

Trichomonal Balanitis

Q.—Ten days after extramarital exposure a patient was seen with a copious purulent discharge from, and marked inflammation of, the glans and prepuce. There was no frequency, little dysuria, and no urethral discharge. Microscopic examination showed secondary invaders, no gonococci, and was positive for trichomonas. A repeat examination on the following day gave the same result. Wassermann reaction was negative. The patient's wife was found also to have a vaginal discharge which was positive for trichomonas. Treatment has consisted in giving 2 million units of procaine penicillin and 15 g. "sulphatriad" with saline baths. This has cleared up the secondary invaders, but small ulcers persist on the glans and on the inner surface of the foreskin. He is uncircumcised, but the foreskin is easily retractable. As I believe this condition is resistant to treatment and inclined to be chronic, I would welcome your suggestions on what course I should adopt.

A.—In view of the fact that the patient suffers from slight dysuria there should be an examination before the first morning micturition and bath to ascertain whether there is an associated urethritis. However mild this may be, it might well indicate the presence of *Trichomonas vaginalis*. This protozoon is nowadays not uncommonly the cause of urethritis in the male. Infection of para-urethral ducts can also cause resistant infection in both male and female and should be specially looked for.

Though the penetration of tissue in some genital infections by *Entamoeba histolytica* has been demonstrated, no one, so far as the writer knows, has succeeded in doing so in the case of *T. vaginalis*. However, a biopsy of one of the small ulcers might show the latter to be present. For this circumcision alone would suffice (it would also help in treatment) and there could then be an examination of ulcers of prepuce.

Treatment suggested is the application in powder form of aureomycin, terramycin, or acetarsol. The glans and prepuce should be bathed three times daily in warm saline and dried thoroughly before the application of whichever powder is selected.

Psychiatrist and Psychotherapist

Q.—What distinction is there between a psychiatrist and a psychotherapist? Is a specialized training required in order to become a psychotherapist? If so, are there "recognized" centres, how long is the training, and what does it consist in?

A.—The term psychiatrist is now used when referring to the medically qualified who have obtained further education in the diagnosis and treatment of mental illness in adults and children.

The term psychotherapy is generally applied to all those methods of psychiatric treatment of mental illness in children and adults, whether mild or severe, in which personal contact alone is exploited—although the term is also sometimes applied to those types of personal contact in which consciousness is modified by hypnosis or drug. Not all psychotherapists are medically qualified. As yet in this country there is no Ministerial or academic sponsorship for the education of non-medical persons in psychotherapy, regardless of their academic qualifications in, for instance, psychology or education. "Recognized" training in many types of psychotherapy is part of general psychiatric education in all postgraduate centres, but the intensity of such training varies greatly from centre to centre. Training, whether in an academic centre for medical graduates or in one of the other organizations where both medical graduates and other adequately qualified persons are trained, in general consists in

(a) some method to increase the student's understanding of his own development and of his own personal reaction to other people's difficulties, as it is he himself

who will be both observer and operator in the psychotherapeutic situation ;

(b) a series of lectures and seminars on the history and present status of psychotherapeutic methods ; and

(c) supervision of the student's first attempts to apply to patients the methods he has been studying.

The length of training (part-time for from two to five years) depends upon its type. The best summary of facilities available in this country is one compiled on behalf of the British Psychological Society, B.M.A. House, Tavistock Square, London, W.C.1—*Careers in Psychology* (price 6d.). Details of the various courses are also given each year in the educational number of the *Journal*.

Inheritance of Spina Bifida

Q.—A young couple's first child had a spina bifida, and died after one or two months. So far as can be ascertained there is no family history of this condition on either side. What chance is there of this occurring in a further pregnancy? Would it be worth while having either parent radiographed for evidence of spina bifida occulta?

A.—Following the birth of a child with spina bifida, the chance that any subsequent child will be similarly affected (including the chance of some other serious malformation—for example, anencephaly) is greater than in a random pregnancy. Nevertheless, the risk is a small one, perhaps about 1 in 30. It is not a big chance compared with the inevitable risk that any pregnancy will result in a child suffering from some serious malformation or other, and this couple should not feel deterred from having another child.

The genetics of spina bifida in the human are obscure. There is doubtless some measure of hereditary predisposition, but other and at present unknown factors must be considerably more influential. The parents would probably prove normal on x-ray examination; even should one or other have spina bifida occulta, its discovery would be of little help in assessing the chances for subsequent children.

Correction.—We much regret that a line was unfortunately omitted from the "Recommendations on the Use of Antimalarial Drugs" prepared by the Colonial Medical Research Committee's Malaria Subcommittee (*Journal*, July 17, p. 148). Col. 2, line 14, on p. 149 should have read "Emergency Treatment.—(i) Quinine dihydrochloride," and not "necessary. Or (iii) Chloroquine salts. The hydrochloride." The paragraph in question, which appears under the heading "Suggested Dosage: Treatment of the Overt Attack," should therefore read:

Emergency Treatment.—(i) Quinine dihydrochloride, 650 mg. (10 gr.) in sterile normal saline injected intravenously and repeated in six hours if necessary. Not more than three injections should be given within 24 hours. Distilled water can be used as a solvent if the volume does not exceed 10 to 15 ml. It is imperative that quinine be injected slowly, at a rate not exceeding one grain per minute. Or (ii) Mepacrine methane sulphonate, 375 mg., or mepacrine hydrochloride, 300 mg., intramuscularly, repeated in six hours if necessary. Or (iii) Chloroquine salts. The hydrochloride is given intramuscularly in dosage of 200 to 300 mg. of base (supplied in ampoules in aqueous solution), repeated in six hours if necessary, and intravenously, 400 mg. of base in 500 ml. normal saline by intravenous drip over a period of one hour. The sulphate supplied in 5 ml. ampoules (40 mg. base to 1 ml.) is given in dosage of 200 mg. base intravenously, repeated after eight hours if necessary.

We have been asked to state that Major-General Sir John Taylor was secretary of the Malaria Subcommittee during most of the period when the report on malaria drugs was being prepared.

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