

Correspondence

Because of heavy pressure on our space, correspondents are asked to keep their letters short.

Length of Textbooks

SIR,—Much thought has been given recently to the lightening of the medical curriculum, but little to the length of textbooks. The situation is admittedly worse in the United States, but it is bad here and is deteriorating. There are the abler students who can profit from the large book, and those with good memories do not waste their time in reading them. But students of average intelligence have no choice save to buy and to try to read heavy tomes of more than 1,000 pages, from which they obviously can learn very little, because there is far too much to remember. Even shorter books of about 400 pages are sometimes little better, because in the endeavour to keep down the number of pages, each page is packed so tightly with information that it is indigestible.

There is, however, little inducement to the author who writes the short book, for he will be told that "the short book is unworthy of him," that "it is just a crammer," and that it is "uninspiring." The publisher of course likes a long book, because he makes much more money by selling it.

I am convinced that the difficulties of the medical curriculum would be materially reduced if quite short books were available on physiology, biochemistry, anatomy, and pathology, as well as on the clinical subjects. Those who have examined know quite well that the questions they ask cover a limited range. The questions are chosen to find out if the candidate has a grasp of the essential features of the subject. A book which attempts to prepare the student to answer such questions is not a crammer. It is an aid to education. Nor is such a book necessarily uninspiring. The student's inspiration must in any event depend chiefly on the lecturer to whom he listens. But he may well be inspired by a book which seeks to make clear what the student is expected to know, and, still more important, why he should know it.

The importance of many scientific observations is not difficult to explain, nor need many words be used to do it.—I am, etc.,

Oxford.

J. H. BURN.

Mercury Poisoning

SIR,—In Dr. D. M. Evans's medical memorandum on mercury poisoning (May 26, p. 1458) the following sentence occurs: "An early sign of mercury absorption has been stated to be opacities in the lens of the eye and discoloration of its anterior capsule."

This is misleading. Lens opacities are not a sign of mercury absorption. Discoloration of the anterior lens capsule is, but it does not occur early. It occurs after prolonged exposure, lasting at least a year, to relatively low atmospheric concentrations which do not usually result in sufficient systemic absorption to cause erethism. Short exposure to high concentrations will cause erethism but does not produce visible changes in the lens.

This discoloration of the lens capsule, known as mercurialentis, is almost certainly caused by local absorption through the cornea and is not directly related to systemic mercury poisoning. The subject is more

fully dealt with in a recent paper presented to the Section of Ophthalmology of the Royal Society of Medicine.¹—I am, etc.,

London W.1.

R. A. BURN.

REFERENCE

¹ Burn, R. A., *Proc. roy. Soc. Med.*, 1962, **55**, 322.

Metformin in Treatment of Diabetes Mellitus

SIR,—I must comment on the letter by Dr. G. F. Joplin and Dr. M. Hartog (April 28, p. 1208). They appear to have misinterpreted our meaning. The relevant paragraph in our paper (March 10, p. 680) reads as follows:

"In our small series the type of patient who appeared to respond best was over the age of 40, had no tendency to severe ketosis, and was not suffering from 'pancreatic diabetes'—the type of case, in fact, that may well respond to sulphonylureas. Metformin can therefore be considered in such cases if there is complete or partial resistance to the sulphonylurea derivatives. Two of our cases were resistant to tolbutamide but responded satisfactorily to metformin."

The obvious inference is that metformin could be considered in such cases for a clinical trial, our own experience being limited to two cases only.

They report that in an unspecified number of sulphonylurea-resistant non-ketotic diabetic patients only three showed any response to metformin, and that in all of them the response was inadequate and was no better than that previously obtained by tolbutamide. It would be helpful to know how many patients they have actually treated, what their ages were at the onset of the diabetes, and their weights, for in our experience at St. Mary Abbots Hospital a response is most likely to occur in non-ketotic patients whose diabetes started under the age of 40 and whose weights were over 10 st. (63.5 kg.). It would also be helpful to know whether all their patients in the trial actually completed a minimum period of two weeks on metformin, which we considered essential when assessing a response to treatment.

I was surprised by the high incidence of side-effects, for our experience now extends to well over 50 cases, some treated continuously for over two years, and such side-effects are infrequent. In the early days of our trial several of our patients did complain of nausea and mild anorexia, but these symptoms ceased when they took their tablets with their meals. We did, however, report in our paper that we had to discontinue treatment in two patients because of persistent nausea and vomiting in one and diarrhoea in another. Two other patients had diarrhoea when taking 3 g. of metformin daily, but this symptom ceased when the dose was reduced to 1.5 g. daily. Since we have written our paper two other patients on long-term treatment had their dose of metformin reduced because of a tendency to mild diarrhoea, and their diabetes appears to be satisfactorily controlled on the reduced dose. I wonder whether side-effects in some of their patients were due to fear that questioning may have induced.

Alternation of the true tablets with placebo tablets, identical in appearance, could be a satisfactory way of assessing the oral antidiabetic drugs, but the dietary intake by the patient is more satisfactorily controlled by admitting them into hospital as we have done. The blind trial was not therefore essential, particularly as every one of our patients, when admitted to hospital, was told that we did not know whether a response would occur or not, and that they were being admitted for clinical trial only. When we were uncertain whether

improvement was due to metformin or diet, we included such patients under the heading "Could not be assessed" and they were not considered metformin successes.

I would welcome more details before I could accept their conclusion that metformin could not be considered for a clinical trial in sulphonylurea-resistant non-ketotic diabetic patients. I should certainly consider trying the effect of metformin with tolbutamide in their three patients who showed some response to both substances, and it is quite possible that a satisfactory response might occur to the combined treatment. It is to be hoped that Drs. Joplin and Hartog, as well as others, will continue their trials in such cases, to determine the precise place of the drug in the treatment of diabetes mellitus.—I am, etc.,

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B. GOTTLIEB.

Treatment of Acute Osteomyelitis

SIR,—There will be general agreement with Mr. N. H. Harris's views (May 26, p. 1440) that early surgical decompression is usually advisable in acute osteomyelitis. Delay in coming to a correct diagnosis frequently precludes early surgery and results in the complications of bone necrosis and chronic sepsis. Differential diagnosis is not always easy either in the child or in the adult, but certainly the paediatrician and the physician are asked to see as many of these early cases in consultation as are their surgical and orthopaedic colleagues. We therefore disagree with Mr. Harris's view that this remains a surgical disease. In the early stages, when we hope to see these patients, the rational way to deal with them in hospital is by joint consultation and corporate responsibility. This is particularly important in the early age-groups in which the majority of cases occur.

This has been the policy in this hospital for many years. Unfortunately we still have referred to us a proportion of late cases, but in our paediatric ward we obtain a unified approach with gratifying results. We cannot agree that the diagnosis and treatment of this condition can ever be simplified by a more surgical approach, even with antibiotic help. Careful clinical assessment and judgment will always play a major part in the handling of this disease at all ages.

We would refer Mr. Harris to Sir Harry Platt's report 30 years after the quotation he gives in his article. As chairman of a central health services committee he states¹:

"We strongly recommend that children should not be nursed in an adult ward. This principle was supported in evidence by the Royal College of Physicians, the Royal College of Surgeons, the British Medical Association, the British Paediatric Association, the Royal Medico-Psychological Association, and the Royal College of Nursing."

In non-orthopaedic hospitals—where the vast majority of the cases are treated—orthopaedic wards are adult wards.

In the district general hospital the child with acute haematogenous osteomyelitis should receive the full benefits of being nursed by specially trained staff in the paediatric unit under the joint care of an orthopaedic surgeon and a paediatrician.—We are, etc.,

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J. H. ANNAN.
W. P. SWEETNAM.

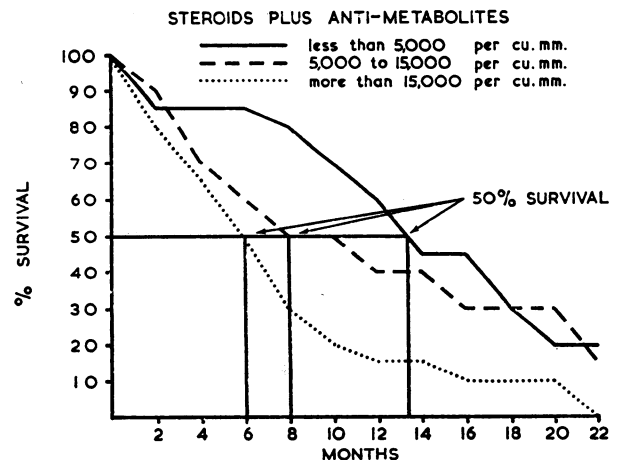
REFERENCE

¹ Platt, H., *The Welfare of Children in Hospital*, 1958. H.M.S.O., London.

Acute Leukaemia in Childhood

SIR,—In their recent review of 50 cases of acute leukaemia in childhood (April 28, p. 1165) Dr. R. B. Thompson and Dr. W. Walker state that they were unable to confirm the inverse relationship between initial leucocyte values and survival time which had been demonstrated by many previous authors. Unfortunately they did not give the full data but only the mean values, and as the scatter is usually so wide this is not very informative.

In an analysis of 89 cases of acute leukaemia in childhood occurring in the Liverpool area I found a clear relationship between initial leucopenia and prolonged survival time. This was apparent even before any specific therapy was used and has been emphasized by the introduction of corticosteroids and antimetabolites. In those patients who had no specific treatment the 50% survival time for those with an initial white cell count below 5,000 was three months and for those above 15,000 it was two months. This is only a small difference but it fits in with the observations of Zuelzer¹ on untreated patients. In the group who have been treated with corticosteroids and antimetabolites (see Graph) the



Survival time in relation to initial white cell count.

50% survival time in those with an initial leucopenia is 14 months as compared with six months in those who had an initial leucocytosis. Zuelzer and Flatz² suggest that the use of the present therapeutic agents merely accentuates the natural pattern of response and that the same patients who show the most favourable picture initially are those who are likely to respond best.

It is strange that a relationship which seems to hold good in the United States,^{2,3} Australia,⁴ Japan,⁵ and Liverpool should not apply in Newcastle upon Tyne, and I wonder if Drs. Thompson and Walker have any further comments to make on this.

Intracranial complications occurred in seven patients in my own series of cases and two more cases have subsequently been seen. Four patients were treated by irradiation of the skull and four by intrathecal "methotrexate."⁶ One patient developed intracranial complications terminally and no treatment was given. Irradiation sometimes produces distressing alopecia, but, on the other hand, it avoids the necessity for repeated lumbar punctures. D'Angio *et al.*⁷ found that symptomatic relief was produced in half their patients who had neurological involvement by lumbar puncture alone