correction of known or suspected risk factors. There is clearly no magic formula, in my experience, which can be placed across the board and applied on a mass scale. There is, unfortunately, no alternative to the careful investigation of every patient on an individual level, correcting each risk factor presented, energetically, by the safest and most acceptable means for the patient. Clearly, the correction of hyperlipidaemia by all reasonable means must be included in any treatment programme for the prevention of atherosclerotic arterial disease. Unfortunately, all large multicentre trials that I have seen seem to fail in that they do not treat the whole patient, and for this reason grave doubt must be thrown on their validity in testing the concept of the primary prevention of arterial disease by studying one factor and seeking to match all other factors.

The review article by Professor Lewis (19 July, p 177) gives a clear and positive approach to the problem without leaving the physician with no guidelines to offer the patient.

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[1] A report from the Committee of Principal Investigators. *Br Heart J* 1978;40:1067-118.
[2] Royal College of Physicians of London. *Prevention of coronary heart disease*. London: Royal College of Physicians, 1976:21.

Social environment and relapse in schizophrenia

SIR,—Your leading article on social environment and relapse in schizophrenia (19 July, p 173) summarised the recent excellent work of the Medical Research Council Social Psychiatry Unit. It identified the value of medication and the importance of family life for the course of the illness. It lacked, however, a clear statement of the possible value of intervention in the family interaction processes to reduce excessive "emotional involvement, hostility, and dominance," which predisposes to relapse.

At least one methodologically adequate study in the United States suggests that family therapy may be useful,[1] and work in this country has examined some details of the pathological interactions.[2] The only family intervention explicitly suggested is removal of the patient from the family. As clinicians know, this is often unsatisfactory or unworkable. It is not unreasonable to think that sophisticated epidemiological research may clarify the value of family therapy techniques.

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[1] Langsley DG. *Am J Psychiatry* 1971;127:1391-4.
[2] Scott RD, Ashworth PL, Casson PD. *Soc Sci Med* 1970;4:41.

What is "emergency"?

SIR,—I have no wish to play sword and buckler with my friend Mr W H Rutherford (26 July, p 308)—there might indeed be a casualty.

Shakespeare did *not* use the word casualty for the seriously injured—as a glance at a concordance will show.[1] Dickens's "casualty ward"[2] contained more than those injured. If Mr Rutherford knows of other references perhaps he will tell me.

In the sixteenth century casualty meant "a chance event" and it was used in this sense in the Rules and Orders of Newcastle Infirmary (1751).[3] In soliciting support, its founders[4] had drawn attention to the case of a poor woman, run over by the York Waggon, who lay in a public place for six hours before she received attention[5]; and so we have in the rules, repeated by other voluntary hospitals,[6] the phrase "casualties when patients are suddenly brought in." The use of the word casualty depended on the communal setting and the irregularity of timing, not the injury. The word casual, as "casual losses," not casualty, was used by the Army until much later than 1810.[7] Mr Rutherford is quite correct in quoting the *Lancet* reports of 1869. It was probably the interest being shown which prompted Robert Bridges to write his now famous account of the casualty-outpatient department at St Bartholomew's Hospital.[8] In reading this first-hand account we see that the work of Robert Bridges there was at set times and was that of a dispensary physician. The "casualties" were the third category of patients, many with far from trivial complaints, being treated by the house surgeons (and house physicians) in the corner of the room. Perhaps it was the realisation that in protesting about the number of his patients he was talking himself out of a job which made him turn to other, perhaps less frustrating, pursuits. In any case it was these patients whom all subsequent reports have tried to restrain. Mr Rutherford's "casual" patient never has been a problem; if he does not come with a flea in his ear he certainly leaves with one.

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[1] Bartlett J. *Concordance of Shakespeare*. London: Macmillan, 1927.
[2] Dickens C. *Sketches of Boz. The hospital patient*. London Gresham Publishing Co, 1860:180.
[3] Statute of Rules and Orders for the Government of the Infirmary for the Sick and Lame Poor, 1751. Draft, Newcastle upon Tyne Medical Library, copy presented by W A Sanderson: 23.
[4] Hume WE. *The Infirmary, Newcastle upon Tyne*. Newcastle upon Tyne: Andrew Reid and Co, 1951:2
[5] *Newcastle Courant* January 1751, daily for one week.
[6] *Rules and Orders of Nottingham General Hospital*. Cresswell, 1781:15.
[7] Charles J. *New and enlarged military dictionary*. London: T Egerton, 1810.
[8] Bridges R. *St Bartholomew's Hospital Reports* 1878; 14:167.

Factor VIII supply and demand

SIR,—Dr Peter Jones (21 June, p 1531) is to be congratulated for his perceptive analysis of what is a complex and fascinating topic. He is right to conclude that nothing can be achieved in our search for self-sufficiency in blood and blood products without considerable changes in the organisation of collection and processing of blood and in our attitudes to its optimum use. Dr Aronstam's cri de coeur (21 June, p 1532), though understandable, was somewhat one-sided in defining where the problems lay and how they could be solved. Perhaps it would be helpful to make the following comments:

(1) There is now sufficient evidence to support the view that the calculations made in 1975 of the future factor VIII requirements in the UK were a significant underestimate. This view is fully recognised by many colleagues in the UK Transfusion Services and current forward planning is cognisant of this fact.

(2) Considerable efforts are being made to secure a position in which sufficient plasma fractionation capacity, based in the United Kingdom, will be available to meet the anticipated demands for the future. It would be naive to conclude that the single major problem in this area is lack of finance. However, this and the other problems are being actively explored against a background assumption that the vital and sustaining quality of our voluntary blood donation services must be secured. None of these difficulties is insurmountable; but resolution will require much effort, improved organisation and business skills, active collaboration between all concerned, and a resolve to maximise flexibility and minimise unnecessary expenditure.

(3) Unlike Dr Jones, Dr Aronstam failed to mention a most important aspect of the problem of national self-sufficiency in blood products—the availability of plasma for fractionation. Although there are several outstanding exceptions, there is little doubt that unless those in charge of hospital blood banks are more successful in persuading clinical colleagues to use red-cell concentrates rather than whole blood in the management of the majority of routine hospital transfusions, the creation of major new plasma fractionation facilities will not be the salvation Dr Aronstam seeks. Each year many thousands of litres of fresh plasma are being directed away from fractionation in the United Kingdom, and it is increasingly clear that the key to preventing this loss is held by the medical profession. Here is an area in which Drs Jones and Aronstam and their colleagues can make a contribution now and in so doing reduce the necessity for the transfusion services to develop large-scale plasmapheresis programmes.

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Pre-eclampsia and eclampsia and change of paternity

SIR,—We appreciate that the printers' dispute in the spring has made a nonsense of the dates appearing on your numbers over several months. This presumably accounts for the fact that your leading article "Inheriting pre-eclampsia" (28 June, p 1557), which gives a generally excellent review of the current state of knowledge on immunogenetic possibilities and pre-eclampsia, fails to refer to the important short report from Nigeria by Mr Dozie Ikedife (5 April, p 985). This provides strong support for the idea that pregnancies by new consorts carry a higher risk of severe pre-eclampsia or eclampsia than that holding for multigravidas in general.

This information is very important in relation to immunogenetic ideas about the aetiology of this strange condition and underlines the value of collecting data from parts of the world where the condition is still relatively common. Retrospective studies in our own area[1 2] showed that out of 34 201 deliveries there were 47 instances in which severe pre-eclampsia had occurred in multiparas who had normotensive pregnancies. Thirteen of these patients were found to have a change in paternity for the affected pregnancy compared with three matched controls.

The evidence is beginning to suggest that a pregnancy by a particular father gives the mother a degree of immunity to the condition in subsequent pregnancies by that father but that this does not cover pregnancies by other men. It would thus seem that pre-eclampsia