can the patient be given a sense of continuity in the process of treatment.

By such means it is also possible to avoid the sudden last-minute urgent admission of a dying patient to a totally strange hospital for the final few hours of a prolonged illness; this is not terminal care but terminal mismanagement. If patients are to be transferred for terminal care in geriatric units it is desirable that the prognosis should be assessed in weeks or months rather than days. On the other hand, it must also be acknowledged that unexpected remissions can occur when it may be desirable for the patient to return home for a time. There are, among 114 women in this hospital to-day, two cases of carcinoma of breast admitted for "terminal care" 21 months and 32 months ago.

If, as Dr. Morton states, the teaching hospitals fail to set a good example to their students in managing terminal cases of cancer, this particularly thoughtless form of man's mutual inhumanity will be perpetuated.—I am, etc.,

Department of Geriatric
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St. Mary's Hospital,
Etchinghill, Kent.

R. S. STEVENS.

Role of the Child Psychiatrist

SIR,—I wish that Dr. R. L. Moody's submission in his letter (21 August, p. 477), "that the family doctor should be recommended to refer cases of emotional disorder to the child psychiatrist when specialist advice is needed," were possible in all parts of the country.

In this borough, with a school population of some 25,000 young people, the opinion of a child psychiatrist cannot be sought easily at the present time. The last child psychiatrist has emigrated, and even when he was with us we could expect only one and a half sessions a week at the most. The difficulties were not of his making, as he served three other areas in addition to this large borough, and his frustrations were not eased by the absence of beds for severely disordered adolescents. Our information suggests that the problem may be eased in two years, but even then provision will be inadequate for this densely populated area. At the present time there does not seem to be a suitable applicant for the post of child psychiatrist.

While we wait in hope for a child psychiatrist, our school psychological service is run by a depleted psychological team helped by school doctors, and when a child's emotional difficulties need specialist help the advice of the local paediatrician is sought. Where he cannot manage, help is obtained from the adult psychiatrist, though he can only see the severely disturbed, psychotic children. If the adolescent needs admission this means a bed in an adult mental unit; fortunately it is rare for us to have to resort to this unsatisfactory state of affairs.

Dr. Moody tells us that most paediatricians reach consultant status with no more than undergraduate training in psychology and psychiatry. I hope this is incorrect, and that the future lies in training all doctors, particularly those in the school health service and paediatrics, to have a greater understanding of the disciplines of child psychiatry—the more postgraduate courses that can be arranged the better. It would seem that at

the present rate of training child psychiatrists in many of the vast industrial northern areas, where young people's emotions are strained by difficult social conditions, much of the help for maladjusted children must necessarily come from psychological teams developed around the school health service and the paediatricians, with overall supervision from a child psychiatrist. This would probably enable the few child psychiatrists to guide the treatment of many more emotionally disturbed children and reduce the appalling waiting-lists. In this borough there are some 50 children at least needing psychiatric help. We give them all the support we can, but the present support is inadequate.—I am, etc.,

Health Department,
Bolton, Lancs.

P. O. NICHOLAS.

SIR,—Dr. R. L. Moody's letter (21 August, p. 477) raises important issues concerning the present and future division of work between paediatricians and child psychiatrists.

So far as organic illness is concerned, paediatrics as a specialty is not expanding, but, like general practitioners' surgeries, paediatric out-patient departments have an increasing load of children and families suffering from emotional disturbance. It is understandable that many if not most psychiatric disturbances presenting with an organic component—for example, encopresis—are initially referred to the paediatrician who has facilities for in-patient investigation and treatment and also junior medical staff. In a hospital with a department of child psychiatry the consultant children's psychiatrist is in the same position as the paediatrician—that is, he has junior psychiatric staff and, additionally, the facilities for investigation and treatment available from the team of specialist colleagues (educational psychologists, psychotherapists, psychiatric social workers, etc.) to which Dr. Moody refers. Frequently he also has in-patient facilities for children suffering from psychiatric disturbances. This being so, family doctor and consultant paediatrician needing psychiatric advice have no hesitation in referring cases of emotional disorder directly to him.

However, in many parts of the country this state of affairs does not exist. Often the only child psychiatric service available to family doctors, paediatricians, and consultants in other branches of medicine is the local authority child guidance clinic. Here, a single-handed consultant children's psychiatrist, without junior medical staff, and often lacking in addition the team of experts referred to by Dr. Moody, is trying to deal with the vast numbers of emotional and social problems in children and parents which contribute to waiting-lists. The waiting-list for investigation, let alone treatment, which prevails in many child guidance clinics is so long as to be a virtual negation of treatment. It is seldom that the psychiatrist who acts as medical director of the clinic has junior staff, for it is said that training posts cannot be established without beds, and the Ministry and regional boards seem reluctant to provide beds for children who are psychiatrically ill. This is a vicious circle indeed. Most local authority clinics have establishment for educational psychologists, psychotherapists, and psychiatric social workers, but often these posts are advertised only to remain unfilled for months or years. Psychotherapists and

psychiatric social workers especially are in very short supply and some of them prefer to work in a hospital setting—sometimes a paediatric unit.

When the child psychiatrist working in a child guidance clinic is absent (ill, on leave, or attending necessary meetings) diagnosis and treatment in the clinic, for which he is the responsible head, comes almost or completely to a standstill. Under these circumstances it is not surprising that those paediatricians who have the interest, the time, and the staff feel more or less compelled to deal with many of the psychiatric problems which present in their own clinical practice. Because family doctors know this, they may feel they have no real alternative to sending disturbed children to the paediatrician, who will at least attempt treatment, rather than to the psychiatrist, who, however well qualified he may be to deal with the problem, may be unable to look at it for many months.

I submit, Sir, that the first step in ensuring that all serious emotional problems presenting in children are seen and treated by the appropriate specialist is to give the children's psychiatrist the same facilities with regard to junior staff which are enjoyed by his colleagues in other specialties. Also he should, in addition to his duties in the child guidance clinics, have a hospital appointment in a children's department, so that he and the paediatrician together can deal with the "whole child" in his family setting.—I am, etc.,

Aylesbury, Bucks.

EDITH M. BOOTH.

Jaundice in Severe Infections

SIR,—In their recent stimulating paper (10 July, p. 75) describing cases of jaundice in severe bacterial infections Mr. A. Eley and his colleagues presented evidence suggesting that intrahepatic cholestasis is the cause of such jaundice. We should like to describe a similar case, in which cholestasis did not seem to be the only mechanism.

A 29-year-old Jamaican woman of Indian extraction was admitted with a severe pleuritic pain in the right lower chest and a dry cough of 4 days' duration. On examination: temperature 100° F. (37.8° C.); clinical and radiological signs of extensive consolidation with fluid at the right base; liver tenderness. In the light of the next day jaundice was observed with dark urine and pale stools. The causative organism of this pneumonia was not isolated, despite numerous cultures of sputum, blood, and pleural fluid.

For two and a half weeks she had a hectic temperature, at times rising to 105° F. (40.6° C.), despite treatment with ampicillin, penicillin, and tetracycline. There was little change in the signs, although the W.B.C. fell from the initial 21,000/c.mm. (84% neutrophils) to normal after the first four days. At this stage the chest x-rays revealed cavitation within the consolidation. This and the clinical picture were suggestive of pneumonia due to a staphylococcus resistant to the antibiotics used. Celbenin was then given, the temperature falling immediately, with slow resolution of the pneumonia.

On admission the abnormal tests of liver function were: total serum bilirubin 4.8 mg./100 ml.; conjugated bilirubin 1.6 mg./100 ml.; serum alkaline phosphatase 9.8 K.A. units/100 ml.; serum glutamic-oxaloacetic transaminase (S.G.O.T.) 150 units; serum glutamic-pyruvic transaminase (S.G.P.T.) 55 units; urine bile+, slight increase in urobilinogen. E.S.R. 92 mm. in 1 hour (Westergren). Initially the Hb was 86% but

after 14 days it had fallen to 60% with 10% of reticulocytes in the peripheral blood. Then the S.G.O.T. was 57 units; S.G.P.T. 44 units; total serum bilirubin 2.9 mg./100 ml.; conjugated bilirubin 2.3 mg./100 ml. The urine and faeces were returning to normal colour, the urine containing a marked excess of urobilinogen. 24 days after admission the Hb was 68%; reticulocytes 10%; E.S.R. 127 mm. in 1 hour; S.G.O.T. 60 units; S.G.P.T. 50 units.

As the infection cleared the jaundice faded, the liver tenderness subsided, and the patient subsequently made an uninterrupted recovery, with return of Hb to normal (97%).

Appropriate tests were performed to exclude sickle-cell anaemia, glucose-6-phosphate dehydrogenase deficiency, virus infection, including psittacosis and Eaton agent pneumonia, and systemic lupus. Direct Coombs test was negative.

Although cholestasis was undoubtedly present in this patient, the degree of haemolysis and liver-cell damage appeared to be much greater than could be accounted for by the consequences of intrahepatic cholestasis itself, although presumably the cause of the haemolysis and cell damage was basically the same as that of the cholestasis. The precise mechanism by which these occurred, as in the cases of Eley and his colleagues, is not clear, but a circulating toxin, presumably bacterial in origin, was probably responsible, affecting the cells of the excretory pathway, the liver cells, and the circulating red cells.—We are, etc.,

A. GORDON BECKETT.
J. D. WARD.

New End Hospital,
London N.W.3.

Injured Baby

SIR,—Dr. Patricia A. Russell's excellent review of 25 cases of infantile subdural haematoma (21 August, p. 446) shows birth trauma is no longer the only, or indeed commonest, aetiological cause. It appears that nowadays post-natal trauma, including deliberate injuries, accounts for three times as many cases as birth trauma. The importance of this was brought home to me quite recently.

A male child aged 3 weeks was admitted to the Torbay Hospital with a week's history of excessive irritability, jerky movements of the hands, and lethargy. The right eye was noted to be closed for four days and he had refused feeds over the same period. On admission he looked ill and marasmic. He had a paresis of the right upper lid, twitching of the left eye, and neck stiffness. The fontanelle was tense and there was a retinal haemorrhage on the right side. He was found to have subdural collections of fluid on both sides, with a larger collection on the left. He was treated with repeated aspirations initially at the Torbay Hospital and later in the neurosurgical unit at Bristol. No surgical treatment was necessary. After discharge he was found to have a mild left-sided hemiparesis for which he received physiotherapy.

In July 1965, when the patient was 6 months old, the physiotherapist noticed painful swellings of the right arm and leg, and signs of bruising. Treatment was discontinued and the child referred back to the clinic. By then the right arm was improved, but now the left upper arm was swollen and tender. X-rays of the long bones showed oblique fractures of both humeri, periosteal reaction along the medial sides of the shafts of both femora, and a deformity at the upper end of the right tibia. The appearances were thought to be compatible with multiple trauma. On interviewing the mother it seemed

difficult to believe that anything other than loving care and kindness had ever been shown towards the infant. The general practitioner and health visitor alike expressed their amazement at the diagnosis.

It is well known that the syndrome of multiple epiphyseal injuries is often unsuspected. Subdural haematoma in an infant may well be the first indication of this, and careful surveillance of families in whom a case has occurred is advisable. This must include the watching of subsequent siblings.—I am, etc.,

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Torquay, Devon.

L. HAAS.

Amenorrhoea

SIR,—Professor T. N. A. Jeffcoate's article (14 August, p. 383) is very interesting and informative and quite properly emphasizes the importance of fully investigating patients with primary amenorrhoea. It is also right to refer to the need to investigate "certain cases" of secondary amenorrhoea, but the statement that "not less than 60% of cases" of secondary amenorrhoea are accounted for by "psychological and environmental" factors may be misleading, since it implies that some 40% of women with secondary amenorrhoea have causes other than psychological or environmental factors. Although this might be so among women attending hospital gynaecological out-patient clinics (although I doubt it), it is certainly nothing like this incidence in women seen in general practice.

The figures comprising the accompanying table are taken from several studies in my practice and show, as Professor Jeffcoate states, that the commonest cause of secondary amenorrhoea is pregnancy. In my experience, the next commonest cause is a mixture of fear that pregnancy may have occurred and the guilt so often associated with promiscuous sexual intercourse. Although it is true that change of environment for a young woman may be followed by a period of amenorrhoea, it does not follow that the relevant factor is an environmental one. In fact, the statement in your leader (14 August, p. 380) that "Professor Jeffcoate concludes that, apart from pregnancy, environmental and psychological causes underlie more than 60% of cases of secondary amenorrhoea," also tends to mislead the reader by perpetuating the myth that environmental factors are relevant when it is so often the effect of the environmental change on the woman's (or girl's) psychological or emotional state that is important.

Year of Study	Amenorrhoea*		
	Primary	Pregnancy	Psychological
1951 (Publ. 1955) ¹	—	22	11
1955/57 (Publ. 1959) ²	1	57	19
1960 (Publ. 1965) ³	1	24	13
1963 (Publ. 1965) ⁴	1	31	12
1964/65 (in preparation)	—	34	15
Totals	3	168	70

* Women with post-menopausal amenorrhoea not included.

Professor Jeffcoate's statement that: ".... whatever be the nature of the treatment given there is a 60% chance of cure in cases of

secondary amenorrhoea of more than one year's duration. In most cases this cure is spontaneous..." regrettably does nothing to make it more widely known that many more of these very anxious ladies could be helped very much more by formal psychotherapy, often of quite a superficial level, with or without simple sedation according to the general condition of the individual patient.

The "... sympathetic attitude and cheerful encouragement..." advocated in your leader are surely required by all our patients? But those patients also requiring a surgical operation have this as well. Surely those patients having somatic reactions to psychological or emotional disturbances should also be treated with psychotherapy.

There would be far fewer patients having assays of their urinary excretion of 17-ketosteroids and gonadotrophins, to say nothing of enormous numbers of other complex, expensive, and perhaps unnecessary investigations if we doctors in general practice could only have the time in which to treat our patients as the sick people they are, instead of having to pass them on to hospital as cases of disease for investigation.—I am, etc.,

London N.W.3.

PHILIP HOPKINS.

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SIR,—I was most interested in Professor T. N. A. Jeffcoate's paper on amenorrhoea (14 August, p. 383). I would like to draw attention to the fact that amenorrhoea, which he found to be such a common symptom of pelvic tuberculosis in the Liverpool area, does not appear to be true for other areas. In 73 consecutive cases diagnosed and treated by me not one case complained of amenorrhoea. In fact, the only menstrual disturbance complained of was menorrhagia, and this in only four patients. I mention this fact only in case anybody might be inclined to dismiss the possibility of pelvic tuberculosis in a patient not complaining of menstrual disturbance, and because somebody might suggest a reason for this variation.—I am, etc.,

Galway, Eire.

DIARMUID O'DRISCOLL.

Umbilical-vein Exposure for Transfusion in Newborn

SIR,—It is sometimes necessary to expose the umbilical vein of newborn infants for transfusions, and this vein is the one most commonly used in exchange transfusion. After about 24 hours the umbilical stump is not serviceable, and a cut-down is necessary.

The procedure for this exposure described in books¹ involves an incision about $\frac{1}{2}$ in. (12.7 mm.) above the stump. However, in this position the vein is deeply situated and is already well on its way towards the abdominal cavity. The peritoneum is there—