separate treatment rooms for physiotherapy, occupational therapy and speech therapy, school classrooms, a room for psychological testing and play therapy, general play-room, dining-room, kitchen, pantry, staff duty-room and rest-room, administrative offices (principal, medical director, clerk, typist, waiting-room for parents), store-rooms, brace shop, waiting-room for out-patients, board-room, etc. Living quarters will be required for the principal and his family, the nurses, nursery attendants or assistant matrons, kitchen and dining-room staff as well as for one or two teachers. A flat with two or three bedrooms, a sitting room and bathroom and a kitchenette should be held available for parents who have brought children for examination and are to receive instruction in the home training of the children.

Children not Provided for by the Proposed Centre
The proposed centre does not provide for the adolescent C.P. in need of vocational training. This is offered at the schools at Kimberley, but there will remain a need for an after-care home for cerebral palsied persons in the older age-ranges. The after-care home should offer sheltered workshop employment and farming activities for the cerebral palsied who are unemployable in the open labour market. This is a pressing problem needing study and planning.8

Another group of C.P. children for whom the centre would make no provision are those whose disabilities are so severe as to defy medical treatment, or who are so mentally or expressively handicapped as to be unable to cooperate in the treatment programme. These cases are in urgent need of custodial care, and provision will have to be made for them.

MONGOLISM IN THE BANTU
REPORT OF A CASE
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Ever since Langdon Down1 attempted an ethnic classification of idiots in 1866, when mongolism was described for the first time, an enormous amount of literature has been published on this type of mental deficiency. Formerly the consensus of opinion was that mongolism occurred only in the white (Caucasian) race.2 This opinion was shown to be wrong when Bullard,3 in 1909, reported his first observed case of mongolism in a Negro. Since then instances of mongolism have been reported to occur in Indian, Chinese and Japanese populations.1 Cases have also been reported in Egyptians, Indonesians and Jamaicans.3 Tredgold6 recently stated: ‘It now seems clear that the condition occurs among all races and in practically every part of the world’. Nevertheless the incidence seems to be particularly high among Europeans, occurring in about 1 birth per 600.7 4

In South Africa mongolism seems to be extremely rare amongst the pure-blooded Bantu tribes; an intensive search through the medical literature to find a recorded case was negative. Kluge,8 of the Alexandra Institution, Maitland, who has been devoting attention to this subject and has been in contact with authorities throughout the world regarding the incidence of mongolism in their respective countries, after searching intensively for 2 years among pure-blooded Bantu, found 2 cases—one amongst the Xosa, and the other amongst the Fingo. Walt,9 of Durban, saw 2 other cases among the Bantu, apparently of pure Zulu origin. It seems therefore that these 4, together with one

CONCLUSION AND SUMMARY
In conclusion it should be stated that the establishment of a Central Diagnostic and Treatment Centre for Cerebral Palsy would not replace or do away with C.P. clinics in other localities. These clinics and schools should be encouraged and aided. The centre here proposed would be a ‘court of last appeal’ providing thorough examination, diagnosis, and treatment unavailable at other clinics or schools for the cerebral palsied. To summarize the proposed centre will provide the following services:

1. A thorough diagnostic service for children with cerebral palsy.
2. An intensive treatment, training and educational programme for selected C.P. children who are able to cooperate in and benefit by the programme.
3. A training and counselling service for parents of C.P. children.
4. A research and training centre for the medical profession and ancillary medical personnel.

REFERENCES
to be described, are the only known cases of mongolism in the Bantu.

CASE REPORT

R.M., a 12-year-old Basuto male child, was admitted to the Oranje Hospital, Bloemfontein, on 29 October 1942 from the Trompsburg district. His place of birth was reported as Mafeteng, Basutoland. No family history could be obtained, and all efforts to trace any of the relatives were unsuccessful. He was certified because of his behaviour, and was reported to be noisy, aggressive and destructive at times. He tried to injure animals by throwing stones at them. He could not give any account of himself or even the name of his master.

On admission he was unable to give any information about himself except his name. He could not distinguish between left and right, and was unable to wash or dress himself. It was difficult to understand him, as he was practically inarticulate. He was diagnosed as being a low-grade mongolian imbecile. As the years passed his mental condition showed no appreciable change.

Present State. He is amiable and placid and gives no trouble in the ward. He remains mostly asocial, solitary and withdrawn. He does a little work—helps polishing floors. He speaks in a low husky voice, and is unable to give any account of himself. He knows his name and counts up to four. His habits are correct, but he has to be assisted in undressing and washing. He shows a remarkable faculty of mimicry (Fig. 3) and has a sense of rhythm. He is also fond of music, and a sense of humour has been noticed at times.

General Structure: Small and stunted growth, (height 4 feet 7½ inches), with a slight dorsolumbar kyphosis (Fig. 2).

Muscle Tone: General hypotonia of the muscles.

Head and Neck: He has the typical microbrachycephalic skull, with flattening of the occipital area.

Eyes: There is some narrowing of the palpebral fissures, which slant downwards medially (Fig. 1), and a convergent strabismus.

Mouth: The hard palate is high and narrow. Teeth irregular and carious.

Ears: The external ears are very small, and the external auditory meatus narrow on both sides.

Hands: Short and plump. The thumb and little finger are very much shorter than the other fingers and the little finger is slightly incurved (Fig. 5). When using a spoon for eating he fixes the handle between the 2nd and 3rd finger while the bowl of the spoon is held with the tips of the 1st and 2nd fingers and of the thumb, which, according to Doyle, is the typical way in which a mongol holds a spoon (Figs. 2 and 3). There is extraordinary laxity of the metacarpo-phalangeal joints due to muscular hypotonia.

Feet: Short and broad. A relatively large cleft is present between the big and 2nd toes.

Blood Picture: Haemoglobin 15.9 g.%. Colour index 0.98. Erythrocytes 5,400,000 per c.m.m. Leucocytes 12,400 per c.m.m. Differential count (the normal figures are shown in brackets for comparisons): basophils 0% (0%), eosinophils 0.78% (3%), myelocytes 0% (0%), juvenile cells 0% (0%), stab cells 14.59% (4%), segmented cells 23.99% (63%), lymphocytes 57.68% (23%), monocytes 2.93% (6%). The Nuclear Shift Index (N.S.I.—Schilling index) = Myelocytes + Juvenile cells + Stab cells

Segmented cells

In this case the N.S.I. is 1:1.6; normally the N.S.I. in South Africa is between 1:10 and 1:8. In this case therefore the N.S.I. shows an immature or foetal blood picture—the blood picture of an 'unfinished' child. This blood picture supports the theory of Bendall regarding the etiology of mongolism, viz. that mongolism is the result of a deceleration of the developmental rate due to noxious agents which interfere with the proper nutrition of the growing foetus. Another characteristic

Fig. 1. Showing the mongoloid eyes with the narrow palpebral fissures slanting downwards medially.

Fig. 2. Showing the small stunted growth (height 4 feet 7½ inches) and typical way in which a mongol holds a spoon. Height of person next to mongol is 5 feet 9 inches.

Fig. 3. Showing grimacing by mongol, mimicking another person standing next to photographer.
is the marked lymphocytosis, which is a fairly constant finding in mongolism.
The blood Wassermann test was negative.

SUMMARY

1. The first report of a Bantu case of mongolism is presented.
2. Most of the characteristic physical features of mongolism are present, e.g. the microbrachycephalic skull, the short broad hand and the 4-finger line, the mongoloid eyes, the cleft between the big and 2nd toes, and the general hypotonia of the muscles.
3. The characteristic mental features are present, viz. the low-grade imbecility, faculty of mimicry, and sense of rhythm.
4. The blood picture shows a general immature or foetal state. A marked lymphocytosis is also present.

REFERENCES

10. Doyle, P. J. (1949): quoted by Engler, M.

UNION DEPARTMENT OF HEALTH BULLETIN

Plague, Smallpox: Nil.
Typhus Fever. Cape Province: No further cases have been reported from Cradock district since the notification of 16 May 1955. This area is now regarded as free from infection.

Epidemic Diseases in Other Countries:
Plague: Nil.