do the same, and to inquire whether it is by any chance possible that he has a "scunner" (dislike) for such new-fangled notions as higher obstetric qualifications, maternity hospitals, gowns, gloves, masks, and the like.—I am, etc.,

London, W.1. D. G. WILSON CLYNE.

Penicillin in Gonorrhoea

SIR,—In his article "Penicillin in Gonorrhoea" (March 2, p. 314) Dr. Alastair Allan stresses the need for a follow-up lasting twelve months in cases of gonorrhoea treated with penicillin. It would be interesting to know what facts or theories have led Dr. Allan to advocate this long period of surveillance.

My own observations in cases of gonorrhoea[1] treated with penicillin in doses of 100,000 units by the divided dose method have led me to believe that the six-months follow-up used in the Allied Armies is adequate. Indeed I have not yet seen any cases where syphilis became evident later than three months after penicillin therapy for gonorrhoea and without another exposure to possible infection. The incubation period of syphilis is lengthened by penicillin in the dosage used for gonorrhoea, but when signs of disease appear they are in no way altered, and *Sp. pallida* is readily demonstrable in primary lesions. In my experience, even after the treatment of syphilis itself with penicillin in doses of 2,400,000 units, cutaneous and mucous relapse phenomena appear in the majority of cases within six months after treatment.[2]

I think that Dr. Allan is overestimating the antispirochaetal powers of small doses of penicillin, and that any improvement in his default rate caused by speeding up actual treatment will be offset by the length of the surveillance period. It would be interesting to have the reasoned opinions of your readers on the length of follow-up necessary after the treatment of gonorrhoea with penicillin in the doses now used.—I am, etc.,

London, S.W.1. JAMES MARSHALL.

REFERENCES

1 Marshall, J. (1945). *Brit. J. vener. Dis.*, **21**, 150.
2 —— (1945). *Nature*, **156**, 769.

Penicillin and Pursers

SIR,—It is interesting and comforting to read in Mr. James Hall's most instructive article (Feb. 16, p. 244) that penicillin is used (and with satisfactory results) under the direction of the pursers of many American ships. Surely the time has now come when the general body of practitioners in this country may be trusted with the precious stuff. I write not only as one of the "ninety-and-nine" unprivileged general practitioners whose work over the past few years has been from time to time embarrassed by this invidious veto, but also as one who, thanks to the timely action of a specialist colleague, owes his very life to penicillin therapy.—I am, etc.,

Worthing. O. P. CLARK.

Anaesthesia

SIR,—Dr. W. A. Bellamy (Feb. 16, p. 252) bows his devoted head awaiting the storm to burst: and I am sure it will burst indeed before very long. I should like to add my raindrop to the storm.

He deduces from the fact that the percentage of anaesthetic deaths has not decreased during the last fifteen years the curious conclusion that the older methods are equal in efficiency to more modern and elaborate techniques. It would appear to me (and I am open to correction by any statistically minded colleague) that this deduction is unsound. Surely it is since the introduction of these "tubes, taps, and turncocks" that surgery has become safer for a large class of patients who were poor risks under the open ether and chloroform techniques; and so a multitude of patients are submitted to surgery now who would not have been operated on at all previously. Thus it seems that if this mass of poorer-risk material is included in the statistics of anaesthetic deaths, the fact that the death figure is so constant is a credit to the newer methods. Furthermore, the percentage of deaths is not the only index of the success or failure of any anaesthetic method. The time the operation takes, the look of satisfaction or otherwise on the surgeon's face, the recovery time of the patient, and the incidence of post-operative complications, pulmonary and otherwise, all must be considered. The anaesthetist usually sees only the first two of these. As a house-surgeon I have seen the others, and over a period of many months, with various classes of patient, I have been able to foretell with reasonable accuracy who was going to be "chesty" after operation, who was going to have to endure the agonies of prolonged sickness after operation, simply by looking at the anaesthetist's name and knowing what method he used. If an anaesthetist wants to know if he is a good anaesthetist or not, he should consult the people who see his cases in the post-operative period—the housemen and the ward sisters. They know very well indeed who is good and who is bad without ever, of necessity, seeing the person concerned, or seeing whether he is a "tube-and-turncock" or a "rag-and-bottle" merchant.

But from my experience it is the open-ether patient who suffers most with chests, "ether eyes," and sickness. These things naturally do not alter the percentage deaths very much, but they do mean much to the patient both in the matter of comfort and in the willingness to have an anaesthetic again. With open ether one can give a good anaesthetic, of that there is no doubt; but one can also shoot a rabbit with a blunderbuss, and doubtless shoot it very well. The advent of "tubes, taps, and turncocks" does not of course by itself make the anaesthetic better, but it does place in the hands of the operator better and surer ways of controlling his anaesthetic agent. It is the anaesthetist who controls his agent who has the best results, interpreted in terms of help to the surgeon and post-operative comfort of the patient. Of course, to use the newer and more complicated machines one must study them and learn their uses and limitations. Shockingly bad anaesthetics can very easily be given using one of the most efficient machines if the operator does not know how to employ the control methods at his disposal.

I am glad to hear Dr. Bellamy say that housemen cannot give open chloroform. I have never given chloroform nor seen it used. I hope I shall never have to give it so long as safer agents continue to be available. It is, I feel, quite true to say that really good anaesthesia by inhalation methods is "a cult known only to a favoured few," and this few is only favoured in so far as they have the intelligence and common sense to study their equipment, use it carefully, choose the agent most suiting the patient and the operation, and, above all, at every stage, to control the anaesthesia.

Modern machines are designed so that the anaesthetist has perfect control over what the patient is breathing and when he breathes it. There are no superfluous knobs, taps, or tubes. The careful and skilled anaesthetist has welcomed these machines because they give him ever-increasing control of the anaesthesia; and he will continue to use them to the benefit and comfort of surgeon, patient, and staff, irrespective of whether percentage deaths fall over a period of fifteen years or not.—I am, etc.,

Aberdeen. MALCOLM R. MILNE.

SIR,—As an anaesthetist devoted to the art and banded together with Dr. A. H. Galley in the Anaesthetics Section of the R.S.M., I should like to congratulate him on his admirable reply (March 2, p. 332) to Dr. Bellamy's nostalgic wail over the otherwise unlamented passing of an era in anaesthesia characterized by a high incidence of post-operative morbidity. My feelings, however, were more poignant, since for twenty years I have striven to associate Aylesbury with progress in anaesthesia and have pleaded in the columns of the *Journal* for an eclectic attitude and flexibility of technique, whereby the drug or method calculated to produce the best result in each individual case may be employed.

With regard to "over-specialism," Dr. Bellamy's devoted head has remained so bowed that he has not noticed that the trend of the specialist anaesthetist is not to limit but to enlarge the scope of his activities, so as to include not only all branches of anaesthesia and analgesia, but also oxygen therapy, resuscitation, pre- and post-operative treatment, etc., the high value of his services in which has been abundantly proved in the late war. It would appear a far greater danger that he himself should become a super-specialist, such as an "avertinist" or "tribromethylalcoholist." Concerning simplicity, one of the

most famous "last words" (for the patient!) is, "Just give her a whiff, old man."

Finally, I should like to invite Dr. Bellamy to journey into Aylesbury and meet Mumbo and Jumbo (two fairly modern closed-circuit machines, so christened in his honour), and see for himself that they, in conjunction with their jungle pal Curare, are not so lethal or so complex as his perfervid imagination would lead him to believe.—I am, etc.,

Royal Buckinghamshire Hospital, Aylesbury. H. W. LOFTUS DALE.

Liver and Spleen Puncture

SIR,—It has occurred to me that the production of apnoea by overbreathing would make the operations of spleen and liver puncture easier and safer. The danger of these procedures is haemorrhage from tearing on respiratory movement while the instrument used is *in situ*.

According to Yandell Henderson *(Adventures in Respiration)* a normal man at sea level can stop breathing for 40–60 seconds. After forced breathing of air he can hold his breath for 2–3 minutes; breathing then recommences owing to oxygen lack and is periodic at first. If, after several minutes' forced breathing, he fills his lungs with oxygen he can hold his breath for 5–6–10 minutes. Breathing recommences without periodicity when sufficient carbon dioxide has accumulated. There is no oxygen lack.

Each patient could have one or more rehearsals to find out how long the apnoea in his case would be likely to last. Hyperventilation tetany is rarely produced by a few minutes' overbreathing; if it should occur and not pass off quickly when the overbreathing ceases inhalations of oxygen and carbon dioxide 5 to 7% or rebreathing from a paper bag will stop it.—I am, etc.,

St. Benedict's Hospital, London, S.W.17. MARY WALKER.

The E.S.R. Technique

SIR,—I am sorry to find that Dr. H. S. Gaskell (Feb. 16, p. 255) is not to be persuaded that the tube-length within wide limits makes no difference to the result when the rate is normal. It is something to find that he does admit that we should both sink at the same rate (barring the effect of salt water) in the Pacific as in the local swimming-bath, and I can assure him that the same principle applies to the rouleaux of red cells in the sedimentation rate. Stokes's Law makes no allowance for the distance the sinking body has below it, as the body soon attains a constant velocity.

When on the Committee of the E.S.R. of the Empire Rheumatism Research Council, my colleague and I worked out the whole subject of tube-lengths and bores at very great length, and I have voluminous records made on the automatic recorder of bloods put up simultaneously in tubes of widely varying bores and lengths. Even in tubes of 25-mm. length the normals come out the same at the end of the hour, and it is only when more rapid rates are measured that the short tubes give lower results, as a consequence of the earlier onset of packing. I can only imagine that Dr. Gaskell is thinking of these. I will gladly send him some of my charts if he is interested.

I am sorry to hear that Messrs. Hutchinson and Hunter have been so misguided as to call plasma "serum," especially in a test in which some authorities consider the fibrinogen to play a most important part.—I am, etc.,

London, W.1. J. W. SHACKLE.

Traveller's Oedema

SIR,—Dr. Zacopoulos's remarks (March 2, p. 322) about traveller's oedema reminded me of a similar condition which was prevalent among older people in a deep tube shelter to which I was medical officer during the "blitz." It was particularly noticeable before bunks were put up; the more select who did not wish to lie on the platform brought deck chairs, and I think the bar behind the knees was partly responsible.

In Sept., 1922, it was my fate to travel from Corfu to Trieste in a rather superior boat containing Greeks and a sprinkling of Armenians from the Smyrna "episode." These people had had their nerves frayed by what they had been through, and they grumbled bitterly to the captain. His deck was so small that they had no exercise and were suffering terribly from swollen legs and constipation. I heard the exasperated Italian captain say: "Look at that Englishwoman over there; I don't know what devilry she is up to now, but she is never still, and I bet you she has no constipation or swollen legs." And he was correct.—I am, etc.,

London, N.1. LINA M. POTTER.

SIR,—In his paper on traveller's oedema (March 2, p. 322) Dr. Zacopoulos does not mention two important aetiological factors. (1) The severity of the condition is much aggravated by a hot, particularly a hot and humid, climate. It commonly occurs amongst the crew of ships in the Tropics, yet I have never seen it in Northern waters. The circumstances of Dr. Zacopoulos's cases—a rail journey from Smyrna to Aleppo—suggest that the heat factor with its concomitant sluggish circulatory condition was present. (2) Tall asthenic people who have a poor circulation anyway, who faint easily, and whose extremities are always icy in cold weather, are usually first affected and develop the grossest swelling. It would be interesting to know the nutritional state of these soldiers. If the oedema of starvation were "just around the corner" it might account for the very high incidence amongst them.—I am, etc.,

Barking. G. S. WIGLEY, Surgeon Lieut.-Cmdr., R.N.V.R.

Physical Therapy in Mental Disorder

SIR,—Without wishing to enter any controversy regarding any comments of Dr. Leroyd concerning Dr. Frank, may I associate myself with Dr. Leroyd's letter (Feb. 16, p. 251) regarding convulsion therapy? What he says concerning its use as a punitive measure is unfortunately occasionally true. So is the indiscriminate use of a method which is valuable in the right cases. The following instance exemplifies the effects of its too facile use on the laity.

Recently while in the Middle East I was called into a hotel to see a middle-aged patient, who appeared to be developing a paranoid psychosis, though he had very good insight. He also had diminished ankle-jerks. Nevertheless a doctor who had seen him the day before had, without more ado, prescribed E.C.T. to be given in the hotel. Largely, I suspect, to rubber-stamp this surprisingly popular prescription, three psychiatrists, including myself, were then called in. (In the country in question it is the custom for consultants, like troubles, to come not single spies but in battalions.) We all agreed that a lumbar puncture was indicated; that a hotel, however luxurious, was not a suitable place for an incipient psychosis; and that, if the condition was not organic, in view of the good insight psychotherapeutic measures had a place in treatment. Also that certainly until investigations were completed E.C.T. was *not* indicated.

We explained this to the patient's mother. She vigorously resisted any question of investigation or hospitalization, and when we said that, at least pending investigation, we thought E.C.T. contraindicated, she exclaimed in horrified tones, "What, you do not wish him to have electric shock treatment?" and burst into hysterical sobs. The mother was undoubtedly a foolish woman, but even making allowances for that, the fact that an over-solicitous mother should be reduced to tears because caution was advocated in giving her son repeated major convulsions, is surely a striking commentary on a tendency to ladle out fits as though they were nothing more drastic than an aspirin tablet.—I am, etc.,

W. LINDESAY NEUSTATTER.

Homosexuality

SIR,—I cannot claim the specialized psychiatric experience and authority which might be regarded as a *sine qua non* for participation in this discussion, but I have recently had the opportunity of debating the subject with a friend who in a past official capacity had considerable responsibility in the conduct of prosecutions for offences which included those under review, and I think the impressions I have derived are worthy of communication to your columns.