of the middle finger will reduce a dislocated hip and pressure of the thumb will dislocate an unstable hip. The essential feature of Barlow's test is that the hip joint is palpated directly by the hand, and slipping the head of the femur in or out of the acetabulum is appreciated by direct digital palpation. Barlow's test is therefore not only more sensitive it is also more accurate than Ortolani's. It detects the unstable hip in the early stages; it also eliminates the clicks which can occur in the absence of any hip instability. Expressed in other words, Barlow's test demonstrates very early "slips," whereas Ortolani's test demonstrates somewhat later "jerks."

The confusion which has arisen between these two tests is perhaps due in part to Mr. Barlow's modesty in describing his own test as a modification of Ortolani's. It is in fact based on different principles. Ortolani's test (like the old "telescoping" test) is an indirect examination in which an attempt is made to assess the hip by manipulating the shaft of the femur. Barlow's test, on the other hand, as Dr. Finlay and his colleagues rightly emphasize, does not involve any manipulation of the shaft of the femur; the examining hand goes straight for the hip joint. I do not think that Barlow's test will ever be adequately understood until we cease to speak of it as a "modified Ortolani" test and until we get rid of the idea that we are looking for a "click."—I am, etc.,

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Mushroom-worker's Lung

SIR,—Dr. C. T. B. Adams (18 November, p. 421), referring to my paper on mushroom-worker's lung (16 September, p. 708), describes a solitary case of a mushroom worker with general and respiratory symptoms, radiological pulmonary nodulation, negative serum precipitin test, and a scalene lymph node showing sarcoid features, and concludes that his patient is suffering from sarcoidosis and not from mushroom-worker's lung as I have described it.

Assuming that Dr. Adams's patient was in fact suffering from sarcoidosis, this does not rule out the possibility that he was in addition suffering from mushroom-worker's lung. In a proportion of cases of farmers' lung the serum precipitin test is negative. Only if the patient were re-exposed at the mushroom farm and his reactions observed could one be certain that he was not suffering from mushroom-worker's lung.

However, the demonstration of sarcoid histology in one lymph node does not justify a diagnosis of sarcoidosis unless there is good supportive evidence, which should include due consideration of possible environmental hazards. I would suggest that two other explanations are possible in Dr. Adams's case. Firstly, the patient might have been suffering from a "non-sarcoid" condition of the lungs, and the sarcoid histology of the scalene lymph node represented merely a local sarcoid reaction. Such local sarcoid reaction in lymph nodes draining, for example, pulmonary neoplasms are well

recognized.^{1,2} Secondly, the patient might have been suffering from mushroom-worker's lung, but the so-called sarcoid histology of the scalene lymph node represented a lymphatic spread from the pulmonary lesions. The histology of farmer's lung at an early stage shows a granulomatous appearance similar to sarcoidosis. Although there has been no previous report of such a case, Dr. Adams's patient could be the first to have shown this phenomenon.

Dr. Adams speculates about the possibility of precipitins in the blood of my Cases 1 and 2 having persisted from previous farming jobs. A careful occupational history was taken, and neither of them had any other farming experience before commencing work at the mushroom farms.

The patients described in my paper showed such a clear-cut relationship between the development of their clinical and radiological features and their exposure at the mushroom farm that there could be little doubt that their condition was a variety of extrinsic allergic alveolitis, and quite distinct from sarcoidosis.—I am, etc.,

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Institutional Care of the Mentally
Subnormal

SIR,—I have been following with considerable interest the recent article by Professor T. McKeown and Dr. I. Leck (2 September, p. 573) and subsequent correspondence (11 November, p. 355) on the care of the mentally retarded in England and Wales. What puzzles me is why a better defined policy for their care has not emerged before now, since provision has been under way since 1913. All that appears to be happening is a process of hair-splitting between what is or is not a medical-nursing concern, what is deemed skilled and unskilled care, and an attempt to farm out certain types of mentally retarded children, and I assume adults, too, between health and education authorities. Those who work closely with the mentally subnormal cannot but hold the view that theirs is usually a lifelong need, from the cradle to the grave, and so continuity of care is essential. A piecemeal project is both wasteful and frustrating. Integration of the services dealing with them is advocated in recent reports.

In Northern Ireland since 1949 there has been operating a service for the mentally subnormal which avoids dichotomy of responsibility.³ Here the care of the mentally subnormal, who are legally designated "persons requiring special care" by the Mental Health Act (Northern Ireland), 1948/61 is vested in one authority—namely, the Northern Ireland Hospitals Authority—as part of the hospital and specialized services. The authority is responsible both for the community care and the hospital or residential needs of all those found to be persons requiring special care. The authority has designated the day-to-day administration of this duty to three special-care management committees. Each regional committee carries out ascertainment, the provision of care in the community, including junior and senior schools (training centres), sheltered workshops, hostels, clubs, etc., and hospital and residential accommodation as is required. This arrangement facilitates the

change of care from community to hospital as circumstances dictate.

Such a unified control has enabled the needs of the subnormal to be assessed and provided for, subject of course to financial control, with that single-mindedness of purpose essential to obtaining speedy results. This is reflected in that from starting in 1949 some 1,283 places have since been created in day special-care schools or centres and hospital accommodation for some 1,363 patients. As well, hostels for 26 girls and 20 boys have been opened. A total of 5,624 are on the special care registers out of a population of some 1,458,000.³

The training of both nursing and teaching staff is undertaken within the hospital precincts. Psychological services are engaged in diagnostic and research projects in association with other disciplines such as speech therapy, physiotherapy, and social work. An active employment service also functions for trained boys and girls. In all of this close liaison is maintained with other agencies such as education, health, and welfare authorities, general practitioners, and the general hospitals. The parents and friends of the mentally handicapped not only contribute generously towards our free funds for the patients but also take an active interest in the standards of care and training extended to those in need. In return, counselling advice is offered regarding problems of the mentally retarded and their management.

It is suggested that co-ordination of the services for the subnormal is the most sensible approach.—I am, etc.,

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Deaths from Tuberculosis

SIR,—Dr. A. Pines (18 November, p. 416) rightly draws attention to one aspect (drug-resistance) of the problem of deaths from tuberculosis. In England and Wales the total deaths in 1966 from tuberculosis were 2,354, and no fewer than 525 were persons not notified before death as suffering from tuberculosis.¹

The Research Committee of the British Tuberculosis Association, with the help of the Ministry of Health and General Register Office, is to conduct a national inquiry into tuberculosis mortality. A letter is shortly to be sent to all chest physicians inviting their co-operation. They will be asked to give details of the circumstances of every death attributed to tuberculosis in their own districts between 1 February and 30 April, 1968.

The main purpose of this inquiry is to determine the nature of any avoidable factors, both clinical and administrative, which contributed to a death ascribed to tuberculosis and whether the death can be strictly attributed to active tuberculous disease or its treatment and was therefore preventable.

The comparable inquiries into maternal mortality carried out by the Ministry of Health have contributed significantly to the