

When it comes to the application of them, it would be surprising if two classifications did give the same results. Which is "best" can only be found out by independent measurements—e.g., by relating the nutritional status to functional disability. McLaren and Read used as a test the fact that children were admitted to hospital on account of malnutrition. I have said that our classification is not appropriate for severe cases, because it is an anthropometric classification, and I do not think that the need for admission to hospital can be diagnosed on anthropometric grounds alone. As an example of the way in which a classification might be used we divided children into four groups: no action; action?; action; and priority. McLaren and Read have interpreted this as meaning that only the priority group should be admitted to hospital. This is not so. Depending on the judgment of the clinician and the facilities available, it might be appropriate to admit many of the "action" group to hospital as well. We did not specify what kind of action was needed.

Finally, I should emphasise that our classification was put forward as a scheme to illustrate the importance of separating wasting and stunting, and not as a definitive system. It is arbitrary to base cut-off points on out-of-date Harvard standards, particularly since W.H.O. is now adopting new standards. The cut-off points are based roughly on standard deviations, which is not very satisfactory, since for wt/ht the distribution is not normal but skewed. All these points will need to be tidied up if a classification such as ours is to be widely used. At the moment the important thing is to get across the principle: that we must separate stunting and wasting; that it is probably useless to treat stunting (as is done if children are selected for treatment according to deficit in weight for age); therefore stunting has to be prevented; this means that action programmes should be concentrated on children in the 1st year of life. What we need to discuss is whether conclusions of this kind are correct, not whether a small percentage of children are "mis-diagnosed" by one classification compared with another.

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SULPHONE RESISTANCE IN LEPROSY

SIR,—In my letter (Aug. 9, p. 280) I stated that sulphone resistance has not affected the interruption of transmission of leprosy in areas where dapsone has been used. Dr Browne (Aug. 30, p. 408) does not dispute these findings, and seems to have missed the point of my letter.

In the areas studied^{1,2} the fall in incidence was so rapid, and the lepromatous cases were so few, that complete interruption of transmission may have occurred by now. These findings and other evidence³ strongly suggest that the *eradication* of leprosy could be achieved by dapsone alone, probably within the next ten years. Smallpox is now confined to only two countries. The next priority should be leprosy, and the World Health Organisation and other interested bodies should be ready to put into effect a campaign based on outpatient treatment with dapsone.¹ In this context the problem of sulphone resistance in the patient with lepromatous leprosy is of secondary consideration. Although individually important it is still of low frequency: one estimate being 2.2%.⁴

Dr Browne does not give figures to support his statement that resistance is "a matter of grave concern". The fact

of the matter is that it is not serious enough to radically alter well-established and proven outpatient treatment schemes. Instead, during a world-wide eradication campaign it should be ensured that lepromatous patients receive regular treatment with adequate dosage of dapsone. The small percentage of patients Dr Browne refers to can be changed to clofazimine or rifampicin when resistance arises.

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SPLENECTOMY AND LYMPHOMAS

SIR,—Unfortunately, the study by Professor Morris and his colleagues (Aug. 9, p. 250) provides little insight into the indications for splenectomy in cytopenic patients with lymphomas. In part this results from the tendency of some to lump Hodgkin's disease and non-Hodgkin lymphoma together, despite their different natural histories, differences in the role of laparotomy for staging, and differences in treatment response.

Certainly one cannot argue with the authors when they state that certain patients with these diseases are deserving of splenectomy, but this study has several deficiencies which prohibit the conclusion that in lymphoma patients with cytopenias "splenectomy is indicated in most instances". Patient selection is poorly defined, severity of the cytopenias is not quantitated, and it is unclear from their non-randomised study whether splenectomy has any influence on either remission-rate or survival. I must take issue with the authors who consider acceptable a 14% operative mortality in non-Hodgkin lymphoma. Equally unfortunate is the failure to consider non-invasive methods of controlling cytopenias, such as splenic irradiation.

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HOME BLOOD-PRESSURE RECORDING

SIR,—I read with interest Dr Traub's letter (July 19, p. 126) describing his experience with home blood-pressure measurements. During the first four or five days of measurement he found, in 22 patients with borderline hypertension, higher blood-pressure readings at home than in the clinic. In our experience with a considerably larger number of patients¹ this does not happen; the home readings tend to be lower from the outset of the measurement. Our patients were not recruited from the hypertension clinic. They participated in a screening programme, and did not know their initial recording, and the diagnosis of hypertension was not communicated to them. It was stated that they might either be controls or have a mild blood-pressure elevation and that we would prefer their not knowing to which category they belonged. Of course they could obtain the information from other sources.

Conditions of measurements notoriously influence the results in borderline hypertension. I agree that "great emotional tension brought on by the necessity for dealing with a new procedure . . . which might very well determine the approach to their future management" may influence the readings. This, however, appears to apply to Dr Traub's experience in a clinical setting, and not to our study.

1. Crawford, C. L. *Nature*, 1975, 254, 168.

2. Crawford, C. L. *Lancet*, 1972, i, 1186.

3. Crawford, C. L. *ibid.* 1971, ii, 1375.

4. Pearson, J. M. H., Rees, R. J. W., Waters, M. F. R. *ibid.* July 12, 1975, p. 69.

1. Julius, S., Ellis, C. N., Pascual, A. V., Matice, M., Hansson, L., Hunyor, S. N., Sandler, L. N. *J. Am. med. Ass.* 1974, 229, 663.

Nevertheless, if there is any doubt, especially if the home reading is higher than the clinic reading, the period of blood-pressure measurement at home should be prolonged. In our hypertension clinic, this does not happen frequently, but our patients take blood-pressure readings for two weeks, and the second week's results are averaged.

Though Dr Traub did not have appropriate normotensive controls, his finding that after two months over 50% of the patients with borderline hypertension became normotensive, as opposed to 28% in our study, may well mean that, with the passage of time, additional patients will become normotensive. This very much depends on the definition. If we add borderline and normotensive subjects after a week of home blood-pressure readings, only 30% of the patients with clinical borderline hypertension will be clearly hypertensive at home—a very similar percentage was found by Dr Traub after two months.

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NO CHILDHOOD

SIR,—People with any knowledge of the lives that children in long-stay hospitals lead will agree for the most part with the recommendations in the Council for Children's Welfare report, *No Childhood*, which was discussed in your editorial (June 14, p. 1326), and in subsequent correspondence (July 5, p. 35, and July 12, p. 78). However, we all know that between a recommendation and its implementation may lie one whole childhood, and it is of the greatest importance that no one nurse, working perhaps against great odds, should read this report and go away broken-hearted and hopeless. At a meeting where this report was discussed, I was impressed less by the repetition of details of deprived childhoods than by the more hopeful discussions afterwards. Children are usually in hospital because there is no other place for them, and a hundred reports of this kind do not of themselves produce one single foster placement, but there are other ways of helping these children. At one hospital, parents form a ward committee, responsible for organising leisure activities for the children. There are many dedicated and imaginative ward sisters, who may have refused promotion because they want to stay with "their" children, who would welcome support and advice from committees of this sort.

I would also suggest that the system of proxy parents, or "social aunties" as they are sometimes called, could be much more widely used. The Parent to Parent Information on Adoption Services already report an increasing number of couples interested in adopting children with handicaps of all kinds, and there are likely to be many more people ready to commit themselves, no less wholeheartedly but less finally, to a child, to help make his weekends and holidays more like a true and continuous childhood. Unfortunately, it is often difficult to satisfy the social workers, usually hospital-based, that you are a suitable person to become a social aunt or uncle. You may have to undergo a fairly rigorous trial period to make sure that your motives are entirely "pure" (whose are, ever?). If you are a member of staff at the hospital where the child is resident, and therefore a natural person to want to do this, you are truly suspect, for your involvement with one child is said to affect your relationship with other children. Yet what these children desperately need, and will not get otherwise, is for someone to get involved with them, someone who will grow to love them, and fight for them. Until the hospitals learn to accept the willingness and the

love in the communities around them, the needs of the children will be lost in a mesh of red tape.

If it is right that children under 7 years of age should never be in hospital at all except for acute medical reasons, and if there are no facilities outside and the parents cannot cope, what is to be done? I suggest that a domiciliary service providing multitherapy could be provided. This could offer practical help of all kinds, including physiotherapy and speech therapy, as well as the daily living advice so well provided by occupational therapists; play advice and toy library facilities could also be given. This service might be combined with short-term care and baby-sitting, as well as a home-help service provided at peak hours, morning, evening, and weekends. A service like this can only be provided by employing highly paid, very skilled people, but it may well be cheaper in the long run, by giving a family hope as well as help.

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HORMONE SENSITIVITY AND BREAST CANCER

SIR,—Salih et al. have suggested that the in-vitro hormone sensitivity of breast-cancer tissue might be useful as a guide to clinical screening for possible hormone treatment.¹⁻⁴ The technique depends on the subjective microscopic assessment of the density of formazan deposit in a frozen tissue section after 24 h incubation in maintenance medium with or without hormones. An assessment of the technique carried out by Beeby et al.⁵ failed to confirm the findings of Salih and his colleagues.

The method used by Salih et al. has been repeated in our laboratory. Over the past 2 years some eighty specimens from primary and secondary breast cancers have been tested in vitro. Of these, 44% showed some indication of hormone "dependence", the percentage of cases falling into each category differing from that reported by Salih et al. The clinical responses are not yet known but an important source of technical histological error has come to light.

A 'Quantimet 720' was used to quantitate the amount of dye deposited in serial 8 μ m sections. When specimens which had been estimated visually by two observers as showing hormone dependence were measured quantitatively no objective difference was apparent. Furthermore, variation in enzyme activity between sections cut from the same piece of tissue was as great as that found between sections from pieces of tissue incubated in other hormones. Tissue heterogeneity can be excluded because the sections were serially cut. It seems therefore that errors in the interpretation of the results using the technique of Salih et al. may be due to variations in section thickness, as well as tissue heterogeneity.

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