short period those considered suitable were transferred to the short-stay ward.

This of course is only a pilot scheme, but the results so far indicate that it warrants further extension.

Since the ward was designated as a short-stay unit the following turnover figures during a two-month period give an idea as to what can be expected. There were 52 admissions to the main geriatric admission ward, and during this time four patients died, 18 were transferred to the Sun Lounge, and of those 12 have been discharged, giving a 25% discharge rate in this short period of time. Relatives were interviewed and reassured that if there were any signs of relapse after discharge the mental welfare office would arrange with the family doctor for readmission if necessary.

The aftercare and follow-up, etc., is of course one of the most important aspects of this scheme. The local authority services, mental welfare officers, etc., have been most enthusiastic about it, and up to the time of writing aftercare reports have been satisfactory, with no indications that any of the patients need to be readmitted.

A more comprehensive review is envisaged when a longer period of time has elapsed.—We are, etc.,

Herrison Hospital,
Dorchester, Dorset.

E. S. LAMONT.
DOROTHY M. P. ROSS.

REFERENCE

- ¹ *Psychiatric Services in 1975, 1963*. P.E.P., London.

Indications for Tonsillectomy

SIR,—Dr. Violet Spiller is, of course, quite right in her letter (March 23, p. 820) in which she suggests that the history is more important than the physical signs. Obviously if the tonsils are out the child cannot get tonsillitis. Even if the child persists with sore throats, earache, and frequent colds after tonsillectomy, honour is at any rate satisfied and the parents and family doctor are happy that something has been done. No doubt this general relief will have a beneficial effect on the child.

I cannot, however, agree that acute rheumatism or bacterial endocarditis, which are rare diseases compared with tonsillitis, are to be expected if the erring tonsils are not removed. These diseases do not depend on luck to any extent and certainly occur in tonsillectomized patients.

Nor can I agree about the swing of the pendulum away from tonsillectomy. It has swung right back and in some places nearly one third of the school leavers have been subjected to tonsillectomy. Perhaps more children have had their tonsils out in the last decade than ever before—chiefly on account of repeated tonsillitis. In 1936, when I was in general practice, tonsillitis was rare in children; now it is extremely common, simply because each attack is treated with antibiotics and as a result the child is prevented from developing immunity. A succession of attacks is inevitable—each with the same risk of complications. It is hardly surprising there is an increase in the incidence of virus infections when the opposing bacteria are continually suppressed by chemical rather than immunological means.

The never-ending arguments for and against tonsillectomy in both medical and lay press are just a waste of print. What is wanted is some proper British research into the functions and the diseases of the pharyngeal lymphoid tissue. It is a disgrace to our nation and to our medicine that a quarter of our

children should be thought to be so abnormal that they have to be subjected to this horrible operation, and very little is done to prevent it.—I am, etc.,

Carlisle.

R. THOMAS.

SIR,—I read Dr. Violet Spiller's letter on this subject (March 23, p. 820), and, in spite of (or because of) my age, propose to comment. I have removed hundreds of T's and A's, by guillotine, during a long life. First at Tite Street, Chelsea, when I often removed 12 or 14 in an afternoon, and after four years in France, 1914–18, in the country. I lived among these families, and mothers brought their children and in most cases said how much better they were in health, and that they could breathe more easily. No doubt I made mistakes, and should be told in these progressive days that only about 3% should have been removed. I am, however, unrepentant, and like, on looking back, to recall the mothers' gratitude.—I am, etc.,

Speen,
Newbury, Berks.

ALLAN FINN.

Side-effects of Methaqualone

SIR,—Having recently written on the subject of methaqualone ("melsedin") we were particularly interested to see the letter from Dr. W. McQuaker and Dr. C. P. L. Bruggen (March 16, p. 749). We have searched our files and find that in 1961 a general practitioner wrote to us reporting transient paraesthesia in the limbs occurring in both his wife and himself following methaqualone administration. He commented that methaqualone appeared to be a good hypnotic and the symptoms in no way suggested the thalidomide type of peripheral neuritis, but he thought patients should be warned of this phenomenon, occurring just about the time the hypnotic was beginning to take effect.

Subsequent to this no other doctors had informed us of similar occurrences until last month, when Dr. McQuaker reported to us the occurrence of similar paraesthesia in one patient. None of the published literature and unpublished observations at our disposal apart from these two reports have referred to paraesthesia occurring in patients taking methaqualone. These observations cover more than 1,000 patients, and five of the 20-odd published studies were carried out at our own instigation by physicians well known to us, so that we are able to be certain that side-effects were properly noted. This seemed of particular importance to us at the time in view of the occurrence of peripheral neuritis reported following the use of thalidomide.

The experimental evidence at present available to us shows that methaqualone—not surprisingly—is concentrated in the central nervous system tissue, it has no demonstrable effect on peripheral nerves as far as pharmacological studies have shown to date, but it does affect synaptic transmission in the spinal cord.¹ In animal experiments the drug has no obvious effect on the peripheral vascular system, but further work to confirm this will be undertaken.

The studies we now plan include the examination of peripheral nerves of experimental animals following large doses of methaqualone and other hypnotics. We are also looking into the possibility of extending studies of ¹⁴C methaqualone distribution in the central nervous system reported by Cohen *et al.*² We shall undertake detailed examination of the central nervous system, including special sensory tests, in subjects who have ingested maximal doses of methaqualone. We also hope

to be able to study the objective changes, if any, occurring in the limbs of patients experiencing the paraesthesia under discussion. We shall collect as much information as we can over the next few weeks and decide what further action, if any, should be taken.

Our present feeling is that the observations of Drs. McQuaker and Bruggen are uncommon, and we do not believe from the evidence available that peripheral neuritis, damage to the central nervous system elsewhere, or other serious toxic effects are indicated. We will be interested to read the comments of other correspondents on this subject, and we are very grateful to doctors who write and tell us either directly or through the medium of your columns of their observations. Once again, we would put in a plea for doctors at home or abroad to communicate their observations on drugs not only to the journals but also to the manufacturers, who obviously have a considerable responsibility and interest and who can only build up an accurate picture of all the long-term pharmacological effects of drugs in this way.—We are, etc.,

Medical Department,
Boots Pure Drug Co. Ltd.,
Nottingham.

J. WARWICK BUCKLER.
JOHN E. HALL.
ERIC V. B. MORTON.

REFERENCES

- ¹ Swift, J. G., Dickens, E. A., and Becker, B. A., *Arch. int. Pharmacodyn.*, 1960, **128**, 112.
² Cohen, Y., and Picard, Y. F. du, *Thérapie*, 1958, **13**, 30.

Mental Health Act 1959

SIR,—May I congratulate you on publishing the article by Dr. H. R. Rollin (March 23, p. 786)? It is so refreshing to read facts. The Mental Health Act 1959 would appear to have been conceived, drafted, and passed on a basis of views and opinions instead of facts and figures, although Government authorities were asked to postpone its passage through Parliament until the results of certain investigations then being conducted were known.

Dr. Rollin's findings are complementary to mine upon mental subnormality.¹ In an investigation covering two independent hospital groups involving four medical superintendents over two adjacent periods of three years each, before the coming into force of the Act, I found that the failure-rate of adult males on licence due to the commission of crime was 202 per 1,000 per year, compared with a total crime-rate of 37.6 for the same sex and age-group in England and Wales for the first period of three years, and 186.1 compared with 42.8 for the second period. These rates for patients permitted to leave the hospitals—that is, excluding absconders—are approximately five and four times those of England and Wales. Middleton² obtained 99.9 for discharged patients as compared with 42.8 for England and Wales.

Comparison of the type of crime committed by Dr. Rollin's cases with 55 consecutive crimes committed by the mentally subnormal male after leaving hospital shows some resemblance in the relative proportions, although it should be pointed out that Dr. Rollin gives a definite history of previous hospital admission in only 63 of his cases.

	Mental Hospital	Subnormality
Offences of a public nature ..	33.7%	23.7%
Offences against the person ..	14.1%	18.2%
Offences against property ..	52.1%	58.2%

Dr. Rollin found that arrest or committal to prison occurred on the same day as (four cases), to over 10 years from (10 cases), the day of discharge

from hospital. None of 28 mentally subnormal males whose history was available had left hospital more than three years before the commission of a crime. The table giving the percentages up to two years after leaving hospital shows that the mentally subnormal tend to commit crime sooner after leaving hospital than do the patients from the mental hospital.

	Mental Hospital	Subnormality
Up to 6 months	49.2%	57.1%
6-12 months	19.0%	35.7%
12-24 months	15.9%	3.6%

As the Mental Health Act 1959 deals with both hospitals for the mentally disordered and those for the mentally subnormal, it is clear that any increased easing of leave or discharge permitted by it may be responsible for a proportion of the great increase in crime that is taking place in this country. The decisions of the responsible medical officers are of great importance in the matter of the protection of the public from criminal acts, and their responsibilities are as grave as those of the Judicature.—I am, etc.,

Mount Pleasant Nursing Home,
Clevedon, Somerset

G. DE M. RUDOLF.

REFERENCES

- ¹ Rudolf, G. de M., *Med. Press*, 1961, **245**, 466.
² Middleton, T. H., *J. ment. Subnorm.*, 1960, **6**, 40.

Chloramphenicol and Blood Dyscrasias

SIR.—Dr. A. A. Sharp in his analysis of 40 cases of chloramphenicol-induced blood dyscrasias (March 16, p. 735) writes that a retrospective survey can never be satisfactory. This seems to me, as regards this report, a definite understatement. If the analysis was meant as a critical one, presenting evidence for and against the assumption that this drug was the cause of the dyscrasias, it would serve a valuable purpose.

It does, however, state that the drug induced the dyscrasias, although he states that in only 25 out of 40 cases were details of the blood marrow available, and that, although the commonest interval between therapy and diagnosis of marrow damage was one to three months, in some cases it was nine or 12 months later.

It would be interesting to see how it is possible to state that the drug was therefore the cause for this condition, and what justification there is for assuming that it has the dangerous properties that have been stated to follow its common use.—I am, etc.,

Oldchurch Hospital,
Romford, Essex.

W. D. PARK.

Cervical Spondylosis

SIR.—Lord Brain in his excellent paper on cervical spondylosis (March 23, p. 771) states: "If a really complete investigation with plain x-ray films is carried out, and considered in relation to the clinical picture, it is rarely necessary to resort to myelography, except when surgery is contemplated."

In the leading article of the same issue (p. 763) it is stated (with regard to cervical spondylosis): "Hence, although in some cases the clinical picture combined with the appearances on straight radiography may seem sufficient for diagnosis, examination of the cerebrospinal fluid and opaque myelography are nearly always necessary to establish the fact that the patient's symptoms and signs of spinal-cord disease are due to spondylosis." This is a considerable divergence of opinion within the