

Further research should bring a greater understanding of the processes at work in the initiation and maintenance of human lactation and help in the elucidation of related phenomena, as well as perhaps providing the immediate clinical benefit of galactagogues and more efficient ways of suppressing unwanted lactation. Pregnancy and lactation interrupt the normal cyclical activity of the hypothalamus and adeno-hypophysis, and during lactation this interruption apparently occurs in the absence of endocrine control from ovarian steroids. A study of the factors responsible for these normal changes and those causing abnormal lactation would increase our knowledge of gonadotrophic activity as a whole, thus leading to further progress in the control of fertility and the management of menstrual disturbances. It is to be hoped that the recent W.H.O. pamphlet may stimulate renewed interest in this unfashionable subject.

Localized Myxoedema

In 1840 von Basedow¹ described the condition that is now called pretibial myxoedema in a woman with exophthalmic goitre. Until 1942, however, when W. R. Trotter and K. C. Eden² published an important paper on this subject, little interest was taken in it except by dermatologists. Pretibial myxoedema has long been recognized to be associated with exophthalmos and thyrotoxicosis, past or present, but the gross finger clubbing reported in two patients by R. S. M. D. Inch and C. F. Rolland³ seemed at first to be an isolated finding. However, during the last decade a syndrome comprising hyperthyroidism, exophthalmos, localized myxoedema, finger clubbing, and hypertrophic osteoarthropathy (presenting in that order) has become recognized. In 1963 F. D. Malkinson found reports of 26 patients (including his own) with pretibial myxoedema and finger clubbing.⁴

Pretibial myxoedema is said to occur in about 3% of patients with toxic diffuse goitre. There may be vague aching in the legs, but more often the condition is discovered only on routine examination. It is doubtful whether localized myxoedema ever occurs in the absence of exophthalmos. The lesions first appear on the anterolateral aspect of the lower half of the legs: they later extend to the back of the legs, to the insteps, and sometimes as far as the knees. Extension of localized myxoedema to other sites is rare. In J. Sunseri's patient the legs and lower abdomen were affected,⁵ and E. Lipman Cohen⁶ referred to a similar patient reported in 1900 by Achard. B. D. Cohen and his colleagues⁷ described two patients with exophthalmic goitre and localized myxoedema affecting the arms as well as the legs, and in a survey of the literature they found that in 317 additional patients the arms were affected in only one. Pretibial myxoedema is usually

bilateral and the skin is raised in irregular firm swellings, the surface being dimpled and faint pink or brown or unaltered in colour. Coarse hairs may be seen over the swellings and local sweating may be a feature. In the course of years spontaneous disappearance of the lesions may occur. Recently an unusual example of localized myxoedema has been reported⁸ in a male negro with the syndrome of thyrotoxicosis, exophthalmos, finger clubbing, and hypertrophic osteoarthropathy. The legs and the right hand were grossly myxoedematous, and surgical excision of masses from the hand with grafting was followed by the appearance of even larger masses. The deposits in this condition contain acid mucopolysaccharides—chondroitin sulphate and hyaluronic acid—combined in some form with proteins. The substance infiltrating the orbital contents is similar.

The common factor in the causation of exophthalmos and localized myxoedema has been thought to be overproduction of the thyroid-stimulating hormone (T.S.H.) of the anterior part of the pituitary gland in the absence of normal thyroid secretion.^{9 10} I. C. Gilliland and J. I. Strudwick,¹¹ however, found that, while thyrotoxicosis with severe proptosis is associated with a raised level of T.S.H. in the serum, a comparable rise is also found in cases of spontaneous myxoedema, in which proptosis does not occur. In thyrotoxicosis without severe exophthalmos the level of T.S.H. is not raised. They concluded that T.S.H. alone is not the cause of exophthalmos, but that some other factor, which may also be of pituitary origin, is involved. This view is supported by the work of A. Querido and L. D. F. Lameyer,¹² who found no relation between the level of T.S.H. in the serum and exophthalmos, though the level was high in a patient with post-operative myxoedema, slight proptosis, and pretibial deposits.

Treatment of localized myxoedema has proved ineffective, though in one patient Malkinson⁴ found to his surprise that injections of T.S.H. into a lesion caused it to become flattened.

Religion and Medicine

In April 1962 the Archbishop of Canterbury held a meeting of interested persons on the subject of relationships between clergy and doctors. As a result of the recommendations of a working party then set up the Institute of Religion and Medicine was formally constituted in June 1964.¹ It has just produced its first Annual Report, and there its two major objects are set out: "To seek greater knowledge of the principles on which health in its widest spiritual, mental, and physical sense is based; and to promote a better understanding and co-operation between all people of whatever creed or discipline who are engaged in the fields of religion and medicine and related areas of human endeavour."

Various bodies, such as the Churches' Council of Healing, have been active for many years in this field, but the time seemed right for the formation of an open forum for discussion, with local field groups linked together by a central administration. There are already 400 members, about half ministers of religion and half members of the medical profession. Although the Institute is mainly Protestant Christian in its membership, Roman Catholics, Jews, and members of

¹ Major, Ralph H., *Classic Descriptions of Disease*, p. 283, 3rd ed. 1945. Thomas, Springfield, Illinois.

² Trotter, W. R., and Eden, K. C., *Quart. J. Med.*, 1942, **11**, 229.

³ Inch, R. S. M. D., and Rolland, C. F., *Lancet*, 1953, **2**, 1239.

⁴ Malkinson, F. D., *Arch. Derm.*, 1963, **88**, 303.

⁵ Sunseri, J., *ibid.*, 1943, **48**, 70.

⁶ Cohen, E. L., *Brit. J. Derm.*, 1946, **58**, 173.

⁷ Cohen, B. D., Benua, R. S., and Rawson, R. W., *Arch. intern. Med.*, 1963, **111**, 641.

⁸ Chremos, A. N., *Amer. J. Med.*, 1965, **38**, 954.

⁹ Chandler, G. N., and Hartfall, S. J., *Lancet*, 1952, **1**, 847.

¹⁰ Ludwig, A. W., Boas, N. F., and Soffer, L. J., *Proc. Soc. exp. Biol. (N.Y.)*, 1950, **73**, 137.

¹¹ Gilliland, I. C., and Strudwick, J. I., *Brit. med. J.*, 1956, **1**, 378.

¹² Querido, A., and Lameyer, L. D. F., *Proc. roy. Soc. Med.*, 1956, **49**, 209.

¹ Organizing Secretary: 58a Wimpole Street, London W.1.