May I point out that many other areas would be within their rights in claiming greater allocation of funds because of special circumstances within their areas? Health authorities serving coastal areas can so claim because of a very high preponderance of elderly population and all the demand for medical care and the high morbidity and mortality that go with it. Regions and areas serving populations in the mining districts of the North and Wales can so claim because of the very high incidence of occupational diseases and, therefore, the increased demand for medical care. Industrial areas of the North, not only cities but towns and villages as well, also have problems of social deprivation: unemployment and an elderly population left on their own by younger relatives in search of education, jobs, etc. Dreary streets and pollution (industrial and/or traffic) are not unique to London, nor even to cities, but exist in wide areas of the North, the like of which Sir Francis would not have seen even in Brent.

Sir Francis, of course, is right to confess that the acute wards have a preponderance of elderly patients and the answer surely lies in transferring one-third to one-half of the general medical beds in each area to the geriatric units of those areas.

As for London, the sooner it learns to cut its coat according to its fair share of cloth, the better it will be.

S S H WASTY

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BCG for handicapped children

SIR,—The letter from Dr D A Isenberg (16 October, p 939) draws attention to the unsatisfactory immune status of handicapped children with reference to tuberculosis. The situation is far more widespread and applies to all ages and other diseases. In the past few years more than 1100 patients of this hospital have been given a Heaf test. Many were found to be negative and these were all given BCG immunisation.

There are usually unsatisfactory records of previous immunisations against other diseases. I have looked through the records of about 340 patients under my care, and where there has been no record of immunisation against poliomyelitis I have immunised those under the age of 40 with three doses of polio vaccine. Patients under 40 who have had previous polio vaccine have not had a booster, so a booster dose was given. In the last months I have given about 340 patients a Schick test and 127 were positive, showing unsatisfactory immunity to diphtheria. These will be given two doses of PTAP.

I wonder whether it is widely known that following an outbreak of diphtheria in a mental subnormality hospital in Essex the Joint Committee on Vaccination and Immunisation agreed that any patient admitted to a hospital for the mentally subnormal or members of the staff, particularly the nursing staff for whom records of immunisation against diphtheria were lacking, should receive a course of diphtheria prophylaxis but not TAF. One or other of the preparations PTAP or PTAH should preferably be used. This course of action was recommended to all physician superintendents and medical administrators of mental subnormality hospitals in the South-west Metropolitan Regional Hospital Board by the then senior administrative

medical officer in a letter dated 15 January 1971. Should this procedure not still be followed?

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Attempted prevention of neonatal thyrotoxicosis

SIR,—With reference to my recent short report under this title (6 November, p 1110) my attention has been drawn to an article by Maisey and Stimmler¹ on long-acting thyroid stimulator in which they described an attempt to prevent its effect on the fetal thyroid. Unfortunately they did not put that piece of information in the summary of the article! I should like to apologise to Dr Maisey and to Dr Stimmler for missing their original piece of work and thus not giving them the due credit for it. They gave 15 mg of carbimazole per day to a euthyroid pregnant woman who had had two partial thyroidectomies for Graves's disease. She gave birth to non-identical twins five weeks before the expected date of delivery. Both babies appeared to be normal at birth but developed neonatal thyrotoxicosis within a few days and were successfully treated with carbimazole.

It seems worth while, therefore, to administer carbimazole antenatally to a mother with high risk factors for the development of neonatal thyrotoxicosis—namely, its occurrence in previous pregnancies, exophthalmos, pretibial myxoedema, and recurrent thyrotoxicosis,¹ particularly if high concentrations of thyroid-stimulating immunoglobulins are found in the mother's blood.² This applies even if the mother is euthyroid or is receiving treatment for hypothyroidism. It may be wise to administer L-thyroxine to all mothers treated in this way in order to prevent hypothyroidism in the fetus.³

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¹ Maisey, M N, and Stimmler, L, *Clinical Endocrinology*, 1972, 1, 81.

² Dirmikis, S M, and Munro, D S, *British Medical Journal*, 1975, 2, 605.

³ Ramsay, I, *British Journal of Hospital Medicine*, 1976, 15, 373.

Acute epiglottitis in an adult

SIR,—When I saw the title of Dr B D Linaker's report (30 October, p 1045) I supposed that there had been a printing error, but since the name "epiglottitis" is used consistently throughout the report it was presumably intended to be spelled that way. However, he was obviously referring to the condition usually known as epiglottitis (or as supraglottitis).

It is clearly established that in children this disease is usually caused by capsulated strains of *Haemophilus influenzae* belonging to capsular type b. The aetiology in adults is less clear, largely because bacteriological investigation has often been inadequate. Mere demonstration of the presence of *H influenzae* in the throat (as in Dr Linaker's case) proves nothing, since this species is common even in healthy throats; but identification of the organism as capsulated and of type b is much more informative since this type is carried by only 1% or so of healthy people.¹ However, blood culture is an even more convincing way of identifying

the causative organism and should be part of the investigation of any patient suspected of having epiglottitis; it will seldom produce results in time to guide treatment of the individual patient, but we need to know how confidently we can assume *H influenzae* to be the aetiological agent in such cases. The emergence of β -lactamase-producing strains of *H influenzae* type b means that ampicillin may fail to control this very serious condition² and my own recent laboratory studies have reinforced my belief that chloramphenicol is currently the drug of choice for life-threatening haemophilus infections.³

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¹ Turk, D C, and May, J R, *Haemophilus influenzae: its Clinical Importance*. London, English Universities Press, 1967.

² *Lancet*, 1976, 2, 776.

³ Turk, D C, *Journal of Medical Microbiology*. In press.

* * * The spelling "epiglottitis" is in accordance with *BMJ* style, the authority for which is *Dorland's Illustrated Medical Dictionary*, 25th edn.—Ed, *BMJ*.

The hospitals we need

SIR,—Your leading article (25 September, p 713) on this subject seems to convey with ill-conceived triumph the message that community hospitals (CHs) are more costly to run than district general hospitals (DGHs), thus destroying "several widely held beliefs."

The research document¹ on which your article was based has at last come to my hands and certain facts should be made clear.

(1) The two experimental units studied were very small: Wallingford with 17 beds and Peppard with 15 beds.

(2) These units had a nursing structure heavily loaded with sisters and offered no place for student nurses.

(3) Staffing was far more costly than that at Abingdon Cottage Hospital, which, to quote the research document, "provides a service similar to that of a CH and has a nursing cost per inpatient week above the national average for that type of hospital." In fact the cost per bed in Abingdon Hospital was on a par with the lowest-costing ward in either of the two DGHs in Oxford and Reading (£752 and £736).

(4) The added cost of ambulances to convey preconvalescent patients to the CH is of course more noticeable for those patients who stay only a few days. It would not be so excessive with normal nursing costs.

(5) The optimum size of CH for nursing costs is about 35 beds. Units the size of Wallingford and Peppard, as judged from national statistics (quoted from the research document), cost some 22% more anyhow.

(6) The cost of larger general practitioner hospitals is difficult to compare and assess because they often have a wider scope, including operative surgery.

Although the possibility of CHs offering an economic alternative to total DGH care has been attractive, it has never been (and should never be) their *raison d'être*. You seem to forget that the main stimulus to the Oxford Region community hospital project was that the DGH alone could not satisfy six criteria of adequate hospital provision. You bemoan the fact that replacement of an old worn-out hospital by a new one leads to higher costs, "for the new structure allows and encourages a higher standard of nursing care and medical treatment." What a remarkable philosophy! Which is more important, quality or cash?