

Poliomyelitis after Immunization

SIR,—In the report of the discussion at the Royal Society of Medicine on poliomyelitis following inoculations (April 29, p. 1004), I am erroneously reported to have said that “the Americans had not got a combined antigen.”

What I did say in effect was that “as one of the combined diphtheria and pertussis antigens used during the Melbourne outbreak of poliomyelitis was a British preparation containing alum, and as the use of a similar combined antigen, or A.P.T. alone, seemed in this country to be associated with post-inoculation poliomyelitis, it may be that the British diphtheria and pertussis prophylactics are more likely to produce an irritant lesion at the site of inoculation than is the case with American prophylactics in which alum is not used so much.”—I am, etc.,

London, W.2.

ROBERT CRUICKSHANK.

Ankle Amputation

SIR,—I read with great interest Mr. W. Gissane's letter (April 15, p. 901) and agree that the Syme's amputation is an excellent operation, and there can be no doubt that a great number of such stumps stand up to limb-wearing for many years. There is no doubt, too, that some of them break down, but this criticism can be levelled at any amputation, especially the below-knee amputation.

Syme's amputation has fallen into disrepute for two reasons: (1) faulty surgery and (2) the difficulty of supplying a suitable prosthesis. In my view, a Syme's amputation is one of the most difficult amputations to perform and requires considerable experience. It is essential when enucleating the os calcis to preserve the blood supply of the heel flap. Furthermore, the plateau of the tibia should be cut horizontally. This is important. The post-operative treatment demands vigilance, because the heel flap is inclined to slide off the tibial plateau and become eccentric. This tendency should immediately be counteracted by appropriate strapping with elastic adhesive plaster.

The advantages of a Syme's amputation are: (1) the patient is left with a stump which enables him to get out of bed without a prosthesis; (2) he walks well with a prosthesis; and (3) psychologically the patient feels he still has his limb.

With a soundly healed and orthodox Syme's amputation a good limb-maker can fit a valuable prosthesis. Of necessity the end of the apparatus is bulky, and therefore women are reluctant to accept such an apparatus and prefer a below-knee stump, where the apparatus is more aesthetic. I cannot agree that the elephant boot which Mr. Gissane mentions is aesthetic. The average good limb-maker can produce a better-looking limb than an elephant boot.—I am, etc.,

Worcester Park, Surrey.

LEON GILLIS.

Cervical Disk Lesions

SIR,—Dr. W. M. Philip's article (April 29, p. 986) on brachial neuralgia is to be welcomed. It draws renewed attention to a common syndrome whose cause and prevention have only recently been understood. However, I am disappointed to find no mention of prophylaxis. When an attack of internal derangement occurs at a lower cervical intervertebral joint an acute stiff neck results. If the displacement takes place more gradually the first symptom is nearly always scapular pain. Clearly it is at this stage, when the displacement is slight and recent, that manipulative reduction is most quickly and easily performed.¹ One or two attempts without anaesthesia nearly always suffice. By contrast, when severe root pain in the upper limb has supervened manipulation is more difficult and occasionally fails.

It is thus vital that these early cases should no longer receive traditional labels such as “fibrositis” or “rheumatic torticollis” and be ordered palliative treatment. Though it is true that many patients do recover spontaneously with or without physiotherapy, injections, etc., recovery is often, as Dr. Philip points out, partial and may take weeks or months. Moreover, a certain proportion get worse and develop brachial pain. This event is wholly avoidable; indeed, cases of root pain from

cervical disk lesions would all but cease if manipulative reduction were carried out as a matter of course in all cases on the first occasion that the patient was seen. This has in fact been the routine practice in the department of physical medicine at St. Thomas's Hospital for the past five years.—I am, etc.,

London, W.1.

JAMES CYRIAX.

REFERENCE

¹ Cyriax, J., *British Medical Journal*, 1948, 2, 251.

Hypercalcaemia during Vitamin D Treatment

SIR,—Drs. H. St.C. C. Addis and R. D. Currie stress the toxicity of excessive doses of vitamin D (April 15, p. 877). However, in the two case histories reported, it would seem that the toxic symptoms were not due to the vitamin. As Case 1 is “typical of Paget's disease,” and Case 2 one of “advanced rheumatoid arthritis,” loss of appetite, fatigue, and pallor may well be due to the disease, as stated by the authors in the discussion, albeit conversely, and not to the high doses of calciferol.

The serum calcium is high in both cases, but in Case 1 the authors declare that it may be due to the Paget's disease. Moreover cases of Paget's disease have been successfully treated with massive doses of calciferol. In Case 2 the serum calcium does not appear to be of any consequence. In fact, a level of 12.8 mg. per 100 ml. is not a sign of calciferol intoxication but is the normal effect of the prolonged administration of massive doses and is not usually an indication for abandoning treatment.

With regard to renal impairment, Case 1 presents a definite previous history of Bright's disease, but in spite of this the urea clearance was 21% of the average normal, even though the patient had been taking calciferol in a dose of 200,000 i.u. daily for at least a year. Renal dysfunction is an absolute contraindication to massive doses of vitamin D, and in this case the excessive administration has oddly enough failed to produce those untoward results which might have been anticipated. In Case 2 the blood urea reached 94 mg. per 100 ml., and because the patient “gave no relevant history of any previous illness,” and as “he had been taking calciferol in a dosage of 600,000 i.u. twice a week for about a year, he was considered to be suffering from the effects of calciferol intoxication.” Patients become uraemic without taking calciferol. As the authors state, “No conclusion concerning the presence of previous renal impairment was arrived at.”

The authors conclude the history of Case 2 without even suggesting a cause for the patient's death. Written as it is, and on quick reading, one could be given the wrong impression that death was due to the vitamin. In conclusion, it seems that the amount given to these two patients should not be called “excessive,” since the toxic symptoms cannot be definitely ascribed to the calciferol.—I am, etc.,

London, W.1.

A. E. GREMEAUX,
Medical Director of Roussel Laboratories Ltd.

Carcinoma of Stomach

SIR,—I am bound to agree with Mr. Harold C. Edwards (April 29, p. 973) that the radiological report he quotes (p. 976) is a bad one and the advice given is bad, and I can only conclude that it was made, as he says, by an inexperienced radiologist. But to infer from this that the radiologist should never give advice to the clinician appears to me to be most unsound. It is the duty of the good radiologist to know the significance of what he sees on the screen and in his films and to pass this information on to the clinician. To make a bare factual report is only to have half done his job. The whole art of radiodiagnosis lies in the interpretation of the facts.—I am, etc.,

Ryde, I.W.

J. CONWAY-HUGHES.

“Disprin” Tablets

SIR,—Dr. M. Coplans (April 22, p. 958) is mistaken in stating that reference is made to his name in the brochure included with each carton of “disprin” tablets. It is only in our booklet concerning disprin which is issued to the medical profession that any