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NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Deployment of mental handicap specialists

SIR,—The number of specialists in mental handicap is falling as consultants retire and few young doctors are attracted to specialise entirely in mental handicap. Sooner or later this must force a change in the pattern of consultant provision for this subspecialty.

It is contended that a large proportion of the residents in existing hospitals for mental handicap do not strictly need psychiatric care. For a consultant to be held responsible for hundreds of patients whom he is able to see in practice for only minutes in a year is unfair to the specialist and to the patients. Instead of being appointed to hospital bases, consultants in mental handicap should be appointed to an area or district and given a broader brief. This should include an advisory role and cover community and hospital facilities. Instead of being in charge of hundreds of patients in a hospital, the specialist should be allowed to fulfil a more truly consultant role for those mentally handicapped people who need consultant psychiatric advice, whether they are in hospitals or hostels or living at home.

This arrangement would have the advantage that it would be a more economic and efficient use of limited consultant manpower. Such a change might help to revitalise a dying specialty and by offering new opportunities and challenges attract more recruits.

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Gastric and duodenal ulceration after burns

SIR,—Your leading article (1 September, p 512), noting the frequency and importance of ulceration of the stomach and duodenum after burns, refers to the use of antacids in prevention of this condition and to the need for further studies "since we know little about how this occurs."

The role of acid in this condition must surely be a secondary one, since at least during the first few hours after burns intraluminal gastric acid is reduced, yet it is at this stage that congestion and mucosal erosions occur. It appears that there is loss of mucin from the goblet cells, perhaps related to the high blood cortisol level after shock, and it is this depletion of the protective layer which makes the mucosa vulnerable to even small quantities of acid. Stress erosions are thus more related to depletion or even to chemical changes in gastric mucin than to alterations in the pH of the gastric juice.

It has been suggested that the use of H_2-antagonists may even act adversely in this respect.[1 2] Surely more studies are needed to find some means of increasing or changing the protective mucin of the stomach rather than to reducing the level of acidity. Very early treatment to stimulate mucin production, or even routine treatment *before* severe trauma such as major surgery, would appear to be a more hopeful approach, and controlled studies on these lines, as have been suggested,[3] might lead to interesting results.

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[1] Guslandi, M, *et al*, *British Medical Journal*, 1978, **1**, 1486.
[2] Guslandi, M, *Lancet*, 1978, **1**, 1267.
[3] Hunt, T, *South African Medical Journal*, 1969, **43**, 1443.

Opiates in acute abdominal pain and head injury

SIR,—I would like to support the suggestion made by Mr J C Angell (25 August, p 485) in his excellent review of the 15th edition of Cope's *Early Diagnosis of the Acute Abdomen* that we reconsider the stringent prohibition of opiates before diagnosis in cases of acute abdominal pain. As Mr Angell says, this prohibition causes much agony to the patient; and I find it difficult to believe that it really interferes with the diagnosis to the extent that is maintained by some surgeons.

While the problem of analgesia in abdominal pain is being reviewed, perhaps the time has also come to review the prohibition of opiates in cases of minor head injury. It can be difficult, if not impossible, to assess properly cases of multiple injury without adequate analgesia.