Antimony Therapy

SIR,—Drs. Hans Schmidt and F. M. Peter are to be congratulated on their English edition of *Advances in the Therapeutics of Antimony*, which may well be compared with what is included in Dr. G. M. Findlay and C. M. Wenyon's *Recent Advances in Chemotherapy*. Unfortunately the report states on page 112 that the first patient to receive the tartar emetic treatment was not cured, though Dr. J. B. Christopherson[1] recorded absence of ova and a negative antigen reaction. Difficulty in obtaining evidence of cure is specially difficult in *japonicum* infection, and for this reason the advocation of proprietary remedies in place of tartar emetic must be taken with caution.

I have recently had the opportunity of observing a gradual increase of degenerative changes in the ova of *Schistosomum mansoni*, which was the only type present in the urine of a little schoolboy of 11 whilst undergoing treatment with anthiomaline. I observed between forty and fifty of these ova during treatment. Four months later, though no symptoms of infection were detected, I observed one ovum of *Schistosomum haematobium*, thus confirming a report from the Natal Pathological Laboratory of mixed infection some months before I had seen the case. This suggested that a total of only 30½ c.cm. in twenty-seven days had been insufficient to effect a cure of this patient, thus confirming the opinion that it is seldom wise to discontinue treatment before the twenty-eighth day.—I am, etc.,

Durban, South Africa, July 11. F. G. CAWSTON.

Small-pox and Compulsory Vaccination

SIR,—I am indebted to Dr. C. Killick Millard for the information contained in his letter (*Journal*, July 16 (p. 151). I admit ignorance of the current views among those most familiar with the questions of the aetiology and prophylaxis of small-pox, and his letter was therefore enlightening, perhaps to some others as well as myself. I should be interested to hear to what informed opinion does attribute the decline of small-pox in this country; is it considered to be naturally dying out? Most of us have heard the opinion expressed that the repealing of compulsory vaccination might expose the next generation to a severe epidemic of the disease. Having recently witnessed the effects of a severe epidemic in a country in which small-pox is endemic, perhaps I may be pardoned for feeling that we should be absolutely confident of the results before abolishing compulsory vaccination, and those who advocate it must presumably have a sound basis for their confidence.

The fact that Leicester, where compulsory vaccination was abandoned over fifty years ago, has had such a fortunate experience is perhaps not such a convincing criterion as a similar experience might be in a city like Liverpool, where exposure to infection is presumably greater. Has the experiment of abolition been tried in this city or in any other large port? It would appear on the surface that Leicester's experience might be misleading, in that compulsory vaccination may have been responsible for a reduction in the incidence of infection from which the whole country, including unvaccinated areas, might have benefited. I was chiefly concerned in my previous letter with the question of compulsory diphtheria immunization, and if it was somewhat startling to hear from Dr. Killick Millard that both the Association of County Medical Officers of Health and the Society of Medical Officers of Health have passed resolutions in favour of the abolition of compulsory vaccination, at least it would be interesting to know whether they would recommend its replacement by compulsory diphtheria immunization.—I am, etc.,

London, W.12, July 21. A. L. CRADDOCK.

[1] Christopherson, J. B. *British Medical Journal*, October 8, 1921, p. 551.

The Cancer Campaign

SIR,—Are we conducting the cancer campaign aright? Judging by the meagre results obtained the question can hardly be answered in the affirmative. Great efforts are being made to discover the cause, but, as Mr. Hastings Gilford in his thoughtful letter (*Journal*, July 2, p. 41)—one of the best I have seen—points out, already many of the causes are known, to which may be added tertiary syphilis, especially of the mouth, also lupus. Mr. Lockhart-Mummery (*Surg. Gynec. Obstet.*, 1938, **66**, 257) considers that the condition is bound up with eugenics, which, in my humble opinion, is a very promising field of research, enabling tainted stock to be watched carefully for early manifestations, though marriage on eugenistic grounds is a far cry. I understand that negroes are much less liable to the disease than the white and yellow races, so that a guess may be hazarded that civilization is a factor. It would appear that cancer tends to attack the previously healthy rather than those stricken with other disease, but this is unproven.

Like Mr. Gilford, I think that possibly a cure may be found, as witness the striking successes of sulphanilamide in the treatment of streptococcal infections. It is not right to discourage research work on these lines. One solid rock of truth stands out in this sea of mystery—the fact that *the knife can cure in the early stages*. Admittedly this is a crude weapon, but its results compare favourably with those of radium and *x*-ray therapy, which likewise demand early diagnosis.

To my mind the most obvious method of attack is the dissemination of knowledge already possessed regarding the early symptoms and the discovery of new ones. Nowhere is this called for more than in the case of the commonest of all—gastric cancer. Lord Moynihan used to teach that the symptoms of carcinoma of the stomach were: loss of interest in life, loss of appetite, loss of blood (anaemia), to which may be added loss of abdominal comfort due to meteorism in a patient of previous good health. Now he would be a bold surgeon who would operate for these symptoms, but fortunately we have radiology to clinch the diagnosis. At the very onset the stomach becomes lazy, peristaltic waves are few, and pictures taken at intervals present the same pattern. I have diagnosed a cancer 1 cm. in diameter on this finding alone. The peristaltic waves may be constantly arrested at a particular point, proving destruction of musculature, often by malignant disease. An ulcer of large dimensions is suggestive. A patent pylorus, permitting the continuous entry of barium into the duodenum, means destruction of the sphincter. A small stomach with obstruction signifies malignant disease (L. A. Rowden). Localized disappearance of the mucosal rugae indicates cancer.

All these signs appear long before the classical symptoms occur. Let us examine these symptoms. *Vomiting*: This occurs with a number of gastric and extragastric conditions. *"Coffee-ground" vomit*: The "grounds" represent blood altered by long contact with the gastric juice, not necessarily due to cancer. *Tumour formation*: This is of the utmost value when present; unfortunately the commonest cancers do not produce palpable growths.

Cachexia: But surely this is a sign of hopelessness, as is Virchow's gland at the termination of the thoracic duct. Thus it is apparent that carcinoma of the stomach in its operable stage is diagnosable by *x* rays long before classical signs and symptoms manifest themselves. Similarly, oesophageal and colonic—not including rectal—cancers are diagnosed with greater ease and accuracy with *x* rays than clinically: Renal pelvic growths lend themselves well to this form of diagnosis, as do cerebral growths. Consecutive films reveal bronchial carcinoma long before clinical signs are present.

My idea of a cancer campaign would be the wholesale education of the profession in clinical as distinct from technical radiology. This would be attained by the establishment of an *x*-ray museum on the lines indicated previously (*Journal*, 1937, **2**, 1054): a place where men could wander imbibing knowledge as they can in that magnificent display of the "Pathology of the Living, the Wellcome Museum of Medical Science," organized by Dr. Daukes. It would be supplemented by short intensive courses of demonstrations. I do not agree with Dr. Douglas Webster that the difficulty would be in finding a curator. Provided adequate remuneration was available many men could be found. Money is being poured out on apparatus all over the country with scant justification, judging by some of the results in bone radiology, yet no one seems to realize what a tremendous help a museum would be. I believe, with Dr. Webster (*Journal*, 1937, **2**, 1152), that a long time would be necessary. Rome was not built in a day, but on one particular day it was started. The museum would never be complete, but therein would lie its fascination. I agree with Dr. Webster that a suitable resting place should be found for apparatus which has represented "stepping-stones" in the development of the beautiful apparatus of to-day.—I am, etc.,

London, W.1, July 20. A. P. BERTWISTLE, F.R.C.S.Ed.

Subvesical Diathermy Prostatectomy

SIR,—The short article on subvesical diathermy prostatectomy in the *Journal* of July 23 (p. 175), by Mr. R. Ogier Ward, raises some points which appear to call for comment. The perurethral operation, as he rightly says, is now firmly established as a therapeutic measure of the greatest use in urological surgery. Mr. Ward, in advocating his subvesical operation, claims that in the "ordinary resection operation" a large portion of the trigone, "sometimes almost up to the ureters," is removed. If this were so the operation would long have been abandoned; extensive resection of the trigone inevitably predisposes to sepsis in the underlying space, with serious consequences. The operation as carried out to-day by urologists versed in this type of operation means virtually a subtotal prostatectomy. It has long passed beyond the stage of being a tunnelling or whittling procedure; anything from one-quarter to four-fifths of the gland is removed. The subvesical operation advocated is that which is normally carried out on the subvesical type of gland, but where, as is certainly more common, there are intravesical projections of the lateral lobes, a more radical procedure is manifestly required. The removal of a single piece from the region of the posterior commissure, followed by intra-urethral resection of tissue from the floor and lateral walls, as I interpret Mr. Ward's recommendation, leaves the upper limits of the lateral lobes projecting into the bladder and ideally situated for a ball-valve mechanism to come into play at an early date, so leading to recurrent obstruction. It would to me appear more rational to remove as much of the obstructing tissue as is mechanically possible, bearing in mind, of course, the danger of encroaching too far on to the trigone. Familiarity with the operation should guard against this.—I am, etc.,

London, W.1, July 22. TERENCE MILLIN.

Incomplete Descent of the Testicle

SIR,—"Undescended testicle" is not itself a disease, but is simply one symptom of a general constitutional disturbance of diencephalo-pituitary origin. Investigation of the morphology, reactivity, psychology, and biochemistry of such patients, if carried out with the precision with which the testicles are palpated, points distinctly to this fact. Failure to perform this general constitutional investigation is responsible for many mistakes in treatment. To attempt surgical correction of "undescended testicle" without previous correction of the basic constitutional disturbance is contrary to all the rules of contemporary medical practice. The assertion made by Mr. Denis Browne in his interesting paper (*Journal*, July 23, p. 168) that "pregnyl treatment will not bring down any testis that would not have descended without it" is sweeping, and goes against the experience of most recent workers on this subject. In the first place, pregnyl and all other pregnancy urine gonadotropic substances are far from constituting the whole endocrine metabolic treatment of undescended testicle. Further, I often see in my everyday practice tragedies resulting from the abandonment of cases of diencephalo-pituitary disturbance with undescended testicle to their fate, or ultimately to the surgeon, without any attempt at early correction by means of general constitutional treatment, including endocrinotherapy. The "disquieting possibilities" of hormone treatment mentioned by Mr. Denis Browne do not exist when treatment is planned and given by skilful clinicians, but tragic certainties assuredly make their appearance when such constitutional disturbances are not sought, discovered, and corrected in the early years of life. I am the first to protest against abuse of hormone treatment, but the method is undeniably efficacious provided that the injected hormones are mixed with the commodity used by the great painter in the mingling of his colours—brains.—I am, etc.,

London, W.1, July 22. A. P. CAWADIAS.

Cancer of Pharynx and Larynx

SIR,—This subject, selected for discussion at the recent Annual Meeting of the British Medical Association, was well chosen; for, as Mr. Lionel Colledge mentions when opening the discussion from the surgical aspect (*Journal*, July 23, p. 167), "the introduction of irradiation has rendered the problem of treatment in various situations infinitely more complicated." This problem of treatment—namely, "surgery *versus* irradiation"—is particularly difficult in those early cases of a small cancerous growth limited to the true vocal cord, the extremities of the cord being free of disease.

In an endeavour to clarify the present position, I recorded (*J. Otol. Laryng.*, 1937, **52**, 463) the results which had been obtained at the Manchester Radium Institute following irradiation of intrinsic laryngeal cancer, and contrasted them with those following surgical treatment (laryngo-fissure) in a similar series of cases collected from my own records and those of my Manchester colleagues. This comparative review was restricted to that type of intrinsic laryngeal cancer which was suitable either for surgical treatment or irradiation by the Finzi-Harmer technique. For comparative purposes I adopted a "three-