of the delight of geriatrics. Medical diagnosis is certainly easier in hospital but people live at home, and the pleasure obtained from helping them to do so is great indeed.—I am, etc.,

T. W. LLOYD

Gloucestershire Royal Hospital,
Gloucester

Mercury in the Environment

SIR,—Your leading article on mercury in the environment (10 June, p. 605) stated that the International Red Cross did a fine job in organizing the rehabilitation of 10,000 people paralysed by triorthocresyl phosphate sold as edible cooking oil in Morocco in 1959, "but the devastation in Iraq is probably less amenable to therapy and rehabilitation." We would like to comment on this point.

The damage from the mercury poisoning is believed to be "irreversible." Presumably that is why you state that the condition is "less amenable to therapy." It is true that necropsies, especially in our cases of pre-natal poisoning, have shown extensive cellular necrosis in the brain. Clearly that is an irreversible process. But a remarkable improvement of function in some of our cases makes us feel that the grim outlook predicted for all patients needs to be revised. All the cases that were graded as "mild" or "moderate," having symptoms of numbness, tremors, ataxia, paresis, etc., have made great progress on physical therapy, some of them losing their symptoms completely. Many of those who were graded as "severe," being completely paralysed and bedridden, improved greatly and began to be independent in caring for themselves and walking around after several weeks of patient physical therapy. Partial sight was recovered by some and partial hearing by others. This happened not only in the children who received treatment with chelating agents or polythiol resin but also in those who had no drug therapy. Possibly this indicates that new neurological pathways have come into use.

We shall be publishing these findings soon, but whatever the reason for this improvement we are certain that international organizations could give great help in the field of rehabilitation. W.H.O. should immediately direct its efforts in that way rather than believing that nothing can be done for the large number of crippled patients.—We are, etc.,

SALEM F. DAMLUJI
LAMAM AMIN-ZAKI
SAMI B. ELHASSANI

Medical College,
Baghdad University,
Baghdad, Iraq

Micropipette for Skin Testing with Dinitrochlorobenzene

SIR,—Dinitrochlorobenzene (DNCEB) is a potent skin allergen.¹ Its use in the investigation of cell-mediated immunity in Hodgkin's