The Cleft in Man

SIR,—It is not often that the *British Medical Journal* bestows the hospitality of a full page of its valuable space on the review of a book (December 15, 1951, p. 1445). Impressed by this fact and by Professor Lancelot Hogben's interesting critique, in common no doubt with many others I have read the book, Dr. J. Bronowski's *The Common Sense of Science,* and would be glad to be allowed to comment on it.

In the last chapter Dr. Bronowski takes up the question of science the destroyer, and the indictments which have been brought against scientists for their alleged unthinking and amoral attitude as they go on inventing more and more destructive weapons. He remarks upon the fear of war that has developed, the war of nerves, and the important fact that there seems to be no generally accepted code of values capable of helping to deal with this situation. He offers a solution, however. He believes science can create these values, and states: "The first thing to do, it seems to me, is to treat this as a scientific question; by which I mean as a practical and sensible question, which deserves a factual approach and reasoned answer."

At this point his scientific training appears to desert him completely. He speaks of the cleft in man which two wars have uncovered—between the endeavour to be man and the relish in being brute—and, curiously to my mind, refers to it as a spiritual problem and not a psychological one. Later he asks: "Can science heal that neurotic [*sic*] flaw in us?" and adds that, if science cannot, then nothing can. And how will these very significant values be discovered and the cleft healed? The answer is: "Precisely as literature does, by looking into the human personality, by discovering what divides it and what cements it." That is how, he says, great writers have explored man in the past and that is how Dr. Bronowski believes this scientific problem, so important to us all, should be dealt with in the future. There is no suggestion that the problem may be a psychological one, and apparently a complete absence of awareness that a solution may be found through a scientific psychology or psychiatry. One is left pondering, after this incredible anticlimax with which the book ends, whether it is meant as an example of the common sense Dr. Bronowski is so interested in. As a psychiatrist, and after due consideration, I feel bound to say that it can be described more accurately in another way.—I am, etc.,

London, W.1. FREDERICK DILLON.

Laryngeal Epilepsy

SIR,—Dr. W. Raymond Parkes (September 15, 1951, p. 672) and Dr. Douglas K. Adams (December 1, 1951, p. 1340) suggest that this condition is more likely to be seen or heard of by the doctor than by the specialist. In more than 20 years of general practice I have not actually seen one attack, though I have been credibly informed of some twoscore or so. The name is unfortunate. I have not recognized the condition in an epileptic, though even if it occurred it would be mistaken by the patient for his usual fit. I prefer the name "laryngeal vertigo," or even "cough swoon."

We had a small epidemic of this condition in Bradford in the spring of 1940 or 1941. Those who suffered from it at that time have not shown any tendency to recurrence or indeed to any unfortunate sequel. Most winters bring a case or two. The typical case usually presents a rigid thoracic cage, good muscular development, an irritating cough, tenacious sticky sputum, and some degree of impatience. The sequence of events as I see it is that in the first place some respiratory discomfort sets off a cough reflex, which does not relieve the tickle. Now follows a series of rather futile expiratory efforts through a closed glottis, until the position of full expiration is reached. If a sudden inspiratory movement is now attempted while the glottis is tightly closed and possibly stuck together with gummy sputum the pulmonary circulation is bound to retain all the venous blood reaching it, until some sort of equilibrium is reached. The next stage is syncope, which almost at once causes relaxation of the laryngeal and inspiratory muscles, and the patient gets up from the floor or pavement convinced that his heart is bad. He is usually reassured when it is pointed out to him that a heart which will stand all this abuse and start working again must be a very good one to have.

It is interesting to notice that the swoon only happens when the patient is erect—probably because in that position the weight of the abdominal organs assists the sudden and violent inspiratory effort.

These attacks are rather rare and evanescent. It is most unlikely that any doctor will see many attacks, but I agree that students should be taught to recognize the condition from a description given by the patient.

At present I cannot find it mentioned in any of my books on medicine. Possibly the indexes are incomplete. My experience suggests that a cough swoon is more alarming than dangerous, unless of course it happens when the cougher is crossing a busy road. However, a patient of mine did even this with impunity once, but does not intend to tempt Providence again if he can help it.—I am, etc.,

Wrose, Shipley. HENRY STEWART RUSSELL.

Unsuspected Gangrenous Appendix

SIR,—I consider that the following case history is worth publishing because certain features are evident which give invaluable help not only to the average general practitioner but more especially to the newly qualified house-surgeon, who because of lack of experience may be apt to be unenlightened on the possibilities of some of these features.

The mother of a young girl aged 7 was worried about her child because she frequently became listless and ill-looking but without any other signs or symptoms except for a daily rise in temperature varying between 99° F. and 100° F. (37.2° C. and 37.8° C.).

This state of affairs continued for many weeks, during which time the patient was subjected to various tests. The Paul–Bunnell test was negative. The agglutination tests of the typhoid and paratyphoid group were negative. Lung fields were clear. The urine contained only a faint trace of protein as a possible abnormality. Blood count: W.B.C.s 11,000 per c.mm. (48% polymorphs, 47% lymphocytes, and 2% monocytes). The E.N.T. specialist could find no upper respiratory infection.

The child continued to be "off form" for some more weeks until I was called to see her because she had been vomiting and had a higher temperature. On examination she did not appear unduly ill. There was no localized area of tenderness or pain in the abdomen, which was doughy all over on palpation. Since a certain amount of influenzal gastritis was prevalent at the time this was considered a possibility and she was treated accordingly.

At the next visit 48 hours later she complained of more vomiting in the interval, with pain in the abdomen only with movement. Palpation gave some increased discomfort in the right inguinal fossa. The urine was pink in colour and very opaque. The temperature was 98° F. (36.7° C.) and the pulse 100 per minute. Her mother said that the temperature had been 101° F (38.3° C.) in the morning.

She was transferred to hospital and later operated upon, and was found to have had a perforated gangrenous appendix with generalized peritonitis.

The points to be appreciated in this case are: (1) The signs and symptoms being negligible in comparison to the true state of affairs. (2) The possibility of a normal temperature and pulse co-existing with a gangrenous appendix. (3) The possibility of the red herring of the urinary system being thought culpable.

The patient at the moment is doing well. It will be most interesting to see if her previous spell of many months of pyrexia of unknown origin has at last ended.—I am, etc.,

Whalley, Lancs. C. E. BROWN.

Nature Cure

SIR,—An "Afternoon Argument" on Nature Cure between the Honorary Secretary of the British Naturopathic Association and a Fellow of the Royal College of Physicians was broadcast in "Woman's Hour" on January 31. I feel