you'll never get any information out of the hospital as to what is wrong with yourself, far less your child." The judge then stated : "If it were a child of mine, I would change my doctor," and Mr. Vaughan made a further statement that "one can't get facts from hospitals. They are grossly impertinent when you ask."

I am sure I am voicing the opinion of those who see after children when I say that those in charge of them in hospital try to give parents information about their children. Parents are given appointments for this purpose, told the truth, savoured albeit sometimes with hope which is scarcely justified, and encouraged to come again. This practice, which is rewarding in many ways, was in vogue before the National Health Service Act came into operation. Even then it was our duty to give "a dying pauper" as much attention as we give now to those who pay.—I am, etc.,

Rugby. R. E. SMITH.

SIR,—When an employer of labour is held responsible for an injury to his workman he alone faces criticism, and employers in general are not forced to share in the disparagement. Why, then, is it possible, on the evidence advanced in a single case, for counsel to assert that "nurses and doctors will shut up like clams and you'll never get any information out of the hospital as to what is wrong with yourself, far less your child," or, again, "One can't get facts from hospitals, they are grossly impertinent when you ask." Remarks of this kind are pounced upon by the popular press, public dissatisfaction is intensified, and we are forced to focus our interest not on the patient but upon self-protection. Surely distinguished lawyers are sufficiently in touch with our problems and difficulties to avoid such expressions of personal opinion which can only serve to damage a sister-profession and to destroy, without cause, the confidence of twenty million people.—I am, etc.,

Swansea. C. J. CELLAN-JONES.

Change of Sex

SIR,—Your annotation on "Change of Sex" (*Journal*, March 20, p. 694), coupled with the remarks of your medico-legal correspondent (p. 710), raises a serious problem. Intersexes are imperfect males or females, this imperfection being due to the disturbance of the sex-forming—or sex-differentiating—mechanism which occurs in the course of embryological development. In rarer cases the sex differentiation breaks down in the course of post-natal life following, for example, certain endocrine diseases. Although imperfect men and women, intersexes possess what has been called since the Roman jurist Ulpianus, of the third century of our era, the predominant sex.

The problem is, What is the predominant sex in an intersexual ? As I pointed out in my Thomas Vicary lecture many years ago,[1] with our contemporary ideas the predominant sex is that manifested by the total personality and not that indicated by special features of nuclear genes, gonads, endocrines, or even by the balance of sexual characters. Total personality is shown by the behaviour and will of the individual. Thus, in principle, an intersexual individual has the right to demand of us to perfectionate his sex according to his choice.

The application of this principle is accepted for that class of intersexes designated as hermaphrodites ("true" or "false" according to our ridiculous terminology)—that is, in individuals who show in their genital organs and sometimes in their gonads a mixture of male and female features. Since the work of Ambroise Paré in the sixteenth century we accept to use medical and surgical procedures to perfectionate these unfortunate individuals towards the sex they will and to allow them to register accordingly. Legal complications such as marriage can be settled by the procedure of annulment. Sexual behaviour complications are not important, because, with the exception of certain cases of exhibitionism, hermaphrodites have a very weak libido. Fertility is non-existent.

The application of this principle of free choice for the other class of intersexes, the transvestites, is much more difficult. These are individuals whose genital organs and gonads are distinctly male or female but who feel they belong to the opposite sex and want to live, dress, and work like members of the opposite sex. I have noted the curious fact, however, that this does not apply to their sexual behaviour, and genuine transvestites do not generally wish to act as individuals of the opposite sex. With this group, as with the hermaphrodites, it appears that the intersexualizing process inhibits the development of the libido. In my opinion, these transvestites are as much hermaphrodites as those designated with this term, and, in fact, we find definite endocrine, genital, and other physical stigmata pointing to a definite intersexuality. They are the most unfortunate beings, leading lives of misery often terminating in suicide. We have to help them—but how ? In this country psychotherapy, guidance, and help towards registration are sufficient. In Denmark Dr. Hamburger and his co-workers[2] have had the courage to apply more drastic endocrinotherapeutical and surgical measures. Can we go as far as that ?

One important point : We must distinguish between the real transvestites, who are in fact hermaphrodites, and certain homosexuals, as well as patients with special obsessional neuroses, but the life history, the physical stigmata of intersexuality and the maldevelopment of the gonads and genital organs, and the unimportance of the heterosexual libido will help us. Although there are intermediary forms such differentiation is necessary and usually possible.—I am, etc.,

London, W.1. A. P. CAWADIAS.

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1 *Hermaphrodites, The Human Intersex*, 1946, 2nd ed Heinemann, London.
2 *J. Amer. med. Ass.*, 1953, **152**, 391

Elderly Psychiatric Patients

SIR,—I was impressed by the diagnostic accuracy recorded by Drs. Vera Norris and Felix Post (*Journal*, March 20, p. 675) in elderly psychiatric patients. I would have wished that the distinction between affective and arteriosclerotic illnesses had been more clearly defined. Of four patients over 65 recently discharged from this hospital suffering from mania and depression which had responded to E.C.T., all had been given a hopeless prognosis of which the patient had unfortunately become aware.

Depression in the elderly is often complicated by confusion, and mania always is, but this does not prejudice the response to E.C.T. The statement that "affective disturbance is commonly the leading symptom in cerebral arteriosclerotic dementia" may perpetuate errors. Again, the authors state : "Special inquiry was usually needed to elicit a history of fainting turns, transitory pareses, or speech disturbances ; and this, even in the absence of neurological signs or patchy intellectual defects, was regarded as indicative of cerebral arteriosclerosis." This statement surely needs clarification. Fainting attacks are very common in the aged. Sheldon[1] records that 64.7% of women between 70 and 74 suffer from vertigo and 47.5% are liable to falls. Even patients who suffer from cardiovascular disease or have had strokes may also suffer from depression which can remit completely with E.C.T.

I feel the concept of arteriosclerotic dementia is based on shaky pathological and clinical criteria and the majority of cases so diagnosed are suffering from post-apoplectic dementia and mixtures of psychosis and dementia, but many recoverable illnesses are doomed by this diagnosis. Depression and mania can be fatal diseases, and early death does not necessarily mean a senile process. The points raised in this letter have been discussed at greater length by Gallinek,[2] so I will not trespass further on your space.—I am, etc.,

Sheffield. G. I. TEWFIK.

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2 *J. nerv. ment. Dis.*, 1948, **108**, 293.

"Antidotarie Chyrurgicall"

SIR,—As Mr. L. Jolley truly remarks (*Journal*, February 20, p. 456), the Tweed appears to be an insuperable barrier to the bibliographer. In your note on "Some More Rare Books" (*Journal*, March 20, p. 699) you say that *Childbirth, or the Happy Delivery of Women*, London, 1635, is

very rare, and only one copy, that in the British Museum, is listed in the *Short Title Catalogue*. There are three copies in the West of Scotland, one in the Royal Faculty Library, one in the Hunterian Library of Glasgow University, and one in William Smellie's Library at Lanark. The latter is historic, as it is the copy which Professor Miles Phillips had restored to Lanark after many years' sojourn in the library of the Royal College of Surgeons in Ireland. It may also interest you to know that we in the Royal Faculty and the Hunterian Museum also have the 1612 edition. The other books mentioned are easily available in one or other of the medical libraries of Scotland.—I am, etc.,

ARCHD. L. GOODALL,
Hon. Librarian,
Glasgow, C.2. Royal Faculty of Physicians and Surgeons.

Strangulated Hernia

SIR,—Dr. J. Rendle-Short and Mr. Cyril Havard (*Journal*, March 20, p. 680) have done a service in reminding us that, although nearly all herniae in infants can be reduced by conservative means, occasional cases of true strangulation and incarceration do occur. It would be interesting to know how many of their 45 cases required emergency operation, and whether they advocate early elective operation after successful reduction by conservative means. They remark that the age-incidence is remarkably constant, and that the greatest number of cases are found in the first year of life. Textbooks of surgery seldom mention the age-incidence of strangulation, and it may not be appreciated that this condition is virtually confined to infants and the middle-aged and elderly.

A year or so ago, after reflecting that I had never seen a case of strangulated inguino-femoral hernia in a young adult, I examined the case records of 100 patients admitted to Barnet General Hospital with strangulated hernia, and 100 similar cases admitted to Edgware General Hospital. The records of the latter group were obtained by the courtesy of the Medical Director, Mr. J. N. Deacon, whose remarkable records department produced the relevant data by return of post. The average age of the Barnet group was 65.8 years, and of the Edgware group 64.4 years. Even more striking is the fact that, although both hospitals serve large areas, only two patients under 40 years of age (excluding infants) were admitted to Barnet with strangulated hernia in six years, and only five such patients to Edgware in three years. No patient under 30 years of age was admitted to either hospital. Some rather obvious assumptions were confirmed by the study, among which may be mentioned the much greater risk of gangrene in a femoral hernia, and the predisposition to strangulation imposed by the wearing of a truss for inguinal hernia.

These figures are mainly of academic interest, but they may help to resolve an individual clinical problem. For example, if an inguinal hernia is first noticed during pregnancy in a young woman, the risk of disturbing the pregnancy by elective operation is probably more than the risk of strangulation during labour. In this connexion it may be of interest that no case of strangulation has complicated pregnancy or labour in the last 7,000 cases admitted to the maternity department of Barnet General Hospital.—I am, etc.,

Barnet, Herts. V. J. DOWNIE.

Aetiology of Non-specific Urethritis

SIR,—Dr. R. R. Willcox in his article (*Journal*, January 2, p. 13) dealing with the aetiology of non-specific urethritis, sees the cause of this not uncommon disease in a presence of some "virus" which has not been isolated, and remains to be discovered. In my opinion the bacteria, and even some undefined virus, are just the secondary feature, the main basing on changes of tissue. Non-specific urethritis is a common disease even in my country in recent years, and, besides that, I am observing in practice quite a considerable number of polyurias, pollakisurias, nycturias and enureses in children as well as in adults, without any aetiological grounds. In all these cases we find one constant symptom, and that is the pronounced alkalinity of urine, detectable with litmus paper, and reaching often points from *p*H 7.5–8. The alkalinity is not always present in all portions of urine, usually the morning urine being acid and the afternoon alkaline.

What may be the cause of this alkalinity, which years ago was not so often pronounced? I think there is a relative alkalinity of food due, first, to shortage of proteins owing to the second world war, and, secondly, to the over-emphasizing of vegetable foodstuffs by official medicine in both our countries, in respect to a vitamin fashion. However, if we consider the alkalinity of urine as the aetiological cause of non-specific urethritis, the illness should disappear when the kidney excretion is acidified. That is really the fact. After giving 1 g. of ammonium chloride daily the disease disappears within a week. Ammonium chloride forms urea in the body, and free chlorine ions remain acidifying urine finally. Aetiological treatment would be, of course, to enlarge the level of proteins in the food.

For illustration here is one case: a 52-year-old Army colonel, who for six years suffered from a purulent discharge from his urethra, bacteriologically non-specific flora, gonococci never present. During these six years he went through all kinds of treatment: antiseptics, antibiotics, sulfadrugs, abstinency from coitus, and kurort treatment with alkaline mineral water. Finally he shifted from cavalry to artillery, without effect either. After taking the above-quoted medicine he was within a week without any discharge, and remains in good state until now—that is, after a year. He takes ammonium chloride occasionally, when he feels itching in the urethra. The puzzle remains why his wife, vegetarian as him, and many other vegetarians remain without any ill symptoms from the urinary tract.

Please excuse, dear Sir, my bad English—it is now over 15 years since I was a short while in your country, and a year in the U.S.A. I am very indebted to the extraordinary high level of your *B.M.J.*, which is the best one from all Western papers dealing with general medicine.—I am, etc.,

Brno, Czechoslovakia. JIRI STEFL.

Poliomyelitis

SIR,—In your annotation on immunization against poliomyelitis (*Journal*, March 13, p. 635) you speak of poliomyelitis as "a disease with so low an attack rate . . . and one of which the dissemination is so mysterious that we cannot know whether or when any given individual has been exposed to infection." Can you really say that the attack rate is low or the whether and when of infection mysterious when we have repeated examples of exactly the reverse? As many as 4 out of 13 babies infected in a maternity home,[1] 16 out of 120 inhabitants on a housing estate,[2,3] 3 cases in the infant class of a school of 22 pupils,[4] 4 cases in a children's hospital ward,[5] 12 cases in a school of 73 pupils,[6] 6 cases (1 fatal) in a school of 65 boarders,[6] numerous examples of multiple infection in a family,[7,8] etc.

A great problem is often made of the odd sporadic cases although these form only a small minority of the annual notifications; the majority of cases occur in local outbreaks[9] and so, far from being distributed over the total population of the affected area, are confined to those associated with an infected school, nursery, hospital, family, or other group, in which the individual's chance of developing the disease and/or transmitting the infection may be a hundred or more times that of the rest of the local population. Thus in the epidemic in Rye in 1952[10] 17 of the 23 cases were either pupils or home contacts of pupils of the Rye Elementary School, and five of the remaining six cases were indirect contacts.

The tragedy is that the mumbo-jumbo of "mysterious dissemination" of the virus—more worthy of the pre-Pasteur days of "spontaneous generation" than of the present day—is preventing our using the only effective weapon we have against the disease; namely, prevention of transmission of the virus by the enforcement of quarantine restrictions. "Prevention," one is tempted to urge, "is better than cure." But in poliomyelitis we have no cure. Wrong treatment can certainly add to the disaster, but we must recognize that the results of even the best treatment are pathetically insignificant compared on the one hand with what we might do by prevention, and on the other with the