Roman Catholics believe it to be so. I have no desire to use your columns for an ethical debate, but I would beg your indulgence to answer some of the points made by Dr. G. I. M. Swyer (January 26, p. 218).

It is not the principles and practice of Roman Catholic theology that are involved in discussing the problem of masturbation, but rather the conclusions which result, in the light of pure ethics, from a consideration of the natural law—i.e., the sum-total of all that our reason prescribes as necessary for the proper moral ordering of our lives. It would take up too much space to describe in detail the reasoning involved in determining the moral norm of the use of the sexual faculty, but any who are interested can consult textbooks of ethics written by abler pens than mine. Briefly, then, I would reiterate firmly that masturbation is a perversion of the sexual faculty, and its use is gravely sinful and not permissible under any circumstances. The questions of whether masturbation is used for the purpose of investigating fertility or whether or not pleasure is obtained by its use are quite beside the point. If the action is wrong the presence or absence of pleasure does not affect the issue.

I can assure Dr. Sawyer that no Catholic priest can sanction masturbation—no more than any bishop, archbishop, or even the Pope can alter the rulings laid down by considerations of the natural law.

I feel that I need hardly discuss Dr. Swyer's argument whereby he seeks to throw doubt upon the perversity of masturbation by pointing out, on eminent authority, that it is frequently indulged in by human males and monkeys. Come, Dr. Swyer, are the Ten Commandments or the laws of the land invalid because they are broken every day? Finally, Sir, I would apologize for the very brief and incomplete exposition of the ethical principles involved, but would repeat that those interested will find abundant literature on the subject.—I am, etc.,

Manchester. F. N. VALDEZ.

Interesting Tumour of the Palate

SIR,—Simple tumours such as adenoma, fibroma, papilloma, and dermoid cyst are rare and only occasionally seen.

The patient was a woman aged 41 years with a four-years history of a small lump appearing in the hard palate region on the left side and gradually increasing in size. It was 1 in. by ½ in. (2.5 by 1.25 cm.), ovoid, edge well defined, and consistence hard. It was attached to the mucous membrane by a short stalk. There were no other lumps present and no enlarged glands.

As it appeared benign and causing an ill-fitting denture it was decided we should remove it and send a section for pathological report. The patient was lightly anaesthetized and removal attempted with a scalpel, but the stalk proved too hard. However, a diathermy needle was used and the lump removed. Haemostasis was secured and the stump touched up with carbolized resin. The patient has had no further trouble.

Pathological Report.—Appearance, an oval hard mass 2 cm. in greatest width; incision shows a dense fibrous stroma. Sections show a purple submucosal fibroma with zones of calcification and occasional collections of chronic inflammatory cells. The appearances suggest a response to chronic irritation.

Since such simple tumours are rare we presume that this one was the result of chronic irritation over years, and it was large enough to cause trouble, hence removal was needed and was a complete success.—We are, etc.,

Honiton. A. T. H. GLANVILL.
B. MARTYR.

Treatment of Tuberculous Meningitis

SIR,—After reading the article by Dr. S. Russell Jamieson (January 12, p. 83) on his cases of tuberculous meningitis I would like to make the following observations, as I cannot agree with his dosage of streptomycin, criteria for continued bed-rest, or the relation of B_{12} and increase in weight in these cases.

The daily injections of streptomycin both intramuscularly and intrathecally for six months continuously may give the impression that this is a generally accepted scheme of dosage and in my opinion may lead to unnecessary over-treatment It is well known that even to-day there is no general agreement on the optimum dosage for these patients, owing to the difficulty in finding an adequate dose to cure the patient without producing toxic effects which may be avoidable: the tragedy of curing a patient yet leaving him stone deaf is only too common. Combined with this is our lack of knowledge about the development of drug resistance, although experience has shown that treatment is usually still effective long after resistance may have been expected to have developed.

I wish to emphasize that whatever principle of treatment is adopted the intensity and length of treatment are mainly determined by the response of the patient and not by an arbitrary dose decided on beforehand. Most authorities agree that an intensive course of daily injections is required until the patient shows a satisfactory response. This may occur at any time, often between the eighth and tenth week. After this has occurred a rest from daily intrathecal injections is both desirable, from the point of view of the patient, and quite safe, as the patient is under the closest observation should a relapse occur. It is again the patient's progress which determines the length of subsequent treatment, and, although most schemes employ daily or alternate daily injections with varying rest periods, it is of interest that recent views in this country and America suggest that twice-weekly injections may be just as effective as daily ones. Twice-weekly injections have indeed been used with satisfactory results on patients who have responded to the conventional daily dosage. It may well be the answer in avoiding the neurotoxic effects of streptomycin in the future.

It is well recognized that the protein content of the cerebrospinal fluid may remain raised for very many months, and, provided progress is otherwise satisfactory, it does not seem justified to keep the patient completely in bed until the C.S.F. is normal in this respect, though obviously the closest observation is required until this occurs.

I do not feel that Dr. Jamieson has made a convincing case for the association of vitamin B_{12} with gain in weight in these patients, as a steady increase in weight occurs anyway when the patient is responding to treatment, and in the later stages is probably the most important guide to satisfactory progress.—I am, etc.,

Northampton. C. J. ZERNY.

Technique of Shock Therapy

SIR,—Dr. D. T. Maclay mentioned Dr. A. Stephen and myself in his letter about the technique of shock therapy (December 15, 1951, p. 1464); Dr. J. L. Esplen (January 12, p. 109) suggests that this technique may be improved by the use of thiopentone. In view of these letters, and the association of my name with the first, I should like to set out some facts and express a few opinions about electroplexy modified by curare and other drugs ("flaxedil," decamethonium iodide, and "celocurin"). I hope shortly to write of this subject in a paper, the material for which has been collected for the past six years; in the meantime I should be sorry to see the defence of a valuable method neglected for want of a letter.

My colleagues and I have given doses of curare of between 5 and 15 mg. to the conscious premedicated patient on over 6,000 occasions. The premedication in use for the past two years has been hyoscine 1/200 gr. (0.3 mg.) and atropine 1/200 gr., given together. The incidence of breathlessness sufficient to cause complaint has been very low; it occurs sufficiently rarely to cause comment among the staff when it does happen. Other complaints of fears of various kinds are certainly not uncommon, but these are associated with any method of treatment, and do not bear any relation to the giving of a particular drug or injection. The patients who are most afraid are those suffering from obsessional and phobic disorders; a knowledge of the psychopathology of these diseases would seem readily to explain the frequency with which fear is a symptom in such cases. Some patients suffering from schizophrenia are also more apt to be frightened than the average patient. Melancholia is perhaps more commonly treated by electroplexy than are other diseases; in the straightforward case of melancholia it is our experience that complaint of breathlessness does not arise. However, endogenous depressive illness, occurring earlier in life, may show different characteristics. In the case of a Pole who, owing to his marked muscular development, received 15 mg. of curare, there was a severe reaction. He became panic-stricken—partly no doubt on account of the language difficulty—and a struggle ensued, in which he became cyanosed. This case was, however, exceptional in many ways, not the least in the size of the dose of curare.

It is not possible in the space of a letter to go into the reasons which prompt a psychiatrist to use curare, but it is pertinent to remark that in its use by us no deaths have occurred (though some patients were gravely ill physically and mentally) and only two known fractures were sustained (both crush fractures)—the circumstances under which they occurred being again quite exceptional. If the aim of treatment is to safeguard the skeletal system and yet give adequate treatment by electroplexy, then curare with premedication has seemed to myself and my colleagues to be adequate for more than three-quarters of our cases. Several hundred cases during this time have received thiopentone or other form of anaesthesia, but it seems inescapable that there is then an added risk, and there is certainly a greater expenditure of time by both nurses and doctors. In my view there is no doubt at all that thiopentone increases the danger of laryngeal spasm, particularly if it is not given in sufficiently large doses. It seems that the nervous patient is the one particularly likely to show vagal over-activity, especially after the onset of unconsciousness, when large-scale sympathetic over-stimulation due to fear probably comes to an abrupt end.

I would add that a distressed patient can very often be reassured effectively by being given between three and nine grains of sodium amytal by mouth at about the same time as the premedication is given by injection. So far as I know, this barbiturate given by mouth has no influence in producing untoward symptoms and may probably prevent them by inducing greater relaxation and calmness.

May I make a plea that electroplexy should not be called shock therapy? This is a most misleading term.—I am, etc.,

London, W.1. E. BERESFORD DAVIES.

SIR,—The letters of Dr. D. T. Maclay (December 15, 1951, p. 1464) and of Dr. J. R. Esplen (January 12, p. 109) lead me to anticipate what was to have been the subject of a later communication.

It appears desirable, on behalf of the patients about to be treated by electrotherapeutic techniques, to bring to wider notice the existence of new short-acting muscle relaxants which in my view so alter the principles of treatment that "straight" E.C.T. may be considered to be outmoded. I refer to the drugs described by Ottolenghi, Thesleff, Von Dardel, and Scurr which produce satisfactory relaxation for a minute or two and are therefore specially suitable for the purpose. By the kind action of the manufacturers experimental quantities of succimethonium iodide have been made available and have been found so valuable that uncomplicated cases can be treated as out-patients in about the time taken by straight E.C.T., with all the efficiency and muscle control of previous long-acting relaxants. It has been found possible to do away with the pre- and post-treatment atropine and oxygenation, and, since very much less than the usual dose of intravenous barbiturate (miscible with the relaxant, provided the mixture is used immediately) is necessary to cover the prodromal symptoms, the patient is awake within two or three minutes and movable within a few more. The net result is complete elimination of all the possible skeletal troubles, anxiety, restlessness, noise, and furor. Naturally it is early days yet to produce a statistically accurate, analysed statement, but, in the interest of patients everywhere, I will of course be happy to send details of the technique so far elaborated to anybody interested.

Incidentally, Dr. Maclay's letter gives a false impression of the frequency of bone fractures and other strains occurring in straight E.C.T.; with proper technique and reliable apparatus, accidents of this kind are almost unknown to-day.

I would add that I have been assisted very greatly in widening the field for these trials by the kind co-operation of Dr. E. B. Strauss, my chief, and Drs. D. O. Macaulay and J. Gould, my colleagues, in the Department of Psychological Medicine, St. Bartholomew's Hospital, Dr. J. F. Perredes, of the Lowestoft and North Suffolk Hospital, Dr. A. H. L. Baker, and others.

—I am, etc.,

London, W.1. LOUIS ROSE.

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Gastro-duodenal Perforations

SIR,—The recent observations (see January 19, p. 164) on the subject of gastro-duodenal perforations are timely and of great interest. The following case gives some of the points that confront a surgeon in treatment.

A man aged 73 started suffering from peptic ulcer dyspepsia, with pains in epigastric area after meals (½–1 hour), relieved by powders; had constipation and reported attacks of vomiting food in January, 1950, when he was diagnosed as gastric ulcer and treated by medical means. His pains were controlled, but vomiting tended to increase in severity and frequency. No loss of weight and appetite good. In January, 1951, he perforated his ulcer, and was admitted into hospital, where the surgeon sutured a "perforated gastric ulcer." Further progress was satisfactory and he was discharged in February.

From February to December, 1951, the patient was free from all symptoms, gained weight, had a good appetite, and was well on his way to what he termed "complete recovery." During Christmas, however, his symptoms reappeared suddenly, with severe pains, vomiting, and loss of appetite. Investigations revealed a neoplasm of stomach. On January 8, 1952, laparotomy revealed an inoperable carcinoma of stomach covering the site of previous suture.

Thus, (i) The incidence of ulcer-perforation rises in the older age groups, and it is in these groups that carcinoma usually occurs. (ii) Perforation of gastric carcinoma is not very uncommon, the polypoidal and ulcerative type being particularly known for this complication. (iii) At the time of closure oedema and inflammatory exudate sometimes make it impossible to say if the ulcer is benign or malignant, and its exact site (viz., duodenum or pylorus) cannot be determined. (iv) About 5% of benign peptic ulcers which perforate and are sutured undergo a malignant change: this transformation is seen in the elderly group and is fairly rapid. (v) Biopsy in a doubtful case of perforation is not a routine procedure: even if it were carried out, the result may not be very conclusive in all cases. (vi) It would be interesting to work out the percentage of gastric carcinomata that first declare themselves as a perforation. (vii) Do any of these problems make the claim for partial gastrectomy at the time of first operation (provided the patient is in a fairly good condition), or, as in gastro-duodenal haemorrhage, at a later date, any stronger? (viii) It can be deduced that all patients past middle age who have a perforation sutured should be kept under constant observation, failing which a subtotal gastrectomy should be carried out a month after the suture. (ix) The conservative regime, in this elderly group, carries an obvious risk. (x) Is the mortality rate of partial gastrectomy in cases of gastro-duodenal haemorrhage (under "selective surgical 'intervention'") any lower than that of a similar procedure in suitable cases of perforation?

—I am, etc.,

Orsett Hospital, Essex. M. ISMET-ANWAR.

Nomenclature of Diseases and Operations

SIR,—A leading article in the *Journal of the American Medical Association* for December 8, 1951, deals with a new edition of *Standard Nomenclature of Diseases and Operations* and its relation to the *International Statistical Classification of Diseases, Injuries, and Causes of Death*. It points out that the two are by no means interchangeable: "The Standard system, as a clinical system, is necessary for the proper separation of individual differences in diseases for reading and research purposes," whereas "the International system applies mainly to much broader disease groupings for statistical purposes."

This difference has been emphasized since the International classification was adopted in my own H.M.C. area under the N.H.S. and has replaced the M.R. Classification I formerly used.

As the *J. Amer. med. Ass.* suggests, I find the new classification unsatisfactory for a number of purposes in which I am interested. It suggests that the World Medical Association might appropriately consider a combined clinical and statistical system, and perhaps you could bring your influence to bear on this if, as I think will prove the case, widespread adoption of the International classification is unsatisfactory for clinical purposes.—I am, etc.,

Hove. W. A. BOURNE.