to be able to provide the complementary portion. Since this situation can lead, as it has in the past, only to mutual recriminations, I can only deprecate the impression you have given. The same of course applies to any combined procedure in which two or more specialties are involved.—I am, etc.,

Cancer Institute, Melbourne, Australia. T. F. SANDEMAN.

⁂ We regret any ambiguity in the leading article. The point would have been made more clearly had the sentence in question read, "It is now clear that preoperative radiotherapy improves the prognosis after surgical excision."—ED., *B.M.J.*

The Talbot Fingers

SIR,—Dr. S. G. Elkington and Dr. R. G. Huntsman (18 February, p. 407) have given us a very fascinating historical account of the deformity of the fingers of the Talbot family, and I may be able to give them a little information about the Scottish family with the same deformity.

When I was house-surgeon in the Royal Infirmary, Edinburgh, in 1933, one of my chiefs was the late Mr. D. Stewart Middleton, who had a great interest in unusual skeletal abnormalities. I remember very well how he demonstrated several members of a family with symphalangism of the proximal interphalangeal joints of the fingers, one surprising feature being the almost total lack of disability. I still possess copies of the original *x*-ray films, but, many years later, I was unsuccessful in an attempt to trace any of the family. However, Mr. W. I. Paterson was more successful several years later, and read a paper at the meeting of the British Orthopaedic Association in 1952[1] based on what is certainly the same family as I had seen.—I am, etc.,

Morpeth, Northumberland. J. F. CURR.

REFERENCE
[1] *J. Bone Jt Surg.*, 1952, 34B, 509.

Foetus—or Fetus?

SIR,—By one of those curious coincidences of academic life, I recently composed a letter about the spelling of *fetus*, having tried unsuccessfully for over a decade to get British editors to accept a change from current to correct usage. This letter was addressed, at their request, to the joint editors of *Archives of Disease in Childhood*.

Now I see a remarkably similar but wholly independent letter from Professors J. D. Boyd and W. J. Hamilton in your columns (18 February, p. 425). These letters may be expected to reach very different groups of readers.

I should like to add my support to the proposal made by Professors Boyd and Hamilton, since it is etymologically correct.—I am, etc.,

BERNARD TOWERS.
Anatomy School, University of Cambridge.

SIR,—Professor J. D. Boyd and Professor W. J. Hamilton make a strong case, on etymyological grounds, for the adoption of the American spelling *fetus* in place of the British *foetus* (18 February, p. 425). I not only support this proposal but submit that it would be much simpler and more logical to follow American usage by substituting "e" for the digraphs "ae" and "oe" in such words as aetiology, gynaecology, haemorrhage, oestrus, oesophagus.

There is an etymological argument for retaining the digraph, as John Hunter did when he wrote of the animal *oeconomy*, but this spelling is nevertheless completely obsolete in our time.

Contemporary British usage in this respect is full of inconsistencies. The modern spellings economy and ecology are universally accepted, but oecumenical is preferred by the *Concise Oxford Dictionary*. Why is someone who teaches children a *pedagogue*, while someone who looks after their health is a *paediatrician*? If the etymological argument for retaining the digraphy is valid why do we follow it in some cases and not in others? If we must write *aetiology*, why not *Aegyptian*, *aequal*, *aenigma*, *aesteem*, *aeternal*, *aethyl*, and *aestuary*. Why should not all words with the prefix (why not "praefix"?) "pre-" be written "prae-," together with *paeninsula*, *paenumbra*, and *poenal*? In the vast majority of cases the digraphs or diphthongs of words of Greek or Latin origin are represented in modern English by the simple "e." It is difficult to see what is gained by retaining the archaic digraph in a small minority of words, especially when this results in differences in American and British usage.—I am, etc.,

Geneva, Switzerland. N. HOWARD-JONES.

SIR,—The American preference of the word "fetus" for "foetus" is due to the avoidance of the use of ligatures, as in esophagus and hemorrhage, etc. This explanation is simpler than that implied in Professors J. D. Boyd and W. J. Hamilton's interesting letter (18 February, p. 425).

If "foetus" could be derived from *foveo* (to keep warm) the traditional English spelling is preferable and more picturesque, even if there is loss of accuracy in pronunciation.

It appears that the paediatrician prefers the word "foetus," whereas the pediatrician favours "fetus." Is this too pedantic or—paedantic?—I am, etc.,

London W.1. VALENTINE SWAIN.

SIR,—Professors J. D. Boyd and W. J. Hamilton have not convinced me that "fetus" should replace "foetus" in English medical literature (18 February, p. 425).

While there is no doubt that *fetus* is the correct form in classical Latin and that it was used by some early English writers, and was given by Dr. Samuel Johnson in his *Dictionary of the English Language* (1755), nevertheless the form foetus was well established in the English medical literature of the eighteenth century. Perhaps Dr. Johnson's many medical friends were more interested in his conversation than in his dictionary.

I find foetus in the English translation of Haller's *Physiology* (1754), in Smellie's *Midwifery* (1764), in Manning's *Female Diseases* (1771), and it was used by Dr. Slop in describing some recent advances in obstetrical knowledge (Smollett, 1759).

Medical dictionaries do not help much, as they show a kind of local patriotism in the matter. Dorland (American) gives only fetus, Faber and Black (British) both give only foetus, and MacNalty (British) gives foetus but adds that fetus is used in the U.S.A. and is more correct.

Professors Boyd and Hamilton think that "fetus" is less ugly in print than "foetus," an opinion with which I disagree. They say it gives no alteration in pronunciation, but is it not more likely to be pronounced to rhyme with "get us" than with "cheat us"? They end by saying that the change could hardly be considered as mere rationalization; but what else is it? There is a limit beyond which language should not be confined in the straitjacket of etymology. The proposed change transgresses that limit and should be resisted. Foetus is a word of respectable antiquity and lineage. It ceased to be a Latin word a long time ago and stands on its own English feet. Anyhow, the French prefer it to *fétus*, and nobody can deny their care for their language.—I am, etc.,

Whitehead, Co Antrim. H. G. CALWELL.

Trigeminal Neuralgia: Complication of its Surgical Treatment

SIR,—The comprehensive study of the results of surgical treatment in 650 patients with trigeminal neuralgia undertaken by Mr. W. R. Henderson (7 January, p. 7) focuses attention on the aetiology of neurotrophic ulceration of the skin of the face and nostril, which was reported in 12 (18%) out of 66 patients with permanent anaesthesia of the cheek and nose following the injection of alcohol into the Gasserian ganglion. Mr. Henderson writes that an ulcer appeared on the alar margin of the nostril, usually from one to six months after this procedure, and, though the cause is uncertain, self-inflicted trauma in response to paraesthesiae may be important.

Ulceration of the skin of the face with erosion of the ala nasi is a recognized complication of interruption of the peripheral sensory fibres of the trigeminal nerve. *Ulcération en arc* of the ala nasi may follow the injection of alcohol into the Gasserian ganglion (Fig. 1) or sensory root section of the nerve, and has also been reported in one patient with isolated trigeminal neuropathy,[3] but there seems little doubt that *trophic* lesions involving the analgesic skin may more often be seen by dermatologists than by neurologists and neurosurgeons, and that the true incidence is much greater than the paucity of reports in the neurological literature hitherto suggested.[1–8]

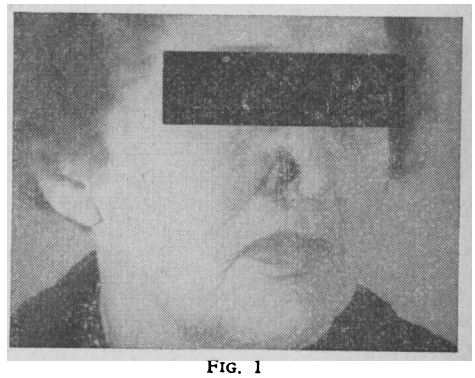

FIG. 1

I have recently reported the development of ulceration of the skin of the face and nostril with erosion of the ala nasi in two patients with vascular disorders of the brain-stem.[6] The neurological process described in these cases seen personally, and in a further three case reports reviewed, would of necessity have involved the central sensory pathways of the trigeminus. Full clinical details have been presented elsewhere,[6] but in this

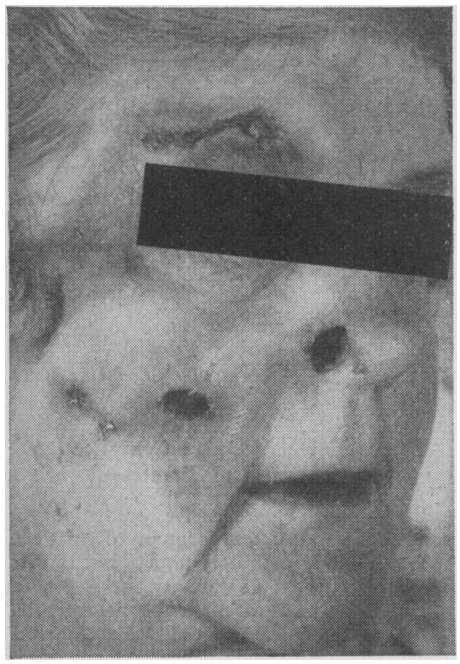

FIG. 2

connexion it should be stressed that in each of the patients seen with these ulcerative lesions, who had kindly been referred to me by Dr. Mark Hewitt and Dr. K. D. Crow, consultant dermatologists, dissociated anaesthesia, with loss of pain and temperature and preservation of light touch, was present over the ipsilateral cheek and nostril, and in one case (Fig. 2) was also found above the eyebrow, where a raw area of skin had developed.

It transpired that since the onset of these brain-stem vascular lesions producing ipsilateral trigeminal analgesia and thermo-anaesthesia, and prior to and during the development of ulceration of the skin with cartilaginous destruction of the nostril, each patient had experienced severe pain and intense and persistent irritation on the affected side of the face. The pain was described in such terms as a "deep gnawing burning pain as if the whole of the cheek was on fire," and the irritation like "something crawling about under the skin and inside the face." On further questioning, the patients admitted to picking repeatedly at the analgesic part of the face, often waking up during the night to find themselves doing this involuntarily, and our belief that the *trophic* lesions on the analgesic skin of the face and nostrils were, in fact, the direct result of excoriation of the finger-nails on account of the persistent pain and irritation, was confirmed conclusively in one patient who was admitted for careful observation.

On the basis of evidence submitted in respect of patients seen personally and from analysis of published data it is reasonable to postulate that the ulcerative lesions described following interruption of the peripheral or central sensory pathways of the trigeminal nerve were not trophic (by definition, "pertaining to nutrition") but were self-induced. It is evident that, in each of the two cases studied with vascular disorders of the brain-stem, ulceration of the skin of the face with erosion of the ala nasi was the direct result of repeated trauma by the finger-nails to those parts rendered analgesic through involvement of the central sensory connexions of the trigeminus in the spinal tract and nucleus, being provoked by intense and persistent pain and paraesthesiae referred to the ipsilateral trigeminal area.—I am, etc.,

Princess Margaret Hospital, Swindon, Wilts. A. G. FREEMAN.

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Future of Clinical Pharmacology

SIR,—I agree with many of the objectives indicated in the leading article "Future of Clinical Pharmacology" (21 January, p. 125), but not with the method by which they may be attained.

Undoubtedly "many aspects of the use of drugs in hospital need further study" and "research is needed on the absorption and fate of drugs in man as well as on their therapeutic and toxic properties." Fundamental work of this type is chemically and biochemically based, and a thorough knowledge of the application of physico-organic analytical techniques to biological problems is necessary, as well as a knowledge of pharmacology and of the influence of drug formulation on biological availability. Medical training on an acceptable time scale cannot embrace in depth all these aspects as well as provide a training in clinical medicine. It is equally important that "information about new drugs ought to be disseminated throughout medical staff generally—particularly knowledge about the interactions of drugs and special contraindications."

To deal adequately with all these aspects and functions, the *correct* use of personnel in different disciplines—that is, physicians, pharmacists, biochemists, and pathologists—and the integration in certain aspects of their work to achieve the above objectives are indicated. It is illogical to introduce another type of hospital service because of failure to make use of the training and expertise of personnel in existing services.

One of the most misused persons in the hospital service is the "understaffed, overpressed hospital pharmacist." In general, because of conditions, he is not allowed to make his contribution to the attainment of the above objectives, to which his academic training now fits him uniquely. The degree in pharmacy now involves more training in pharmacology than occurs in most medical courses, training in the use of modern physicochemical analytical instruments and courses in drug formulation and its influence upon biological availability. The hospital pharmacy should therefore be the centre in the hospital for the dissemination of information and advice about drugs and drug interactions, and the pharmacist should play a role in the integrated research effort involving clinical trials and in studies involving drug absorption and distribution and in drug quality control. Conditions should be changed, where necessary, to allow him to make this contribution, and an appropriate career structure introduced to ensure the recruitment of sufficient numbers of suitably qualified pharmacists and appropriate supporting technicians.

From personal experience I have found that research workers with degrees in pharmacy, working in association with medical research workers, are able to make significant advances in some of the above research fields. Considerable interest and appreciation of the work have been shown by many medically qualified research workers and medical advisers to the pharmaceutical industry. I will welcome discussions with hospital consultants interested in research on drug kinetics and absorption and fate of drugs in man, and on the effect of drug combinations and interactions, because proof of the value of joint medical-pharmaceutical research is quickly apparent and will further validate my arguments concerning the role of the modern trained pharmacist.—I am, etc.,

ARNOLD H. BECKETT,
Chairman,
Hospital Practice Subcommittee,
The Pharmaceutical Society of Great Britain.
Chelsea College of Science and Technology,
London S.W.3.

Depresssion

SIR,—I am surprised to find Professor Henry Miller (4 February, p. 257) taken to task by psychiatrists in the *B.M.J.* of 25 February (p. 497).

He may be "an amateur invading a specialist field," but nevertheless he provided the readers of your journal with a far clearer picture of endogenous depression than I have seen in any textbook. An appreciable proportion of patients with undiagnosed abdominal pains with or without other alimentary symptoms are in fact suffering from endogenous depression, and the diagnosis can be very easily overlooked. It is important to make the diagnosis, as treatment in a fair proportion can provide spectacular success.

I thought Professor Henry Miller's lecture was one of the best and certainly one of the most practical articles which you have published in the last year. I would recommend those who have not read it to do so.—I am, etc.,

London W.1. F. AVERY JONES.

SIR,—May I comment on two recent points that have arisen in the *B.M.J.*?

I notice that Professor Henry Miller, in his paper on depression (4 February, p. 257), apparently allows to pass unchallenged the statement of his African colleagues that depression is rare in the African. I have recently returned from a two-year appointment with the Government of Uganda, working in Butabika Mental Hospital. During this time my personal experience has been that it is true that depression in the African is comparatively rare as experienced in psychiatric practice. However, I think it is reasonable to suppose that this does not reflect the true instance of the illness in the community.