Preventive child care

Sir,

Your editorial headline 'General practice united on preventive child care' (December *Journal,* p.643) is highly misleading. General practitioners have never been united in their view of the value of developmental screening of apparently normal children. Indeed many of us are highly sceptical on this matter because there is no good evidence that such screening is worthwhile. Until a UK-based controlled clinical study of developmental screening of apparently normal children shows significant benefits in screened children, general practitioners would be wise to avoid this time-consuming work, which will inevitably distract them from other work which may be of more value.

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Long-term sequelae of Coxsackie B virus infection

Sir,

I recently had occasion to read Dr J. A. Gray's editorial 'Some long-term sequelae of Coxsackie B virus infection' in the January 1984 issue of the *Journal* (p.3).

I must take issue with the statement that 'although some epidemics of BME [benign myalgic encephalomyelitis] have involved districts or all-male institutions, most took place in residential institutions with a wholly or largely female population', and the suggestion that this probably lent credence to the 'mass hysteria' theory of the syndrome. This statement concerning the majority of myalgic encephalomyelitis outbreaks is simply incorrect. For the past 50 years since the syndrome was first recognized most of the outbreaks have been reported for districts.

Dr Peter Behan's article in 1980[1] lists 44 outbreaks of myalgic encephalomyelitis worldwide, from 1950 to 1977. Twenty-eight outbreaks were reported for districts, seven for male and female hospital workers, one for 'factory and district', and one for an all-male military institution. Only five outbreaks were reported specifically for 'nursing staff' and 'student nurses' (all or most, presumably female) and only one outbreak was reported for an all-female residential institution — a convent in upstate New York, USA. (Also in 1977, although not listed in the article, the Australian School of Public Health and Tropical Medicine reported an outbreak of myalgic encephalomyelitis for the town of Sydney.) So of all the recognized epidemics of myalgic encephalomyelitis from 1950 to 1977, fully 84 per cent took place among mixed-sex district residents, hospital staff or all-male institutions.

The myth that the majority of myalgic encephalomyelitis epidemics have occurred among cloistered females is, unfortunately perpetuated in a 1981 Dictionary of Medical Syndromes. But as evidence, the brief article on 'Akureyri syndrome' cites the single outbreak in the New York State convent (1961), reported in 1965 by a former Communicable Disease Centre investigator who had participated as well in on-site research of the Punta Gorda, Florida, epidemic. In that, 42 per cent of hospital personnel, including male attendings, interns and residents, were affected but only six per cent of the town's residents. The higher prevalence among hospital personnel for many recorded myalgic encephalomyelitis outbreaks seems to follow a pattern seen for recently reported outbreaks of Legionnaire's disease, where the majority of cases come from clinics and hospitals.

It is unfortunate that the epidemiological evidence collected in the medical literature should continue to be ignored, but it is all to the good that even more recent reports of myalgic encephalomyelitis epidemics in districts are now being published. These will make welcome additions to the available material on this interesting syndrome.

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Reference

1. Behan P. Epidemic myalgic encephalomyelitis. *Practitioner* 1980; **224:** 805-807.

Sir,

Although I agree that many epidemics of benign myalgic encephalomyelitis appear to have been in districts rather than among the cloistered females in residential institutions, there is really no doubt in my mind that some of the descriptions do suggest a female preponderence of cases and indeed in the article which Dr Spitz mentions, Peter Behan comments that 'The afflicted patients, normally young women, have a wide variety of complaints'.

I agree that my statement that 'most took place in residential institutions with a wholly or largely female population' is probably an exaggeration and I would be willing to modify this to 'many took place in residential institutions'.

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Mumps polyarthritis

Sir,

I am writing because I have recently seen a case of mumps polyarthritis in an adult male and subsequent research of the literature shows this to be a rare complication. I would be interested in finding out quite how rare.

Case History

The patient is a 31-year-old male Caucasion who developed bilateral parotitis. This settled on conservative treatment of fluids and regular analgesia. Five days after initial presentation he attended surgery complaining of a painful left testis which I diagnosed as mumps orchitis. This was again treated with regular analgesia. Seven days later we received a request for a visit because he was unable to walk. At that time his right wrist was very swollen and tender, as were all the finger joints on that hand. Both hips were painful, with marked limitation of active movement, and he was unable to bear weight. His left knee was painful and had a slight effusion. Both shoulders were slightly painful. The previous day his left wrist, and hand, and right knee had been involved, but this had largely settled.

The symptoms settled over a period of 48 hours. He was treated with local heat and ibuprofen (Brufen) 400 mg tds.

I shall look forward to any replies that may come my way as I found researching this subject quite fascinating; especially as mumps arthritis usually occupied only two to three lines in all the large textbooks on infectious diseases.

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