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On the street in America

The link between removing patients with chronic psychiatric illnesses from institutions and homelessness, a topic of earnest debate by psychiatrists in the United States, has suddenly become headline news.¹⁻³ For example, a recent series of informative and compassionate articles in the *Los Angeles Times* described the squalor of Skid Row in America's "homeless capital" and the bewildered state of mind of the many people who live there.⁴

As if to pre-empt an easy solution to the problem another human interest story has thrust itself on to front pages and television screens. A previously indifferent public has followed eagerly the plight of Joyce Brown, a 40 year old psychotic woman. She lived on the streets of New York until October 1987, when she was taken against her will to Bellevue Hospital for treatment, as part of Mayor Edward Koch's initiative. The New York Civil Liberties Union regarded this as a breach of human rights and, counter to the wishes of Brown's sisters, appealed successfully to the Manhattan Supreme Court for her release. The city of New York attorney then appealed, and the release order was overturned. At the time of writing a further appeal against this appeal is under consideration.

Mayor Koch has sought to expand state law on involuntary psychiatric treatment to encompass those deemed to be a danger to themselves in the foreseeable future. Exercising this latitude in interpreting the law is, according to Koch, a *mitzvah* (Hebrew term for "good deed"), but it demands that psychiatrists and coprofessionals act as soothsayers. The disquiet in civil liberty and legal circles has implications for British mental health law and the proposed community treatment order.⁵

Estimating how many people, mentally ill or otherwise, are homeless is notoriously unreliable. The figures for the United States (population 242 million) range from 300 000 to 3 million, depending on whether they come from federal agencies or welfare organisations.⁶ Government figures show that in some cities (Baltimore, Maryland) nearly 2% of the population are homeless, while in others (Jacksonville, Florida) the proportion is said to be as low as less than 0.05%.⁷ In Los Angeles the United States Department of Housing and Urban Development claims that about 30 000 people are homeless⁸; local estimates start at 75 000. The government figures show that 20-80% of the homeless are mentally disabled. Many are schizophrenic (M Robertson *et al*, Los Angeles Basic Shelter Research Project, UCLA,

1985), and an increasing number of them are young chronic patients.⁹ Such estimates of psychiatric morbidity are typical of other urban areas,¹⁰ although more epidemiological research is needed to provide an accurate measure of the size of the need. There are no equivalent statistics for homelessness in British cities, although it has been estimated that of 67 000 long stay patients discharged from mental institutions in England and Wales since 1954 only 5% have been placed in local authority accommodation.¹¹ Furthermore, the number of reception centres in Britain fell from 270 in 1948 to 17 in 1970.¹²

What lessons can be drawn from the American experience? Surely aggressive, medical, hospital centred intervention is not a practical answer, and passive reliance on an expanding private housing stock or number of charitable shelters is morally unacceptable. The provision of low cost, serviceable housing and hostels must go together with a community orientated health plan. A mentally ill person needs a base from which to receive the available care. Likewise, the stability ensured by regular treatment and follow up is necessary for him or her to maintain that base. Some form of national control of housing, health, and welfare would seem to be the best solution. Such a system is for historical and geographical reasons inconceivable in the United States, but it has a framework in Britain. This must be vigorously upheld if we are to prevent America's national tragedy becoming international.

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Time to end a conservative treatment for mild hyperparathyroidism

Primary hyperparathyroidism is the commonest cause of hypercalcaemia. Since the arrival of the multichannel analyser for biochemical measurements patients with hypercalcaemia have been increasingly identified—and at least half have no symptoms. How should the latter, in whom the plasma calcium concentration is only mildly raised, be managed?

Those favouring a conservative approach suggest that such patients run little long term risk of renal damage, skeletal problems, or acute hypercalcaemia.¹⁻³ Most studies have,

however, been conducted over short time periods or have been retrospective. They have used insensitive means of renal assessment, such as measurements of serum creatinine concentration, and formal assessments of skeletal mass or density have not been included. It has been suggested that if parathyroidectomy were the routine treatment of the disease the cost would be large.³ Yet the cost is the equivalent of only five and a half years of medical follow up.⁴

There are many reasons why parathyroidectomy should be recommended for all patients with asymptomatic mild primary hyperparathyroidism. Firstly the patient may have symptoms; subtle physical and psychological changes may be present but are appreciated by patients only when they are cured. Secondly, untreated patients have a small risk of developing renal failure in the long term.⁵ Thirdly, there is an appreciably increased risk of bone loss,⁶ which may have devastating effects, particularly in older women.⁷ In the elderly symptoms such as confusion may be caused or exaggerated by primary hyperparathyroidism and relieved if the disease is eradicated.⁸ The confused elderly may also develop acute hypercalcaemia, particularly if dehydration is brought on by an intercurrent illness.

A further compelling reason for parathyroidectomy comes from a recent study that found mortality during a 14 year follow up period to be significantly higher in patients with untreated hypercalcaemia than in age and sex matched controls.⁹ Cardiovascular disease was the predominant cause of death, and patients with primary hyperparathyroidism are known to have an increased incidence of such disease.¹⁰⁻¹² Now it has been shown that this increased mortality can be reduced eventually by parathyroidectomy¹³: 441 patients who had undergone parathyroidectomy for mild primary hyperparathyroidism were followed for up to 22 years, and the increased risk of death started to decline after about five years and was less than expected by the end of the study.

The accurate diagnosis of primary hyperparathyroidism is now usually straightforward, and with increasing improvements in measurements of parathyroid hormone it is likely to become easier.¹⁴ The most important requirement for parathyroidectomy surgery is an experienced surgeon.

Preoperative localisation of tumours is unnecessary, particularly in patients undergoing neck exploration for the first time.¹⁵ In the past decade one of us has surgically explored 387 patients with hyperparathyroidism and had four failures—a failure rate of slightly over 1%. There have been no deaths and minimal morbidity, and hospital stay has usually been less than five days. Similar results are reported by specialist endocrine surgeons throughout the world. When the results are so good in specialist centres it seems churlish not to refer patients with mild but persistent hyperparathyroidism for an operation.

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Regular Review

Heterosexual transmission of human immunodeficiency virus

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Heterosexual transmission is probably the commonest way that human immunodeficiency virus (HIV) is spread, yet, although parts of Africa already have a heterosexual epidemic, the potential for a major heterosexual epidemic in the United States or Europe remains a subject for speculation. Future heterosexual spread is likely to depend on two key factors: patterns of sexual and needle sharing behaviour; and the probability of transmission of HIV from men to women and from women to men.¹

Epidemiology of heterosexually acquired HIV

By the end of 1987, 1964 cases of AIDS in which the only risk factor for HIV transmission was heterosexual contact had been reported to the Centers for Disease Control in the United States. These accounted for 3.9% of all cases of AIDS reported. Just over two fifths of the patients (857) were born in countries where heterosexual transmission is believed to be important; the remaining three fifths (1107) were hetero-