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Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters must be signed personally by all their authors.

As stated each week in "Instructions to authors" no letter will be acknowledged unless a stamped addressed envelope or an international reply coupon is enclosed.

Who cares for the mentally handicapped?

SIR,—As a single-handed consultant psychiatrist in mental handicap I was interested to read your leading article "Who cares for the mentally handicapped?" (18 November, p 1386). It is a matter of historical accident that the mentally handicapped have been cared for by medical and nursing staff since the inception of the National Health Service. But, accident or not, the fact is that 50 000 mentally handicapped people are being cared for in hospitals, and—as you say—"if these hospitals are to stay for 20 to 40 years or more this must be said boldly"—by the Department of Health and Social Security. With all the uncertainty that exists it is not surprising that "deplorably few psychiatrists in training are prepared to devote themselves to the care of the mentally handicapped."

I suggest that it is impossible for a consultant on his own to provide all that is required of him in a 400-bed hospital and develop a good community service at the same time. But good-quality junior staff will not come into this field, which is of such low status in the profession and whose future as a medical specialty is in grave doubt.

That is exactly why the DHSS should state explicitly whether it wants to see mental handicap retained within the NHS or not. If it does, then major steps must be taken to encourage registrars and senior registrars to become involved in the field. One of these major steps should be the establishment of chairs in mental handicap in a few medical

schools, which would serve to give status and academic respectability to the specialty and encourage young psychiatrists to enter the field. A useful spin-off would be the exposure of medical undergraduates to the problems of the mentally handicapped and their families. Perhaps they would have a little more sympathy later, when they are family doctors and consultants in other fields.

If the DHSS does not wish to see mental handicap retained as a medical specialty, then that must be stated explicitly; those of us currently in the field can then go and do a refresher course in general psychiatry and apply for other jobs.

G KERR

Dovenby Hall Hospital,
Cockermouth, Cumbria

SIR,—I work in a hospital which has cared for the mentally handicapped for more than 100 years (the same one as Colonel W W Ireland, who is mentioned in your leading article (18 November, p 1386)). Originally we were a training school and priority for admission was given to those most likely to benefit from the training. Now we are a hospital and requests for admission are usually for those for whom no one else can or is willing to care for—the physically disabled and those whose behaviour is too upsetting to their family or the community. The patients who are fortunate enough to be admitted here are afforded pro-

tection and a much higher degree of medical and nursing care than is generally available in the community. In addition to our own full-time staff we have excellent relationships with consultants in the nearby general hospital, and any requests for their specialist facilities are willingly and expeditiously given.

At present there are many pressures to develop more community services, as if these were an alternative to "asylum" care, and not enough realisation that these are a necessary complementary service. There is certainly a need for an integrated service, but until there is adequate central funding for this the large grey area for which both the NHS and the social services can deny responsibility will mean that many mentally handicapped will not be cared for.

DAVID A PRIMROSE

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Thyroid disease and pregnancy

SIR,—We read with interest your leading article (7 October, p 977) and the subsequent letter from Dr R T Cooke (11 November, p 1370).

We were surprised to learn that Dr Cooke's search of the literature (to August 1977) revealed only three papers on the subject of myxoedema following pregnancy. We recently reviewed the publications on this topic and found reference to this condition in several other papers.¹⁻⁴ Admittedly, these patients were reported to highlight the accompanying menstrual disturbances and/or galactorrhoea with or without hyperprolactinaemia, but the diagnosis of primary hypothyroidism following pregnancy was established clinically and biochemically. This syndrome therefore appears to occur more frequently than is generally appreciated. Over the past three years we have had an increasing number of such patients

referred to our thyroid and endocrine clinics, and indeed our experience would support Dr Cooke's "suspicion that they represent the tip of an iceberg."

It has been rightly emphasised that primary thyroidal failure is a graded phenomenon,⁵ and in contrast to the frank clinical picture of hypothyroidism in Dr Cooke's patients we have seen several patients who presented with mild and non-specific symptoms following an uneventful pregnancy. Such patients are often reassured their tiredness is due to the "stress and strain" of motherhood or they are prescribed iron treatment despite the absence of any evidence of such deficiency. The subsequent improvement observed tends to perpetuate this practice, although the clinical course merely reflects the transient nature of the thyroid disturbance. The underlying thyroid dysfunction can be easily overlooked in the absence of the characteristic symptoms and signs. We have encountered patients subsequently proved to have primary subclinical hypothyroidism in whom the sole presentation was that of persistent inappropriate galactorrhoea 9-12 months after a normal delivery.⁶ In three of our patients the primary subclinical hypothyroidism was transient and two became pregnant within 3-6 months of achieving spontaneously the euthyroid state.

It would be ideal to screen all patients six months after confinement as advocated by Dr Cooke, but such a scheme is beyond the clinical and laboratory resources of the NHS. We agree with the guidance given in your leading article that a selective group of patients should be carefully watched, and in our experience these include women known to have circulating thyroid antibodies, a family history of autoimmune thyroid disease, or an increase in size of the thyroid gland following pregnancy.

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¹ Ross, F, and Nusynowitz, M L, *Journal of Clinical Endocrinology*, 1968, **28**, 591.

² Bayliss, P F C, and Van't Hoff, W, *Lancet*, 1969, **2**, 1399.

³ Kinch, R A H, Plunkett, E R, and Devlin, M C, *American Journal of Obstetrics and Gynecology*, 1969, **105**, 766.

⁴ Kleinberg, D L, Noel, G L, and Frantz, A G, *New England Journal of Medicine*, 1977, **296**, 589.

⁵ Evered, D C, *et al*, *British Medical Journal*, 1973, **1**, 657.

⁶ How, J, and Bewsher, P D, *European Journal of Obstetrics, Gynecology and Reproductive Biology*. In press.

Review of patients after ¹³¹I treatment for thyrotoxicosis

SIR,—We were interested to see the report from Dr A D Toft and others (21 October, p 1115). Studies which will promote the development of appropriate long-term surveillance programmes for patients treated with radioiodine should be encouraged, but in view of the data which the authors present we feel that their conclusion (namely, that the optimum follow-up interval for post-radioiodine patients with normal serum thyrotrophin (TSH) levels is three years) cannot be accepted as a practicable working guideline. Their sample of patients is the end result of a considerable number of selection procedures; in particular the post-treatment interval of 6 to 18 years indicates that these patients are survivors of many events, including hypothyroidism. It is not indicated how the

post-treatment intervals are distributed in the geographical subsamples. It is probably not justifiable to extrapolate these results to the management of patients in the first six years after treatment. Losses exceeding 11% in the four-year study is an important feature worth noting when interpreting the results.

The finding in this study given most prominence is the occurrence of overt hypothyroidism in only one patient, in the group with normal initial serum TSH levels, after four years' follow-up. It is difficult to draw any serious conclusions about one event of this kind occurring in a relatively small sample of 31 patients. However, taking this figure in isolation we might conclude that the expected incidence of overt hypothyroidism at four years is 3.2%, with 95% confidence limits of 0.08% to 16.7%. The presence of a raised TSH level in only one of the seven lost patients would, of course, make a big difference to the outcome of the study.

What is probably much more important is the development of a raised TSH level in 19 out of the original 61 patients, in which state the risk of overt hypothyroidism is shown to be high. We have applied a follow-up life-table analysis to their data to show that the five-year cumulative incidence of hypothyroidism in the presence of a raised serum TSH concentration is 20.7±5.2 (SE)% and that the cumulative incidence of a raised TSH level in those with an initial normal level is 35.9%±6.5 (full details of the calculations on application). It is not possible to quantify precisely the risk of hypothyroidism for this latter group, because we do not know how long the TSH levels had been raised in those who became hypothyroid in the first group. However, it is clear that an arbitrary three-year follow-up interval may not offer sufficient protection to many patients who have a normal TSH level at a particular point in time. Plans for the long-term surveillance of patients with thyroid disease must be evaluated carefully and shown to be cost-effective, but solutions to the problem are unlikely to be found in small ad hoc studies from which large numbers of patients are lost.

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Incidence of congenital rubella

SIR,—In the parliamentary news section of your issue of 18 November (p 1441) you refer to the reply by the Secretary of State to a question on congenital rubella put by Mr Lewis Carter-Jones. In your report you include the statement that "the average annual number of children affected by congenital rubella is 400" and from the text it might be supposed that this was a correct figure accepted by the Secretary of State.

The relevant paragraph of the reply given by the Secretary of State runs as follows:

"The report which I received from the Children's Committee in September suggested that the number of infants born this coming winter with congenital rubella could, as a result of the recent steep increase in the incidence of the disease, possibly rise to 1500 to 2000. This figure was based on the assumption that the average annual number of children affected by congenital rubella was 400; while there is no firm evidence on which to base statistics, a surveillance scheme which has been in progress since 1971 suggests that that figure is

probably twice as high as the true figure even without allowing for the effect of pregnancy terminations." (*Hansard*, vol 957, col 110-2)

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*.*We regret that this reply was condensed for publication in such a way as to give a wrong impression.—Ed, *BMJ*.

Distalgesic and paracetamol poisoning

SIR,—We cannot accept the views of Drs B A Gennery and R A Lucas (28 October, p 1226) regarding the apparent safety of dextropropoxyphene and their denial of its being the frequent cause of sudden death. Their opinion was based on hospital experience in a small area of Manchester and all overdose cases reported to the coroner in that city over one year (approximate population $\frac{1}{2}$ million). Dextropropoxyphene is a widely used and effective analgesic drug, most commonly prescribed in combination with paracetamol as Distalgesic (paracetamol 325 mg and dextropropoxyphene 32.5 mg).

In the Midlands (estimated population 5 million) quite a different picture appears. The Home Office Forensic Science Laboratory in Birmingham does many of the analyses in the area in cases of possible overdose. In the last 20 months there were 34 cases in which dextropropoxyphene had been the principal cause of death and only three cases were attributed to paracetamol alone. These were all sudden deaths occurring outside hospital. All these persons except one had taken dextropropoxyphene in the form of Distalgesic. Analysis was carried out by quantitative ultraviolet spectroscopy, quantitative thin-layer chromatography, and latterly by high-performance liquid chromatography on samples from stomach contents, blood, and liver. The three methods corresponded and therefore confirmed their accuracy. About half these persons had also taken alcohol.

The findings from the Midlands agreed with those from Belfast,¹ where 30 sudden deaths due to dextropropoxyphene abuse occurred in three years. The possibility of Distalgesic causing sudden death by respiratory depression is well known to coroners, forensic scientists, and pathologists, who recognise the characteristic cyanosis and acute pulmonary congestion at necropsy. Death is rapid and usually occurs before medical treatment is available. The Forensic Science Laboratory finds that dextropropoxyphene is the commonest individual drug to cause death. It is not to be confused with paracetamol, which, in contrast, usually causes death from hepatorenal failure after several days. The contradictory reports from Manchester could be explained by different local prescribing habits, but close study of a report² from a Manchester hospital does not confirm this. Dextropropoxyphene deaths usually occur outside hospital and would not be included in any hospital figures. Analysis too can be confusing, since paracetamol, which is easily detected, may mask the presence of dextropropoxyphene, so that unless special methods of separation are employed the presence of significant quantities of dextropropoxyphene may be overlooked.

The tragedy is that persons, particularly