We can only agree with Dr Skrabanek that there are considerable difficulties with the concept of schizophrenia, syndrome, disease, or behaviour pattern, and he is correct in concluding that we would like to discover an organic cause or, for that matter, a psychological one. However, our observations on typhoid catatonia had little bearing on that question and our argument was directed to showing that typhoid catatonia does not resemble schizophrenia, in contrast to other conditions such as the psychoses associated with epilepsy² or amphetamine abuse,³ which very closely resemble schizophrenia and for that reason have been called "symptomatic schizophrenias." The notion of symptomatic schizophrenia seems to us to be useful in the present state of knowledge and ignorance. "Schizophrenia," like "dropsy," may indeed, in course of time, become redundant, but nevertheless describes something real.

The implication in Dr Skrabanek's second paragraph that physicians "in our part of the world" have somehow superior ethical or conceptual understanding is not only insulting but peculiarly inappropriate, as the senior author had his entire medical, psychiatric (and ethical) training in Ireland. We simply hope that our observations and experience in India may also be of some interest and value to physicians elsewhere.

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¹ Bleuler, E, *Dementia Praecox or the Group of Schizophrenias*, trans J Zinkin, p 248. New York, International Universities Press, 1950.

² Slater, E, Beard, A W, and Glithero, E, *British Journal of Psychiatry*, 1963, **109**, 95.

³ Connell, P H, *Amphetamine Psychosis*. London, Oxford University Press, 1958.

Catatonia after malaria

SIR,—The article on catatonia after typhoid fever by Drs W R Breakey and A K Kala (6 August, p 357) was most interesting. Enteric fevers are common in Rhodesia in the rainy season, but I have never observed this phenomenon.

I have, however, often seen catatonia after malaria, especially cerebral malaria. The subjects are usually African teenage girls. One sees withdrawal, mutism, and waxy flexibility, sometimes with statue posturing. On one occasion I had two young African girls standing on either side of the ward all day like sentries. Delusions and hallucinations do not seem to be present and I have never elicited echopraxia or echolalia. Peripheral blood-films are not always positive in the cerebral cases (as observed by Manson-Bahr) but fever responds to intravenous quinine infusion. Dexamethasone is usually given in these cases. Catatonia has always responded to chlorpromazine in about two weeks and no relapses have been observed.

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Inhumanity to man

SIR,—Your leading article (3 September, p 591) correctly states that under the 1959 Mental Health Act the ultimate responsibility

for admitting patients to psychiatric units is that of the responsible medical officer. However, various other agencies such as social workers, general practitioners, and the police influence the pattern of psychiatric referrals and hence admission. The police, for example, have the option of taking a person who appears to be suffering from a mental disorder and to be in need of care and control to a "place of safety." Alternatively, if an offence has been committed the individual can be charged.

Working in the psychiatric unit of an inner London general hospital, we formed the impression that a disproportionate number of patients admitted under section 136 of the Mental Health Act (that is, directly via the police) or section 60 (that is, from prison) were members of ethnic minority groups. Review of 46 consecutive section 136 patients confirmed this, as 35% were born in the New Commonwealth, while the percentage of New Commonwealth immigrants in the borough aged over 15 was only 13 (1971 Census¹). Sims and Symonds² in Birmingham have reported a fourfold over-representation of West Indians in their series of 252 section 136 admissions.

The same trend was even more obvious in the analysis of 88 consecutive admissions to the hospital under section 60, since 50% of these patients were New Commonwealth immigrants. Many of the immigrant patients had committed relatively trivial offences (such as travelling on the underground without a ticket or failing to pay for a cup of tea in a snack bar), as had a smaller proportion of the United Kingdom-born patients.

Research is required to explain the over-representation of Black patients admitted under section 136 and section 60. The more florid acute psychotic states observed in patients from the Caribbean and Africa³⁻⁶ may account for at least some of the section 136 admissions. This explanation would not apply to the section 60 patients, however, since the majority of these patients had classical (Kraepelinian) schizophrenia.

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¹ Office of Population Censuses and Surveys, *Census of Great Britain 1971, Greater London County Report Part 1*. London, HMSO, 1974.

² Sims, A C P, and Symonds, R L, *British Journal of Psychiatry*, 1975, **127**, 171.

³ Constant, J, *Psychopathologie Africaine*, 1972, **8**, 169.

⁴ Lambo, T A, *British Medical Journal*, 1960, **2**, 1.

⁵ Royes, K, *Proceedings of the Third World Congress of Psychiatry*, 1961, vol 2, p 1121. Toronto, University of Toronto Press, 1962.

⁶ Sutter, J-M, et al, *Encyclopédie Médicale et Chirurgicale (Psychiatrie, 4)*. Paris, Editions Techniques, 1974.

SIR,—May I stress the obvious, that after every kind of medical, paramedical, social, and other help large numbers of people with senile dementia, damaging schizophrenia, or severe mental handicap due to brain disease, injury, or deficit need skilled, devoted care for life?

Accepting that steady efforts must go forward to strengthen available supports outside hospitals, nevertheless absolute priority should be given to enhancing the morale and status of nurses who undertake the permanent care of the most demented, chronically psychotic, and severely mentally handicapped.

Your leading article "Inhumanity to man" (3 September, p 591) was good, although 15 years late. One week later your leading article

"Day services for mentally handicapped adults" (10 September, p 652) welcomes the first move to substitute teachers for nurses and a shift to less beds and more care in the same "community" which has failed the old and the psychotic by reducing beds.

This is a plea that we hasten slowly, lest domestic catastrophes, violence, and horror situations, now avoidable, become inescapable. If the calling to life-long care is demeaned further, irreparable damage could easily follow. Most hospitals for the mentally handicapped of 500 beds or less, preferably about 250, will bear the closest scrutiny as centres of happy, genuine community life and it is these which should form the keys to future care and not the renamed training centres. It would be justifiable to change the name of such communities to "hospitals for the severely brain damaged."

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Radiation and growth hormone deficiency

SIR,—We would like to comment on your recent leading article (27 August, p 536) on the possible effects of brain irradiation in children on future growth and development. We have seen a patient with abnormalities of both growth hormone (GH) and prolactin secretion after a course of radiotherapy some eight years earlier.

A 5-year-old girl presented with slight proptosis of the right eye, which was found to be blind. There was enlargement of the optic foramen on x-ray. At surgical exploration a right optic nerve glioma was demonstrated extending back to the chiasm. Subsequently she was treated with external irradiation to the region—4290 rads in 13 treatments.

She was later investigated at age 13.7 years for short stature, with height at the 3rd percentile. She had normal secondary sex characters and periods had started two years before. A GH deficiency was demonstrated, with the plasma GH concentration not rising more than 3.0 IU/l during insulin hypoglycaemia (blood glucose 1.8 mmol/l (32 mg/100 ml)). The plasma cortisol concentration rose from 335 to 593 nmol/l (12 to 21 µg/100 ml) during this test, and there was a normal response of thyrotrophin to thyrotrophin-releasing hormone (TRH) injection (rising from 1 mU/l to 21 mU/l at 20 min after TRH). The basal plasma luteinising hormone level was 6.0 mU/l, while the plasma prolactin concentration was raised to 20 µg/l. Bone age was not retarded. The patient is at present being assessed for human GH treatment.

The GH abnormalities in this patient correlate with the results described by Shalet et al,¹ who showed that if a threshold of about 3000 rads radiation dose to the brain is exceeded there is an absence of GH response to hypoglycaemia. In other reports^{2,3} there was little evidence of other endocrine deficits except occasional reduced gonadotrophin responses. Serum prolactin was not measured by these workers and it is therefore of interest that an elevated level was found in this patient. An increased serum prolactin concentration would be in keeping with the idea that the effects of irradiation on pituitary secretion are the result of a hypothalamic disturbance.

In a large proportion of the patients who have received cerebral irradiation there seems to be a marked sensitivity of regions responsible for GH secretion. In view of this it is obviously important to measure accurately the heights of children at risk of growth retardation after irradiation at subsequent follow-up visits. If growth velocity⁴ is estimated any tendency