My greatest worry about your article is that it may have implanted in the minds of rapid readers an idea that all GP hospitals are costly. There has recently been a spate of closure threats from area health authorities seeking a simple solution to financial strictures. The busy members of these authorities rely on responsibile sources for information on which to base their difficult judgment. They cannot be expected to read research documents in detail. It is the considered view of myself and many others that the closure of flourishing GP hospitals solves no financial problem.

Your suggested comparative trial and pilot scheme for different regions seems rational but is probably doomed before it starts because no two regions or areas are comparable and no GP hospital will allow itself to be closed for experimental reasons. To quote the Oxford document once more, "a full analysis has not been achieved mainly because of the enormity of the task of collecting data on so many outcome variables. . . . Doubts remain on qualitative aspects which are not capable of measurement. . . . Yet the qualitative aspects may ultimately be the critical factors in any decision."

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[1] Rickards, J A, *Cost-effectiveness Analysis of the Oxford Community Hospital*. Oxford, Department of the Regius Professor of Medicine, 1976

"Nurse consultants"

SIR,—I have just read an article (in another journal) by a lady whose official title was given as "clinical nurse consultant (anaesthetics)." When I had recovered my equanimity I felt I must write to ask you or your readers for clarification. To me "clinical" and "anaesthetics" do not marry well, nor do "nurse" and "consultant." I would be interested to discover just what grade on the Salmon scale such a person holds and what she actually does? I cannot conceive of any situation in which any nurse should call herself a consultant and if we allow these things to occur we shall very soon be in a position in which the nurses are at the same level as the senior medical staff. I may well be cantankerous and oldfashioned, but this I will fight to the end of my working life.

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Side effects of prazocin

SIR,—I am grateful to Professor C Rosendorff (6 November, p 1131) for clarifying the points which I raised about his paper on dose-related side effects of prazosin (28 August, p 508). I am sorry that he considered some of my assumptions to be sinister—they were not meant to be. However, in view of the lack of information in the original paper it was impossible to assess the full significance of his results. In this context one has to appreciate the limitations imposed by the "short report" format and clearly Professor Rosendorff has good evidence that these first-dose reactions are dose-dependent.

So far as the ethical context of this work is concerned, my comment is, of course, highly subjective. I accept that rechallenge is an acceptable technique in diagnosis and therapy and can be so in experimental work as well. My complaint is not a general one against the concept of rechallenge but a particular one in this case in view of the severity of some of the reactions to the drug. I am not sure that any further information has been gained from this study than could have been gained from a comparative trial of the drug using a smaller starter dose against placebo and against other established antihypertensive drugs.

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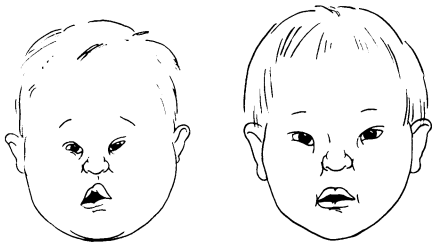
Diagnosis of Down's syndrome at birth

SIR,—Your leading article (9 October, p 835) rightly emphasises the importance of improving the clinical diagnosis of Down's syndrome soon after birth but comments on the shortcomings of existing clinical methods in achieving this.

One particularly characteristic clinical finding deserves wider recognition—namely, the size and *grouping* of the facial features. The newly born infant with Down's syndrome has eyes, nose, and mouth which are not only individually relatively small but which are grouped more closely together towards the centre of the oval represented by the face and forehead. The figure illustrates this in an affected infant (left) compared with an infant with similar but differently spaced facial features (right).



This finding appears so consistently that, taken in conjunction with the other discriminating features described by Jackson *et al*,[1] it should reliably increase the accuracy of diagnosis. Surprisingly it is omitted from nearly all standard textbook descriptions. It may not, however, apply to chromosome mosaic Down's syndrome.

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[1] Jackson, J F, North, E R, and Thomas, J G, *Clinical Genetics*, 1976, **9**, 483.

Disappearing elderly

SIR,—Some 18 months ago a planning document circulated by one of our local authorities implied that the provision of residential accommodation and other services for the elderly were at higher levels per head of population than we believed them to be. Closer inspection revealed that this "improvement" had been achieved by a reduction of over 20% compared with 1971 Census data in the estimated number of people aged 65 and over resident in the local authority area. The new estimate had been obtained by counting the persons on the electoral register who had declared themselves as not liable for jury service by virtue of being aged 65 or over.

We have had an opportunity to investigate the accuracy of this method of estimating the size of an elderly population. The Whickham Survey, carried out from 1972 to 1974,[1] studied various aspects of health among the adults of a geographically defined area by taking a 1 in 6 sample from the appropriate electoral registers. Subsequently we attempted to identify in the electoral register published in 1975 the 557 persons who, from interview or medical records, were known to have been aged over 65 at the time of invitation to take part in the survey. Of the 514 so identified it was found that only 385 (75%) had declared themselves as not liable for jury service on account of age.

Inquiries among a sample of 20 persons who had not declared their age at electoral registration suggested that in this small group at least the fault lay with the design of the registration form rather than with any unwillingness among elderly people to declare their age. Whatever the reasons, however, it is clear that in present circumstances use of the electoral register to count the number of persons aged 65 and over in an area may lead to a 25% underestimate. We wish to draw the attention of your readers to this finding in case this method of estimating elderly populations is being used in other areas for planning purposes. Our analysis is reported in detail elsewhere.[2]

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[1] Tunbridge, W M G, *et al*, Proceedings of the 7th International Thyroid Conference, Boston, Massachusetts, 1975.
[2] Evans, J G, Brewis, M, and Prudham, D, *Age and Ageing*. In press.

Educational placement of children with congenital rubella

SIR,—In 1964 Sheridan reported a follow-up at 8-11 years of 227 children whose mothers were considered to have had rubella during the first 16 weeks of pregnancy.[1] Of these, 206 (92%) were attending normal schools, seven of them with special provision such as hearing aids. It must be emphasised that the diagnosis of rubella was made during pregnancy on clinical grounds only, because serological tests were not then available.

In 1972 Gumpel reported on 83 children who had attended the Hospital for Sick Children, Great Ormond Street, and in whom congenital rubella had been retrospectively diagnosed.[2] She observed that only nine of the 72 school-age children (12·5%) were attending normal schools. Of the nine children, three were deaf, one of whom was being considered for a change to special education.

In March 1976 letters requesting follow-up information were sent to all doctors who had notified the Northern Registry of the National Congenital Rubella Surveillance Programme of children with confirmed or suspected congenital rubella.[3] Information was requested about proposed or current schooling for 88 children of or approaching school age. Replies were received for 83 children, of whom four