Correspondence.

MYCOSES.

SIR,—With reference to Dr. Rupert Hallam's interesting paper on mycotic infections of the hands and feet in your issue of May 19th, I should like to be allowed to emphasize the extreme frequency of these infections in the tropics, and in general in all countries with a warm moist climate, such as Louisiana and Mississippi in the United States, certain parts of Southern Italy, Spain, and the Balkans. In New Orleans more than 30 per cent. of the medical students suffer in the late spring and summer from epidermophytosis of the toes. The condition has, of course, been known for years in Ceylon, Southern India, Singapore, and Hong-Kong, where it is known by a variety of names—" mango toe," " Hong-Kong toe," " Cantlie's foot-tetter," etc.—and a description of it was given by Chalmers and myself in our *Manual of Tropical Medicine*. It is caused, as proved by Sabouraud and Whitfield, by the same fungi that cause ordinary dhobi itch (tinea cruris, tinea inguinalis), the principal species of these fungi being *Epidermophyton cruris* Castellani, 1905 (synonym, *Ep. inguinalis* Sabouraud, 1907), and *Epidermophyton rubrum* Castellani, 1909. Both these organisms were first found and described by me in Ceylon in cases of dhobi itch. They are also the causative agents of certain cases of mycotic pruritus ani.[1]

I should like to call attention to another as yet little known mycosis which is far from rare in the tropics and in temperate zones, including this country, but is often overlooked—namely, furunculosis cryptococcica vel moniliaca (pyosis cryptococcica vel moniliaca). I described this condition several years ago,[2] and recently I again gave a description of it in the Gehrman Lectures on mycoses, delivered by me before the University of Illinois, and published in the *American Journal of Dermatology and Syphilology*, February, 1928 (p. 205).

The condition clinically is often indistinguishable from ordinary furunculosis, the patient presenting on various regions of the body lesions identical with ordinary boils. It runs an exceedingly chronic course. In some cases the scalp is principally or solely affected (folliculitis decalvans cryptococcica). In these latter cases the eruption usually begins as a follicular pyosis of the scalp, each pustule being pierced by a hair. The pustules may be somewhat flattened or conical; in addition to the pustules there are often fairly large infiltrated patches which later on open and discharge through several openings like carbuncles. The hair in the affected areas falls off, and patches of baldness, at times permanent, may be seen.

Pyosis cryptococcica responds very satisfactorily to potassium iodide given in full doses, but not to staphylococcus vaccines. I shall be glad to supply workers interested in the subject with cultures of the fungi I have isolated from various cases.—I am, etc.,

ALDO CASTELLANI.

Ross Institute and Hospital for Tropical Diseases, London, May 22nd.

THE TREATMENT OF MALIGNANT DISEASE BY COLLOIDAL LEAD.

SIR,—The report of Dr. Stanley Wyard on this subject, published in the *British Medical Journal* (May 19th, p. 838), is a highly significant, indeed a surprising, document, and as such calls for some comment from me. Certain past events into which I need not now enter make it a matter of strange taste for Dr. Wyard to have entered the field of criticism in regard to our work, and it may be doubted, in view of his own statements, whether Dr. Wyard ever seriously attempted to give the treatment a fair trial. Alternatively, or as well, we must question his clinical and scientific acumen, for a more unscientifically conducted investigation on which to base conclusions to the discredit of our work could hardly be conceived.

1. Why did Dr. Wyard use lead hydroxide after all our warnings to the contrary? True he does not include the cases so treated in his table of results; but the impression produced on the mind of an impartial observer, let alone that of Dr. Wyard, would have been deplorable. No doubt his views concerning the danger of the method were largely inspired by the effects following the use of a very toxic material.

2. The method of preparation of the so-called " colloidal lead " administered by Dr. Wyard, which he would have his readers believe was similar to our own, is grotesque. As I do not consider it necessary at the present juncture to discuss the full extent of his errors in this respect, I will merely remark that " shot " are not composed of pure lead, but contain what is believed to be an activator (arsenic) of malignant growth. This may surprise Dr. Wyard; nevertheless, it is a fact. What a poor return for the efforts of Professor Lewis and his associates in 1926 to teach Dr. Wyard how a lead colloid should be prepared!

3. The statements are made that " Examination of the blood really helps very little," and " We found that the number of red cells showing punctate basophilia was no evidence whatever for or against continuation of treatment "—statements which leave us bewildered. We can only conclude that Dr. Wyard's methods of observation are less refined than those of ourselves and others.

4. On examination of the table of results we note that of 56 patients treated with " colloidal lead " as many as one-half were under treatment for less than seven weeks, and of these, 17 died within that short period. A number —it is impossible to say from the data given exactly how many, but not less than 14 per cent.—died after a single dose. Forty-six of 56 patients did not receive the *minimum complete* course (0.5 gm. Pb), and 40 of these 46 received *less than* 0.4 gm. Pb. It is characteristic of Dr. Wyard's methods that, in regard to the only case which appears to have been suitable for treatment, and which has improved to so great an extent as to merit special comment, he should throw doubt on the diagnosis.

As Dr. Wyard draws from this assembly of clinical and scientific errors the conclusion that " there is no support for the statement that colloidal lead exerts a beneficial influence upon the progress of a malignant growth," perhaps I may be allowed to state my own conclusion from the same data—namely, that Dr. Wyard is neither competent to treat cases of cancer with lead nor to express an opinion on this subject.—I am, etc.,

Liverpool, May 21st. W. BLAIR BELL.

TREATMENT OF PROSTATIC ENLARGEMENT.

SIR,—I was much interested in the letter from Dr. C. E. Dennis of Melbourne, commenting on mine, published in your issue of April 21st (p. 691) and to note that his experience in the treatment of prostatic enlargement by radiotherapy agrees with mine.

It seems to me a most regrettable fact that British surgeons and practitioners do not recognize the great benefits that *x*-ray treatments can give in suitable cases. It is the same thing in the field of gynaecology where menorrhagias, metrorrhagias, menopausal haemorrhages, etc., are subjected to curettage, or a major abdominal operation, before radiotherapy has been given the trial that, in suitable cases, is always suggested on the Continent and in America prior to surgical intervention. No *x*-ray specialist of experience claims that radiotherapy is a panacea for all these conditions, but it is so often successful in effecting a cure that I plead that patients should be given the chance of relief by the simple and painless use of *x* rays more frequently than is at present the case. Regular consultations between the surgeon and the radiologist, and the mutual recognition by both of the expert knowledge in their own specialty possessed by each, is the only way in which the best interest of the patient can be attained.—I am, etc.,

J. CURTIS WEBB, Consulting Radiologist, Gloucester Royal Infirmary.

Cheltenham, May 21st.

[1] *British Medical Journal*, December 1st, 1923, p. 1037.
[2] See *Journ. of Trop. Med. and Hygiene*, December 1st, 1924.

Br Med J: first published as 10.1136/bmj.1.3517.958-b on 2 June 1928. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.