

**Gastrectomy.**

SIR,—Having read the article by Professor C. Wells and Mr. R. Welbourn (March 17, p. 546) it appeared to me that, while the accepted operations of gastrectomy are curative for a disabling and occasionally lethal lesion, they are bringing in their train a new set of syndromes and even new operations to cure them, not a desirable state in this enlightened day, and I was disappointed to see that relatively little emphasis was placed on prevention of these undesirable after-effects, most of which can be referred to the abnormal new mechanics introduced into the gastrointestinal tract.

In my own opinion the Billroth I operation is, as was stated in the article, much less liable to have unpleasant sequelae and should, I consider, be performed in every case requiring gastrectomy, unless there is an adherent duodenal ulcer.

There is one fallacy in connexion with this operation which has gained common acceptance, and that is that it is not possible to do a true radical gastrectomy. This is not so. The more stomach removed, the easier to bring round the stump, as the vasa brevia must be divided, and, this having been done, the fundal stump is entirely mobile, hinging merely on the cardiac end of the stomach.

The anastomosis is technically a little more difficult than in any modification of the Polya-Sherren operation, but the immediate post-operative course is always pleasanter, and even if the small stomach "dumps," it dumps into the normal receptacle for chyme. Also we have eliminated any chance of kinking or compression of a jejunal loop.

Professor Wells and Mr. Welbourn mention the chance of recurrent ulceration, but I have never seen this and I see no reason why if the amount of stomach removed is adequate, as it should be, it should occur any more commonly than after any other type of gastrectomy.—I am, etc.,

Swansea.

B. BRENDAN HICKEY.

**Conservative Treatment of Perforation**

SIR,—When Hermon Taylor demonstrated so clearly that non-operative treatment could be successful in cases of gastro-duodenal perforation he did much to solve the problem of how best to treat the occasional patient whose local or general condition made a laparotomy undesirable. Many of us have now employed this method for some years on carefully selected patients with satisfactory results. During the last year or two, however, a few enthusiasts have advocated a much wider adoption of this conservative plan as an alternative to surgery in cases where no clear contraindications to laparotomy are apparent, a recent article (March 31, p. 675) claiming "... that immediate operation in simple gastro-duodenal perforation is no longer necessary, and that any operative intervention should be reserved for such complications as may arise." Many will feel that this statement should not pass unchallenged.

Until comparatively recently the mortality of surgical intervention was around 15% and there was every reason to be dissatisfied with this figure and to seek an alternative method of treatment, but during the last few years the mortality rate in cases treated by simple closure of a perforation has dropped to a very low figure indeed, and the few patients who die usually do so either on account of factors unconnected with the method of treatment adopted or because the local condition has been unusually complicated from the start, for instance by several previous operations on the stomach.

Patients without grave constitutional disease do not now die after surgical closure of an uncomplicated perforation, and, although it is true that some perforations are small and found at operation already sealed off, I personally have not been struck by the frequency of this finding and I do not know of any means of determining the size of a perforation before operation with any degree of accuracy.

Mr. E. Scott is to be congratulated on the skill and conscientious attention to detail which he and his nursing staff have used to such good effect on the series of cases he reports. If he continues thus until a significant number of cases have been treated, the likely result is that his figures will be better than those for surgical closure in the cases exhibiting a clear contraindication to laparotomy, but that he will risk losing unnecessarily one or two of his "good risk" cases. His overall figures will probably be not greatly inferior to those obtained by surgery. Where he goes wrong is in not realizing that the best results of all are to be obtained by a careful selection of cases, treating with the conservative plan those cases in which a clear indication against laparotomy exists, and operating upon the others.

The greatest danger in his article, however, lies in the fact that, if his advice is taken literally by all and sundry, some will fail to realize that the successful application of non-operative treatment requires not less but more skill, clinical observation, and attention to detail than operative treatment. Unless this is realized and the conservative plan applied as successfully as in Mr. Scott's cases, to refuse surgery to otherwise healthy adults with uncomplicated perforations can lead to nothing but disaster.—I am, etc.,

London, W.1.

RODNEY SMITH.

SIR,—I was interested to read (March 31, p. 675) about Mr. Edmond Scott's experiences in treating acute perforations conservatively without operation. There is one point, however, which he does not mention, and that is the usefulness of operation as a diagnostic measure. No doubt in the series of cases he quotes there was a reasonable chance of their being all non-malignant gastric or duodenal perforations, but my own feeling is that the non-operative treatment of perforations in the hands of any but the most expert diagnosticians may subject the patient to further hazards.

As a one-time surgical registrar I needless to say lived in fear and trepidation of discovering that my perforations when opened would not be perforations, and it was always with considerable relief that one found an obvious perforation surrounded by fibrinous exudate, but one sometimes felt that this good fortune was in the lap of the gods, and there can be few surgically minded persons who cannot remember the malignant perforation, the perforated appendix, and other abdominal catastrophes simulating in every detail the true peptic perforation. I am sure that there are few experienced surgeons who would not admit the possibility of a misdiagnosis in a strongly suspected perforation.

I think the matter can be summed up simply by saying, "Yes, by all means consider treating a perforation conservatively, provided it is absolutely certain beyond any possible doubt that it is a non-malignant simple perforation of the stomach or duodenum."—I am, etc.,

Wembley, Middlesex.

M. E. ARNOLD.

**Chloroquine**

SIR,—Results obtained with chloroquine diphosphate ("aralen") used as a suppressive and also for the treatment of a small number of cases of *P. falciparum* malaria in a very malarious district of the Gold Coast may be of interest.

Ten Europeans, who had previously been taking either quinine, mepacrine, or proguanil as a suppressive, changed to chloroquine and started with a loading dose of four tablets (1 g.) during the first week, after which they carried on with two tablets (0.5 g.) weekly as recommended by the makers. Within three weeks three of them were suffering from clinical attacks of malaria with parasitaemia. Thereupon all but two changed back to their original suppressive. The two continuing to take chloroquine have so far been free from attacks.

The three cases that occurred were treated with chloroquine. Two received the recommended course of 1 g. as an initial dose, followed by 0.5 g. eight hours later, and

0.5 g. on each of two successive days, making a total of 2.5 g. The third received 5.5 g. over a period of nine days. All had symptoms and parasites in their blood on the completion of treatment, although one of those on the smaller dose cleared on the fourth day. The other two were started on mepacrine after one day's observation and rapidly improved. An indication that the drug was being absorbed in the case that received 5.5 g. was given by the fact that pronounced visual disturbances were produced. This, and nausea in the case of the one woman taking it as a suppressive, were the only toxic symptoms recorded.

Although the number of cases is so few, the response cannot be considered altogether satisfactory. The reason for this may be that the parasites in this area may be resistant to chloroquine, as they are to proguanil, or that the dosage used was inadequate.—I am, etc.,

Accra, Gold Coast Colony.

J. J. MESSENT.

### Enlarged Prostate

SIR,—Mr. E. W. Riches observes (March 24, p. 633), "To put a patient on to self-catheterization halves his expectation of life." Perhaps the following is an exception which proves the general rule. I am looking after a patient in his 97th year who has catheterized himself regularly for 15 years with a gum elastic catheter which he keeps in a simple tin box. He has had no trouble at all, and is yet active and in possession of all his faculties. A recent specimen of urine was clear and free of albumin. Catheterization has handicapped him hardly at all.—I am, etc.,

D. I. EVANS.

### Toxic Chemicals in Agriculture

SIR,—I have read your leading article (March 24, p. 628) and also the "confidential" information issued by the B.M.A. I am probably a fairly typical rural practitioner, in whose district the spraying of market garden and farm crops is general.

My reaction to this information is a desire to find a way of disclaiming in advance any responsibility for the survival of patients of mine who may be affected by these chemicals.

In my opinion it is, first, too much to expect that the workers concerned will observe the strict safety precautions considered necessary.

Secondly, the early toxic symptoms could apparently so easily be mistaken for those due to other causes, such as neurosis, heat stroke, etc., that the responsibility of early diagnosis is too much to ask of the general practitioner, this being more especially so if he is to treat every possible case either by immediate transfer to hospital or by hourly injection of atropine in 1/60 to 1/30 gr. (1-2 mg.) dose.

My final reaction is the opinion that the use of these insecticides should be prohibited until a compound harmless to man has been found.

I am no crank, I hope, but I am slightly dubious about chemical fertilizers. I have always disliked the practice of agenizing flour. I fear these chemists. I feel that this attitude may be widespread enough to warrant recording.—I am, etc.,

Bergh Apton, Norwich.

W. C. WARDLE.

SIR,—In your leading article on this subject (March 24, p. 628), the statement is made that "D.N.O.C. is only cumulative when doses follow one another in rapid succession in periods of hours and not days." Experiments on human volunteers do not support this view. Daily doses of 75 mg. D.N.O.C. by mouth cause a steady rise in the concentration of D.N.O.C. in the blood. After three or four days the maximum level is attained. A further dose of 75 mg. at this stage causes a marked increase in the concentration of D.N.O.C. in the blood and this increase may be accompanied by symptoms.

Excretion of D.N.O.C. takes place remarkably slowly in man. D.N.O.C., 75 mg., was administered daily for five days. Six weeks after the final dose four volun-

teers still had D.N.O.C. present in the blood in concentrations of from 1 to 1.5 µg. per gramme of blood. Details of the experimental work in animals and human beings will be published shortly. We believe that absorption of D.N.O.C. in small amounts each day will result in a cumulative effect. Persons who show any symptoms and signs of D.N.O.C. poisoning should be removed from risk of further absorption for a period of at least six weeks.—We are, etc.,

D. GRAHAM HARVEY.  
P. LESLEY BIDSTRUP.

London, E.1.

### Accelerated Development of Children

SIR,—It is a well-known fact that children to-day are bigger than the children of 40 years ago. They weigh more and are taller. Every well-meaning person is pleased: "That is the result of our child-welfare services," and they all pat themselves on the back.

But the other day in the *British Medical Journal* a writer pointed out (February 24, p. 403) that the average height and weight of the adults of this generation have not altered. This is a very important observation. It means, in fact, that although the children are bigger the adults are not any bigger. A glance at any gathering, such as a football crowd or a crowd on the pavements of our cities, seems to confirm this. What does it mean? It means that the young of our species in England mature quicker than their forebears. A child of 12 is physically three years in advance of his grandfather. In other words, although to us they appear to be children, already they are men and women, say, at 15 or 16 years of age. There are several consequences of prime importance.

*Juvenile Delinquency.*—One blames the education system, lack of parental control, and similar causes, whereas the most salient fact is the early maturity of the individual: man's instincts and a child's brain. Our legislation has not yet caught up with that concept. Yet it is plain that early maturity is a great factor in juvenile delinquency.

*Lack of Fertility.*—A great number of young people marry at early ages, which is very sound biologically, but socially is a nuisance. If marriage is delayed, say, to 25 years of age, the woman has already had about 13 years of sterile sexual maturity, which biologically is bad. No breeder of animals would wait such a long span of the animal's life before mating her. The later marriage rate of the man does not matter quite so much, but fertility does drop a little.

We must also remember the earlier onset of menopausal symptoms, the greater number of cases of impotence, and the rise in the rate of congenital malformations.

I trust that these observations may lead to some discussion; for if, indeed, the views expressed herewith are correct some readjustment is needed both in the nation's laws and in the assessment of the implications of this accelerated maturation of the human adult.—I am, etc.,

Southampton.

E. SAKOSCHANSKY.

### Absorption of Iron

SIR,—I read with interest your leading article on the absorption of iron (February 3, p. 231), because abnormal deposition of the element is frequently observed in the South African Bantu living on the Witwatersrand (investigations up to the present have been limited to these people).<sup>1,2</sup>

Haemosiderosis—apart from being a feature of haemochromatosis—can arise from a high oral intake of iron, from its intravenous administration, from diseases marked by haemolysis, and possibly from malnutrition. Since it has been found that the iron intake of these Bantu is frequently as much as 200 mg. per day, derived mainly from their iron cooking vessels,<sup>3</sup> the role of this high intake, as a causative factor in the haemosiderosis observed, seems worth considering. An interesting observation, barely mentioned in current reviews on iron metabolism, is that, when iron preparations are taken orally in doses of the order used in iron therapy, an abnormal amount, sometimes reaching several grammes, is absorbed by the body. Such iron is retained and not