That is a proportion of approximately one boy to two girls. This preponderance of girls over boys is quite the reverse to the usual proportion of patients of all ages in clinics of four males to one female, and would seem to indicate that the majority of the girls are infected either by older men of all races or by young immigrants, their histories supporting the latter alternative.

It is my opinion that the greater part of the increase of venereal disease among young people is due to their association with immigrants of all colours and to the general increase of venereal disease caused by the latter, making promiscuous youth more liable to infection.

Drug-resistance

There is one other factor which has been mentioned as a possible reason for the increase of venereal disease in this country, and that is the resistance of the diseases to drugs. For all practical purposes this is a fallacy. In my experience early syphilis responds completely to the proper dosage of penicillin in all cases and gonorrhoea does so in at least 95% of patients.

Some strains of gonococci have been shown to be partially resistant to penicillin *in vitro*. However, in any of the very few clinical failures that I have seen, and where cultures have been taken, gonococci have been grown which *in vitro* are completely penicillin-sensitive, their lack of response probably being due to the penicillin not reaching the organism for some reason unknown. They have nearly all responded in the end to very large doses of penicillin given over several days.

There is evidence that certain gonococci have become resistant to streptomycin, but the drug has little place in the treatment of gonorrhoea, since experience has shown that the fear of masking syphilis with small doses of penicillin is unjustified, the syphilis either being cured by the dose of penicillin given or appearing in due course with the usual signs.

Methods of Control

There are several ways in which this increase of venereal disease can be checked and reduced. First, and most important, is the limitation of immigration from all countries, especially of unskilled workers and those who have no job to come to, and the repatriation of all people who have been convicted of a sexual crime. Immigrants should be properly housed and accommodation arranged for them before they come here.

Secondly, by educating the public in the dangers of promiscuous intercourse and of venereal disease, particularly in regard to sterility and chronic ill-health from gonorrhoea among women and the disastrous late effects of syphilis. Both women and passive homosexuals often continue to spread the diseases, not knowing that they are infected, and do not come for treatment until it is too late, the women having developed salpingitis and they and the males eventually developing late syphilis. The public should also know that disease is just as easily caught during homosexual as during heterosexual intercourse. Young people should be warned against sexual contact with strange immigrants. Mixed associations, in my experience, between different races are not often successful, the moral values and sexual mores of the races being seldom the same.

Thirdly, patients should if possible be sent for diagnosis and treatment to specialists in the subject,

because the average practitioner is not equipped for making a microscopical or cultural diagnosis, or for tracing the contacts, who must also be treated. The treatment of the often asymptomatic female contact is very important if the reservoir of venereal infection is to be attacked. The exact diagnosis is necessary for legal reasons, especially where a married person is concerned, as it may be asked for in the divorce court later; and the psychological value of a definite diagnosis is important in the management of the patient. Venereal diseases are sometimes unsuspected in certain gynaecological clinics, and the help of the venereologist can be valuable there.

Lastly, and by no means the least important, it should be part of the duty of every medical school to see that its students are properly taught how to recognize the presence of venereal disease and how best to deal with it. Unfortunately, that is not the case in all teaching hospitals.

If all these methods of controlling venereal disease were pursued we should go a long way to stamping it out.

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LANGWITH LODGE

A DIABETIC CONVALESCENT HOME FOR MEN AND WOMEN

BY

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The idea of having a convalescent home prepared to accept diabetic patients was first put forward in an article appearing in the *Diabetic Journal* of January, 1935. Later in that year five beds were taken over by the Diabetic Association at St. Mary's Convalescent Home at Birchington, in Kent, for the use of diabetic patients. At the end of the second world war more beds were made available at St. Mary's Home, and children in addition to women were accepted (Goodband, 1959). Since 1948 St. Mary's Home has been the responsibility of the National Health Service and at present has accommodation for 50 female patients over the age of 15. Diabetic children between the ages of 3 and 12½, however, are now looked after at the Metropolitan Convalescent Home in Broadstairs.

In 1946 20 male diabetic patients were accepted at the British Red Cross Society's Convalescent Home at Burley-on-the-Hill. This unit was looked after by Dr. Joan Walker from 1946 to 1955, when Burley ceased to be a convalescent home and once again became a private residence. During the nine years that diabetic patients were able to go to Burley, 1,442 men and 199

women were accepted (Dr. Joan Walker, personal communication). To replace the lost accommodation at Burley, Langwith Lodge was bought by the Sheffield Regional Hospital Board in 1955 and was entrusted to the Mansfield Hospital Management Committee to run as a convalescent home for 31 diabetic patients. At the present time, therefore, St. Mary's Home and Langwith Lodge are the only two convalescent homes in Great Britain solely devoted to the care of diabetic patients.

Langwith Lodge is a large country house standing in its own beautiful grounds in a part of England which was once covered by Sherwood Forest. Langwith is equidistant from Nottingham and Sheffield and is eight miles (14.5 km.) from Mansfield. It takes about four hours by the best train from London to Langwith because it is necessary to change trains at Nottingham and proceed to Langwith by a branch line. From 1955 to June, 1958, only male diabetic patients were admitted, but after that date patients over the age of 12 of either sex were accepted. Up to the end of December, 1961, 1,855 diabetics from all parts of the British Isles have been to Langwith Lodge. A survey of patients shows that 384 were admitted in 1960, of whom 231 came from the Sheffield region, 66 from the London area, 28 from Manchester, 19 from Liverpool, 13 from Birmingham, and 27 from other parts of the British Isles.

The admission rate has varied from year to year as shown in Table I.

TABLE I.—Admissions to Langwith Lodge 1955 to 1961

	January to May	June to December	Totals
1955		25	25
1956	68	107	175
1957	90	124	214
1958	70	208	278
1959	137	253	390
1960	142	242	384
1961	150	239	389

Note.—Langwith Lodge opened in November, 1955, and women patients were admitted in June, 1958. 250 patients have made more than one visit to Langwith.

Patients can be sent to Langwith Lodge by their general practitioner or by the doctor in charge of their diabetic clinic, for periods of two to four weeks, but it is essential that they should not be sent unless they have somewhere to go when their period of convalescence is over. Patients are medically examined the day after arrival and all are seen and talked to once a week by the consultant physician in charge of the home. A general practitioner with a special interest in diabetes visits the home on two other occasions during the week. When a patient leaves, a discharge letter is sent to his general practitioner and to the doctor in charge of his diabetic clinic. This letter gives a brief account of the patient's clinical state and an explanation of any changes that have been made in treatment. Application forms for admission to Langwith Lodge can be obtained from the Matron, Langwith Lodge, Nether Langwith, Nottinghamshire. There is accommodation for 31 ambulant patients, but there are only eight beds for men and three beds for women on the ground floor. The other patients have to be able to walk up quite a large flight of stairs as there is no lift. The predominance of middle-aged or elderly patients admitted to Langwith Lodge in 1960 is shown in Table II. An age-group analysis of all the patients admitted to Langwith Lodge has not been made, but my impression is that the 1960 pattern is fairly representative of the whole.

TABLE II.—Patients Admitted in 1960 to Langwith Lodge (in Age-groups)

	Age:	0-40	41-70	71-
Male		18	135	36
Female		14	133	48

The diabetics who come to Langwith Lodge are of two kinds; those who come for a few weeks' convalescence after a period of physical illness or after a period of severe mental stress, and the others, a smaller group, who come for a period of recuperation or for a change. Patients in the latter category can generally be put into one of three groups. In the first group are those with failing vision, amputated limbs, or damaged cardiovascular systems who because of their infirmities cannot stay at hotels or boarding-houses. In 1960 out of 384 admissions 9 patients were blind, 14 had lost one leg, and 10 had lost both legs. In the second group are those patients who come in because the person who cares for them is ill or so that that person can get away for a holiday. Summaries of two letters from almoners give a good idea of the problems which may face diabetics and their families.

Mrs. W., aged 71. "Domestic difficulties. Lives alone and has a psychopathic son in a mental hospital. Her daughter is taking her family for a caravan holiday and cannot take her mother, who is hypertensive and requires a large dose of insulin."

Mr. E., aged 71. "Bilateral amputee. This exuberant personality is subject to hypoglycaemia and is far too keen on life to let a little thing like that worry him, but it worries his wife so much that she is in need of a holiday."

In the third group are the patients who are old and feeble and cannot afford to go away or who are unable to go to other convalescent homes because of the lack of facilities there to keep their diabetes controlled.

Life at Langwith Lodge

At Langwith Lodge patients are encouraged to lead a normal active life. They go out for walks and expeditions, they play indoor and outdoor games, and organize dances and whist drives. They read, listen to the gramophone, and watch television. These activities give the patients confidence and an understanding of how to look after themselves under varying circumstances. Boredom and slovenliness are two evils which have to be avoided in convalescent homes. It has been our experience that mixing the sexes is one way of avoiding these troubles. Contact with the members of the staff who are diabetics and with the other patients goes a long way to breaking down a patient's sense of personal catastrophe and isolation and allows him to get his own troubles into a better perspective. We try to help the patients with the instructions that they receive in their own hospitals and clinics, and we teach them as much as we can about insulin treatment, diet, and the importance of testing their urine at the correct times.

Professor Tunbridge (1953) in the seventh Banting Memorial Lecture quotes Allen and Sherill as saying, in 1922, that insulin has "tremendously improved diabetic treatment but has not simplified it." This statement is certainly true in 1962. The usual reasons why patients cannot give their own injections of insulin are that they have poor sight, shaking hands, or arthritic joints, or that they have never been taught to do it and lack the confidence to make the first jab. People in the

last category usually leave Langwith Lodge able to give their own insulin satisfactorily.

The majority of the patients appear to have very little idea of the special action of the type of insulin that they are taking and in consequence find it difficult to make rational adjustments. Patients still arrive with all sorts and kinds of syringes, but during the last few months there has been an improvement and more are using the standard insulin syringe, B.S.1619. Patients are by and large very conservative about their insulin therapy and many are content to give the injections into the same place day after day and to continue on the same dose of insulin regardless of whether they are bordering on the verge of an insulin or hyperglycaemic coma. Efforts are made to teach all the patients to vary the site of injections, and the more intelligent ones are encouraged to vary their dose of insulin according to their activities and state of health.

In 1948 Professor Tunbridge carried out a survey of the diet habits of 94 of his diabetic out-patients and found that only 16 patients were managing satisfactorily, that 44 were managing moderately satisfactorily, and that 34 were in a hopeless muddle (Tunbridge, 1953). Experience at Langwith Lodge has shown that the majority of patients find their diets difficult to understand and even more difficult to keep to. Between November, 1960, and March, 1961, I talked about their diet problems to 144 patients who had had diabetes for six months or longer. Forty-eight said that they had never been taught anything about diet, and the majority were obviously uncertain about food values, and their diets lacked variety. Only the occasional patient weighed his food. Many were confused by the fact that part of their diet was reckoned in ounces and part in grammes. Some found it difficult to understand why portions could be of 5, 10, or 15 g., and others were muddled by the colour ascribed to their lines. The word calorie was occasionally mentioned, usually with great emphasis but seldom with much understanding. It is scarcely surprising that the average diabetic patient who has never thought of food in terms of calories, carbohydrates, proteins, or fats should be confused unless he can learn under expert guidance spread out over several weeks. Illiterate people are sometimes shy of their shortcomings. The following case illustrates the difficulties caused by an inability to read.

Mrs. Y., a housewife aged 30, was admitted to hospital in diabetic precoma at the age of 25. In hospital she learned to give her own insulin, test her own urine, and to memorize the kind of food she was given. After discharge she appeared to remain stable until she married and moved to a new area, where she attended another diabetic clinic. There her diet was changed. She did her best to remember what the dietitian had said, but she became muddled and her diabetes became unstable. She returned to live in this area and was admitted to Langwith Lodge. After a few days she told us why she could not understand the instructions she had been given. We were then able to stabilize her diabetes. She is now having reading lessons and wishes she had told us the truth long ago.

Dr. Lawrence's (1957) "Simple Diabetic Diet" has been immensely successful because patients are given simple written instructions about their basic diet and about the way to introduce variety into their meals. Miss Rogers's (1959) diabetic cookery book and her special playing-cards (Rogers, 1958) are further examples of straightforward do-it-yourself guidance for diabetics. Unfortunately not all patients are good at or have time to relate what they read to what they eat. Earlier this year

a patient said: "I have been on this diet for six months—do teach me how to introduce some variety into it." The patient was a member of the Diabetic Association, she had received written instructions about her diet and a diabetic cookery book, but still she had never learned to vary her diet. It is for this reason that Langwith Lodge is so valuable, because there the patients are under strict guidance, they have menus for each day which they can keep, and they are encouraged to experiment with food within the limits set by their parent hospitals or clinics. For their first week at Langwith Lodge patients are encouraged to weigh their carbohydrates, but after that they try to judge food quantities by eye. Diabetic diets can be expensive, but so can many other types of food if they are bought out of season or without due care. Once diabetics learn to regard starch-reduced proprietary foods as a luxury and can make full use of the exchange system, the cost of their diets should not be excessive.

Since the introduction of the "clinitest" urine-testing has been simplified and the majority of diabetics can do this test satisfactorily. Mistakes seem to arise because they have not been taught or forget to empty their bladders about one hour before collecting urine for a test.

Patients Presenting Special Problems

Looking after other people's patients is never easy, and it is made much more difficult when patients come with boxes of unlabelled pills. The advent of cortisone, anticoagulants, and oral antidiabetic drugs means constant vigilance if disasters are to be avoided. We try not to alter a patient's prescribed routine unless there is a good reason for doing so, but it is not until you run a diabetic convalescent home that you realize how much the average patient's diabetic state varies, especially when convalescing from an illness or an emotional upset. The relative security that patients find at Langwith Lodge is one of the reasons why so many who have been difficult to stabilize at home leave Langwith Lodge in good order. Unfortunately this is not always the case and some patients never settle and always seem to be against the world. These patients usually remain unstable.

The diabetic urine chart is a very sensitive guide to the mental as well as the physical well-being of a patient, and this point is not always fully appreciated (see Rosen and Lidz, 1949, quoted by Tunbridge, 1953). The only patients that we have had serious difficulties with were a few psychopaths and drink addicts. It has been found necessary to insist that patients do not visit public-houses during their stay at Langwith Lodge. Three other groups of patients present special problems. Firstly, the patient with a low I.Q. who cannot be taught anything about his diabetes and has a tendency to be antisocial and to upset the other patients. Secondly, the patient who has been to Langwith Lodge before and would like to regard his visit as an annual holiday and who has no interest in keeping his diabetes under good control. This type of person has a bad influence on other patients. The third group are patients who have had to make long journeys to reach Langwith before they are fit to do this and often arrive in a state of collapse.

A great deal has been done for diabetic patients by the formation of diabetic societies and the establishment of diabetic convalescent homes, homes for old people with diabetes, children's hostels, and holiday camps.

Despite all these advantages some of the patients who come to Langwith Lodge do not know the basic principles underlying urine-testing, diet, and insulin treatment. When there are empty beds at Langwith Lodge, advantage is taken of this to admit new diabetics from the Mansfield Clinic for stabilization. These patients can learn a great deal in a short time, because for two to four weeks they live in a manner approximating to their home conditions, they are being continually shown how to manage their diets, insulin, and urine tests, and they discuss their problems among themselves and with the members of the staff. This seems to be the ideal way of helping the ordinary patient to understand how to make the adjustment to his life that diabetes necessitates.

Conclusion

I feel that there are three major ways in which diabetic patients can be helped in the future. The first is by more research work; the second is by educating our doctors, dietitians, and patients to a better understanding of the simple problems which the average patient meets in everyday life; and the third is by the development of hostels or annexes to hospitals where patients can live and can learn about the management of their diabetes.

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Nova et Vetera

A HERBAL FOUND BY CHANCE

A few months ago I picked up a fascinating book from the floor of a second-hand bookshop and took it away to read. It was a copy of the 1633 edition of the *Herball* (*Or Generall Historie of Plantes*), which was published in London by John Gerard in 1597. It was later—1633 and 1636—enlarged and amended by Thomas Johnson, "Citizen and Apothecary," as he is described on the title-page. It is from this title-page that the portrait of Gerard is taken.

Gerard was a Master Surgeon or barber-surgeon who was better known as a horticulturist. He relied heavily in preparing his herbal on legend and record dating from King Solomon, Hippocrates, Aristotle, Theophrastus (the Greek botanist), Pliny, Galen, and Dioscorides (the Roman surgeon). He grew many plants and treated many patients himself, so he was able to draw also on his own knowledge and experience in putting together this 1,600-page work. The scope is extraordinary. He comments on about 700 different types of plants, from seaweeds and mosses to bushes and trees, under such headings as kinds, temperature, nature, and virtues. Synonyms, botanical data, and fairly good illustrations accompany each of the descriptions as well.

In not all cases are medicinal "vertues" stated, but even so there is a certain charm and quaintness which justifies reading from the book. Here is an example of what I mean, taken from the chapter on Sweet Williams

and Sweet Saint Johns: "These plants are not used either in meat or medicine, but esteemed for their beauty to decke up gardens, the bosomes of the beautifull, garlands and crownes for pleasure." A few more brief quotations will demonstrate the friendly and enlightening tone of the book: "Little birds in cages (especially Linnets) are refreshed with the lesser Chickweed when they loath their meat: whereupon it was called of some Passerina." Nep, or catmint, is so named, "because cats are very much delighted herewith; for the smell of it is so pleasant unto them that they rub themselves upon it, & wallow or tumble in it, and also feed upon the branches and leaves very greedily. [It is commended as] a present helpe for them that be bursten inwardly by means of some fall received from a high place. . . ." And, under the heading "The Vertues of all the Crowfeet," "Cunning beggars do use to stampe the leaves and lay it unto their legs and arms, which causeth such filthy

ulcers as we daily see (among such wicked vagabonds) to move the people the more to pittie."

Nobody to-day doubts the considerable awareness many people had long ago of the qualities of certain plants. The effect of chewing coca leaves has been appreciated by the Central and South Americans for many centuries, and the poppy and opium were certainly not new to the Orientals (or to Gerard either) 300 years ago. "Wilde Marjerome" was recommended by Gerard to cause a diuresis and relieve dropsy. Readers were told about some of the valuable qualities of "Hellebor," containing the veratrum alkaloids—and warned of its dangers—in the following terms:

"The root of the White Hellebor procureth vomit mightily, wherein consisteth his chiefe vertue, and by that means voideth all superfluous slime and naughty humours. It is good against all cold diseases that be of hard curation, and will not yeeld to any gentle medicine.

"This strong medicine made of White Hellebor, ought not to bee given inwardly unto delicate bodies without great correction; but it may more safely be given unto cuntry people which feed grosely, and have hard tough and strong bodies. . . .

"The root given to drinke in the weight of two pence, taketh away the fits of agues, killeth mice and rats, being made up with hony and floure of wheat. Pliny addeth that it is a medicine against the Lowsie evill."

And about saffron, the autumn crocus, which contains colchicine:

"The roots of Hermodactyls are of force to purge, and are properly given (saith Paulus) to those that have the Gout. . . . The same stamped and mixed with the whites of eggs, barley meale, and crums of bread, and applied plaisterwise, ease the paine of the Gout, swellings and aches about the joyntes.

"The Danger—The roots of all the mede saffrons are very hurtfull to the stomacke, and being eaten they kill by choaking as mushrooms do, according unto Dioscorides.

"It is also a speciall remedie for those that have consumption of the lungs, and are, as wee terme it, at deaths doore, and almost past breathing, that it bringeth