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Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters must be signed personally by all their authors.

As stated each week in "Instructions to authors" no letter will be acknowledged unless a stamped addressed envelope or an international reply coupon is enclosed.

Who cares for the mentally handicapped?

SIR,—As a single-handed consultant psychiatrist in mental handicap I was interested to read your leading article "Who cares for the mentally handicapped?" (18 November, p 1386). It is a matter of historical accident that the mentally handicapped have been cared for by medical and nursing staff since the inception of the National Health Service. But, accident or not, the fact is that 50 000 mentally handicapped people are being cared for in hospitals, and—as you say—"if these hospitals are to stay for 20 to 40 years or more this must be said boldly"—by the Department of Health and Social Security. With all the uncertainty that exists it is not surprising that "deplorably few psychiatrists in training are prepared to devote themselves to the care of the mentally handicapped."

I suggest that it is impossible for a consultant on his own to provide all that is required of him in a 400-bed hospital *and* develop a good community service at the same time. But good-quality junior staff will not come into this field, which is of such low status in the profession and whose future as a medical specialty is in grave doubt.

That is exactly why the DHSS should state explicitly whether it wants to see mental handicap retained within the NHS or not. If it does, then major steps must be taken to encourage registrars and senior registrars to become involved in the field. One of these major steps should be the establishment of chairs in mental handicap in a few medical schools, which would serve to give status and academic respectability to the specialty and encourage young psychiatrists to enter the field. A useful spin-off would be the exposure of medical undergraduates to the problems of the mentally handicapped and their families. Perhaps they would have a little more sympathy later, when they are family doctors and consultants in other fields.

If the DHSS does not wish to see mental handicap retained as a medical specialty, then *that* must be stated explicitly; those of us currently in the field can then go and do a refresher course in general psychiatry and apply for other jobs.

G KERR

Dovenby Hall Hospital,
Cockermouth, Cumbria

SIR,—I work in a hospital which has cared for the mentally handicapped for more than 100 years (the same one as Colonel W W Ireland, who is mentioned in your leading article (18 November, p 1386)). Originally we were a training school and priority for admission was given to those most likely to benefit from the training. Now we are a hospital and requests for admission are usually for those for whom no one else can or is willing to care for—the physically disabled and those whose behaviour is too upsetting to their family or the community. The patients who are fortunate enough to be admitted here are afforded protection and a much higher degree of medical and nursing care than is generally available in the community. In addition to our own full-time staff we have excellent relationships with consultants in the nearby general hospital, and any requests for their specialist facilities are willingly and expeditiously given.

At present there are many pressures to develop more community services, as if these were an alternative to "asylum" care, and not enough realisation that these are a necessary complementary service. There is certainly a need for an integrated service, but until there is adequate central funding for this the large grey area for which both the NHS and the social services can deny responsibility will mean that many mentally handicapped will not be cared for.

DAVID A PRIMROSE

Royal Scottish National Hospital,
Larbert, Stirlingshire

Thyroid disease and pregnancy

SIR,—We read with interest your leading article (7 October, p 977) and the subsequent letter from Dr R T Cooke (11 November, p 1370).

We were surprised to learn that Dr Cooke's search of the literature (to August 1977) revealed only three papers on the subject of myxoedema following pregnancy. We recently reviewed the publications on this topic and found reference to this condition in several other papers.[1-4] Admittedly, these patients were reported to highlight the accompanying menstrual disturbances and/or galactorrhoea with or without hyperprolactinaemia, but the diagnosis of primary hypothyroidism following pregnancy was established clinically and biochemically. This syndrome therefore appears to occur more frequently than is generally appreciated. Over the past three years we have had an increasing number of such patients