doctors with limited experience of its use in V.D. The two chief lessons to be learned derive from the fact that both the gonococcus and the *Treponema pallidum* are penicillin-sensitive organisms. Therefore: (1) Before exhibiting penicillin in a case of gonorrhoea (or, indeed, in any general medical or surgical condition) the practitioner should bear in mind the possibility of coexisting syphilis, particularly with clinically active lesions in vital tissues—e.g., cardiovascular and central nervous systems. (2) The clinical and serological surveillance of penicillin-treated gonorrhoea, to exclude syphilis contracted at the same time and masked by penicillin because of its longer incubation period, must be systematic, thorough, and prolonged. In cases of doubt arising out of either or both of these conditions the advice of an experienced venereologist should be sought.—I am, etc.,

Inverkeithing, Fife. RICHARD SCOTT.

The "Intractable" Vesico-vaginal Fistula

SIR,—Dr. Donald Mackay's interesting report of the spontaneous closure of a large vesico-vaginal fistula (April 27, p. 650) is a useful reminder that this injury, so often regarded as intractable, is in fact possessed of a strong tendency to spontaneous cure. This is particularly so when the fistula is the result of the *tearing* of otherwise healthy tissue rather than the *loss* of tissue by necrosis. The first type behaves in this respect like the deliberate vaginal cystotomy which was much used by a previous generation of gynaecologists, and which invariably closed, it seems, within a few days. In several cases in which I have resorted to vaginal cystotomy spontaneous cure has always quickly occurred without the need for suturing. Dr. Mackay's case is specially interesting inasmuch as the closure took place without the help of urethral drainage, which is, of course, indicated after cystotomy.

Dr. Mackay comments on the difficulty of exposure of the fistula. This difficulty may be very great, but is, in most cases, overcome by the use of a generous episiotomy and the adoption of the knee–chest position as recommended by Sims in his pioneer work. I have found Grey Turner's modification most helpful. The anaesthetized patient is rolled on her face, is drawn by her legs to the bottom of the table, the legs flexed at the hips, and the knees placed on, and bandaged to, a low stool: the table is then lowered until the pubic region is just clear of the top. Whereas the true knee–chest position is difficult to maintain, this modified position can be kept up without difficulty for long periods.

I deplore the pessimistic impression conveyed in Dr. Mackay's report regarding the curability of vesico-vaginal fistulae, and the implication that transplantation of the ureters is an operation frequently required. Mahfouz Pasha,[1] with experience of more than 400 cases—many of a very severe variety—reports a cure rate of 95% in the last 100 cases. Writing of the abdominal and transvesical approach he says: "For the last eight years I have not resorted to any of these abdominal operations; I find the vaginal route safer, and if I fail to close the fistula by the vaginal route I seldom succeed to do so by the abdominal." In my own much smaller experience of 30 vesico-vaginal fistulae it has been possible in all of them to repair the fistula by the vaginal approach alone, using, for the most part, a simple Sims's type operation (one patient is still under treatment with every prospect of cure). Most of these were cases of long-standing incontinence—one as much as 32 years—and most of the patients had had multiple previous operations, many by the abdominal or transvesical route. In view of this satisfactory experience with the vaginal operation I disagree with the pessimism so often expressed regarding the treatment of this injury. The most difficult case is that in which there has been an extensive loss of tissue at the vesico-urethral junction; in it a perfect anatomical repair may be marred by a subsequent severe stress incontinence of urine. In these cases relief may sometimes be obtained by the use of a pessary to press on the urethra, or, more certainly, by the use of the Aldridge fascial-sling operation.[2]—I am, etc.,

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2 Moir, J. C. (1945). *Proc. roy. Soc. Med.*, **33**, 675.

Iritis in the Rheumatic Affections

SIR,—Prof. Arnold Sorsby and Dr. A. Gormaz (April 20, p. 597) wrote an interesting paper on iritis in the rheumatic affections. They made the important observation that iritis occurs in some 5% of cases of rheumatoid arthritis, and again drew attention to the incidence of iritis in ankylosing spondylitis. The rest of their paper, however, only serves to show how completely meaningless are the terms "rheumatism" and "rheumatic." They investigated the incidence of iritis in rheumatoid arthritis, acute and subacute rheumatic fever, Still's disease, fibrositis, osteoarthritis, ankylosing spondylitis, gout, and sciatica. Rheumatoid arthritis, Still's disease, and ankylosing spondylitis are no doubt closely related to each other from the point of view both of aetiology and of pathology, but there is no satisfactory proof that they are in any way related to acute and subacute rheumatic fever. Though both groups of conditions may have an infective origin, this has not been proved.

Osteoarthritis is a degenerative condition, and is often a misnomer in that what is called osteoarthritis is commonly no more than the presence of osteophytes quite unrelated to joints. Although gout may sometimes give rise to diagnostic difficulty, there is nothing to suggest that its causative factors are in any way related to those of the other conditions under discussion. Similarly, sciatica has nothing whatever to do with any of these conditions. It is, therefore, not surprising that they found no significant incidence of iritis in osteoarthritis, gout, or sciatica. Indeed, the only feature common to all these conditions is pain, and on this basis "rheumatism" might just as well embrace such unallied conditions as trigeminal neuralgia, tabes dorsalis, or angina pectoris. Nor is the absence of iritis in "fibrositis" unexpected. This latter must surely be the biggest diagnostic rubbish heap in current medicine; the last three cases bearing this label that have come to my notice have respectively been chronic empyema, lobar pneumonia, and metastatic carcinoma of the spine, though the bulk of cases so labelled are, in fact, examples of psychogenic pain. I have long felt that the terms "rheumatism" and "rheumatic" are so devoid of meaning that they should be expunged from the medical vocabulary or limited to acute and subacute rheumatism or rheumatic fever.—I am, etc.,

Leeds. HUGH G. GARLAND.

Sjögren's Syndrome with Rheumatoid Arthritis

SIR,—Dr. F. Parkes Weber in his letter (May 4, p. 700) questions whether anyone in this country has seen rheumatoid arthritis in patients suffering from Sjögren's syndrome. If he will be good enough to come round here I can show him several such patients, including one now receiving in-patient treatment. Far from being a curiosity in Sjögren's syndrome, rheumatoid arthritis is an essential feature of the condition, and I hesitate to diagnose keratoconjunctivitis sicca unless the patient shows evidence of rheumatoid arthritis.—I am, etc.,

Royal Eye Hospital, London, S.E.1. ARNOLD SORSBY.

Partial Deafness of the Elderly

SIR,—Now that I have myself become a victim of this very common form of deafness I realize that the public (and most doctors) are unaware of its peculiarities. If these were widely comprehended, a little considerateness would enable speakers—in public, in private, and on the wireless—to become intelligible to thousands of these elderly unfortunates. The remedy usually applied is to shout. This is not only unnecessary (except in advanced cases) but is resented as calling attention to their infirmity. No, the main defect is a blurring of the words together when people talk too quickly or indistinctly; also if two people talk at once or if there is another noise, such as a passing aeroplane.

The defect seems to me analogous to an old piano in which the dampers have become worn so that the notes run together if played too loud or quickly. Hence, in conversing with one of these unfortunates, it is considerate and polite to face him, so that he can see the movement of your lips, and to speak more distinctly and deliberately than is customary with most people, especially the young. For this and more important reasons, children should be taught not to speak in a slovenly