

At the beginning of 1964 he noticed he was passing more blood per rectum than he felt he could attribute to his haemorrhoids and when the latter were removed the bleeding continued. At a second operation in September 1964 "something the size of a golfball" was removed from his rectum and he was discharged from gaol on account of this. He returned to civilian life and has since then never engaged in his previous practice, although he was sent back to prison in September 1968; prisoners are now permitted to have tobacco. He did, however, continue to pass blood per rectum at intervals.

The clinical and histological features are so out of the ordinary that we feel that there may be a relationship between the carcinoma and his eight-year habit of hiding tobacco in his rectum. The tobacco was probably not the cause of the carcinoma, because he was adamant that the quality of the tobacco was in no way altered by its storage in the rectum. Whether the lesion is a consequence of the grease, and whether the cement-bag paper contributed to its development, cannot be determined with certainty.—We are, etc.,

O. A. A. BOCK.

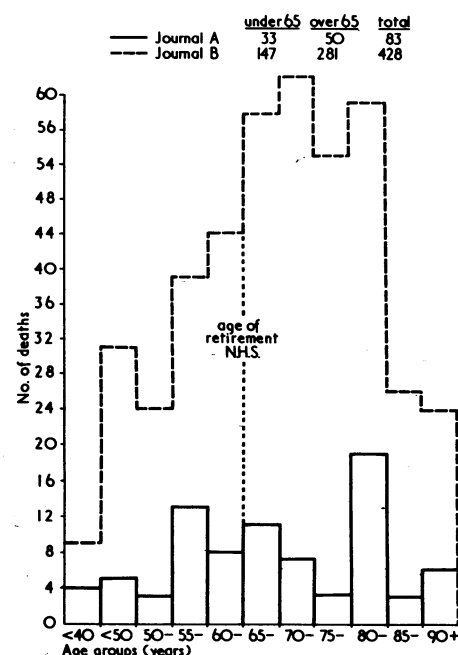
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Death of Doctors

SIR,—Prognosis is an art that can be applied to one's patients, oneself, or to one's profession. The obituary notices of doctors as reported in the two main medical journals in Britain pose interesting prognostic problems. The first journal, reporting 83 deaths, had a definite bias towards consultants, academics, and doctors working in the Government Services. The second journal



reported a very much larger series but it was obviously more comprehensive in as

much as the majority of the deaths reported were general practitioners.

Three points of interest arose from this survey. The first point (and for those who are contributing to a pension scheme possibly the most important observation) was that one-third of the doctors died before the age of 65. The second point was that there appeared to be a small peak in the under-50 age group in both series. In the first series reported, however, there also appeared to be a second peak at the 80-85 range and this, on a somewhat superficial examination owing to small numbers of reports, appeared to consist very largely of academic and Service personnel. The third point of interest is that the difference between the two series suggests that the majority of deaths occurring among general practitioners is in fact occurring in a slightly later age group than among the consultant staff. The relative figures corresponding with the histogram are as follows:

Journal A: under 65: 33; over 65: 50

Journal B: under 65: 147; over 65: 281

It is hoped that next year a more detailed breakdown will be available of deaths that will occur in this subsequent year, since it is obvious that there are points of clinical importance concerning the method of living and the mode of dying of the members of our profession.—I am, etc.,

DAVID WALLACE.

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Management of Deep Vein Thrombosis

SIR,—In his article on the medical management of deep vein thrombosis (13 December, p. 678) Dr. P. T. Flute states that continuous intravenous infusion of heparin causes bleeding more frequently than comparable intermittent doses.

As a protagonist of continuous intravenous heparin therapy¹ I was naturally interested in this statement and sought the reference given. The paper quoted² describes a study on patients treated with heparin for various conditions and concludes that the incidence of bleeding is significantly higher in older females. All patients were given heparin intermittently, either by intravenous or by subcutaneous injections. There is no mention at all of continuous infusion.

It is obviously possible that the reference was misquoted. If so, I should be most interested to hear of any study which does show an increased incidence of complications with continuous heparin infusion. Meanwhile I hope that no one has been deterred from using this method.—I am, etc.,

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REFERENCES

- 1 Handley, A. J., *British Medical Journal*, 1967, 2, 482.
- 2 Jick, H., Sloane, D., Borda, I. T., and Shapiro, S., *New England Journal of Medicine*, 1968, 279, 284.

Intraocular Lenses

SIR,—I apologize to Mr. D. P. Choyce (13 December, p. 686) if I seemed rather summary in my reference to his intraocular lenticuli. It is indeed true that they are being inserted with enthusiasm in certain centres, principally in the treatment of monocular aphakia in childhood. But, as an alternative to ordinary spectacles (which were the subject of my article), even Mr. Choyce admits that "they have no place." He accepts that my conclusion—that the operation has generally been abandoned—would probably have been justified ten years ago; and those figures from our major ophthalmic clinics which were available to me showed that there has been a steady and marked decline in the use of these lenses ever since that date, in spite of Mr. Choyce's able advocacy and his many spirited innovations.—I am, etc.,

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Respiratory Failure in Chest Wall Injuries

SIR,—The following cases illustrate the difficulty of treating major chest wall injuries in the elderly. These can occur from minor accidents and other injuries are rare. Sputum retention and lung collapse are the most common complication.

A man aged 64 years, known to be a heavy smoker and chronic bronchitic, fell off his bicycle and sustained fractures of his left clavicle and of his second to eighth left ribs. Chest x ray showed no lung or pleural injury. Two days later, x ray showed collapse of the left lung (Fig. 1). In spite of intensive physiotherapy,

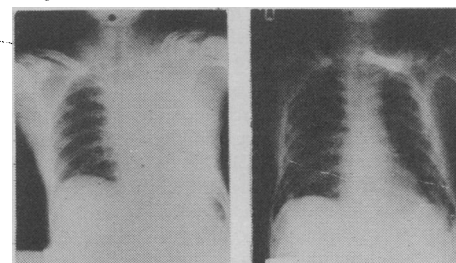


FIG. 1.—Case 1. Collapse of Lung. FIG. 2.—Case 1. On Ventilator.

analgesics, antibiotics, and bronchoscopy, the lung continued collapsed although his general condition remained good. Two weeks later he was intubated and put on intermittent positive pressure ventilation and his lung re-expanded (Fig. 2). However, the lung persistently collapsed whenever the ventilation was stopped and eventually he developed massive pneumonia and died a month later.

A male bronchitic aged 75 years fell off a ladder and sustained fractures of his left clavicle and of his second to eighth left ribs on 12 August 1969. Chest x ray showed surgical emphysema and a haemothorax on the left side. A left intercostal drain was inserted and 400 ml. of blood were drained. Analgesics, antibiotics, and physiotherapy were instituted and he was well enough to sit out of bed. On 16 August x ray (Fig. 3) showed a total collapse of his left lung. A tracheotomy was performed under general anaesthesia and a routine of bronchial suction followed by deep breaths produced by squeezing an Ambu bag in time with inspiration was instituted. The lung expanded and he made an uneventful recovery, the tracheotomy tube

being removed in 15 days. In the final chest x ray on 9 September (Fig. 4) there was noted a moderate falling in of the chest wall.

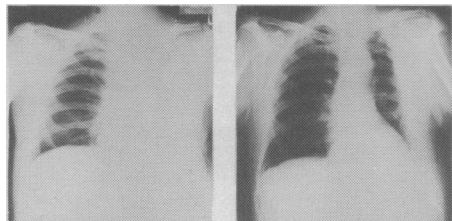


FIG. 3.—Case 2: Collapse of Lung. FIG. 4.—Case 2: On Discharge.

Intermittent positive pressure ventilation is life saving when there is respiratory failure due to chest wall and lung damage.¹ All intensive care units, however, have elderly chronic bronchitic patients so treated whom it has not been found possible to wean off the ventilator. Sputum retention must be treated actively with analgesics, physiotherapy and antibiotics and, if collapse of the lung does occur, then even more active treatment must be instituted as in the patient just described. Neither of these cases were in respiratory failure; their PaCO_2 never rising above 40 mm.Hg. It was noted that moderate paradoxical respiratory movements at this age did not affect their general condition, presumably due to a fixed mediastinum. There was no rise in temperature, probably because of antibiotic therapy. Despite this well-being, with a collapsed lung due to sputum retention, active treatment must be instituted as soon as possible. It appears that tracheotomy repeated suction immediately followed by a few Ambu bag positive pressure inspirations is more likely to produce a live patient than the institution of full intermittent positive pressure ventilation.—I am, etc.,

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REFERENCE

- 1 Griffiths, H. W. C., *Journal of the Royal College of Surgeons of Edinburgh* (1960) 6, 13.

Wigs and Waste

SIR,—Nine months ago, one of my patients, a 17-year-old girl, developed total baldness following treatment with cyclophosphamide for a renal disorder.

Under the conditions of the Health Service I could have ordered a wig at great cost. To do so for temporary loss of hair was in my opinion wasteful, and I considered a nylon acrilan wig costing a few pounds would be adequate. I discovered, however, that there was no source from which this amount of money could be obtained. Finally in exasperation I offered to pay for the wig myself. At this stage a relative lent the patient her own wig and the problem was resolved.

Knowing that this would be a growing problem I wrote to the Department of Health and Social Security. Several letters have been exchanged with little result. It would appear from their last letter that they agree that a cheap wig should be acquired under the above circumstances, the money being taken out of "free monies." Alder Hey

Hospital does not possess "free monies," and so we seem to have reached an impasse.

After this experience I can well understand consultants who "take the easy way out of a difficult situation" (20 December, p. 702).—I am, etc.,

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Minnitt and the End of an Era

SIR,—It was pleasant to read the eloquent and well-deserved tribute to Dr. R. J. Minnitt in your leading article "The End of an Era" (13 December, p. 636). It is perhaps worth pointing out further, however, that the possibility of fetal and maternal hypoxia was much in Dr. Minnitt's mind even in those early days of 1934. Reference to his papers and his book *Gas and Air Analgesia*¹ will show that he did, in fact, carry out blood oxygen studies to an extent certainly not usual for anaesthetists at that time, and so was a pioneer in his recognition of the need for measurement.

That gas and air might not be the all-time final answer was appreciated by Dr. Minnitt for he terminated his first paper on the subject, given at the Liverpool Medical Institution on February 22, 1934, with the following statement "What has been done is not a terminus; it is a thoroughfare to greater possibilities for painless labour."—I am, etc.,

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REFERENCE

- 1 Minnitt, R. J., *Gas and Air Analgesia*, 2nd edition, London, 1944.

The Experience of Time

SIR,—I was interested in your leading article under this title (6 December, p. 575) because, while on the one hand its arguments are well based on empirical and experimental facts, it falls on the other hand short of doing full justice to a wide area of mental activity.

For short, let us call this area "productive thinking." Ornstein,¹ whose new book and interesting theory of time perception are discussed in the leading article, is rightly upheld in his view that not only chemical and rhythmic physiological body functions but also "purely psychological manipulations" are to be taken into consideration. Subsequent passages of the article, however, see mental activity predominantly as a response to stimulation and as information-processing. It would be "timely," in this context, to concede that much "autochthonous" psychic activity concerned with forward planning and productive thinking proceeds in a different pattern. With this area in view, I have² formulated the "time of inner activity" (i.e., the one consumed on intentional attitude formation, planning, and productive thinking in general) as one of the fundamental varieties of human time experience

("the psychoergetic time"). Boldly speaking, "time is worked out in us," I said.

The reference, also in the leader, to the essential link between time experience and memory is very much in place. Here, perhaps, psychopathology should receive a mentioning. The "Korsakov"³ or "amnestic" syndrome is the classical paradigm of the connexion between time experience and memory. In this form of brain-damage the patient has, to use a brief formulation, "lost the continuity" of his time experience and memory. Interpretation of experimental findings in this field has led me to the hypothesis⁴ that in this syndrome it is the "psychoergetic" circuit (conceivably, in this case, subcortico-cortical in the organic substrate) which is affected, and which prevents an effective registration of events and their time correlates from taking place.—I am, etc.,

STEPHEN KRAUSS.

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- 1 Ornstein, R. E., *On the Experience of Time*. Harmondsworth, Penguin Books, 1969.
- 2 Krauss, S., *Netherlands Journal of Psychology*, 4, 1936, 96-110.
- 3 Korsakov, S. S., *Archiv für Psychiatrie und Nervenkrankheiten*, 1890, 21, 669.
- 4 Krauss, S., *Archiv für die gesamte Psychologie*, 1930, 77, 649.

Pulmonary Sensitivity to Nitrofurantoin

SIR,—I refer to your leading article (20 December, p. 704) to which I should like to add a recent self-observation.

After a week's treatment with nitrofurantoin (400 mg. daily) in October last year, I started a second course after a two-week interval. Nine hours after starting this course tightness in the chest and difficulty in breathing set in suddenly. I felt generally ill and went to bed. I awoke at 4 a.m. with fever, cough, and an intense itching on arms and legs. At 7 a.m. I took the morning dose of nitrofurantoin (100 mg.) and continued to feel ill during the day. In the evening my temperature rose to 104° F. (40° C.), my muscles ached, and a maculo-papular rash developed on all limbs. I had suspected the itching was caused by the nitrofurantoin and had stopped the drug after the morning's dose and twenty-four hours later I was symptom-free.

It was, however, only after reading about the possible side-effects of nitrofurantoin that the association between this drug and my pulmonary symptoms became apparent. In my work in dermatology I come across drug reactions frequently but I have never before seen the skin lesions and pulmonary symptoms in patients on nitrofurantoin before.

After my personal experience I wonder if the condition is perhaps more frequent than the scanty references in the literature suggest. I may add that I have a hyperergic constitution with past incidence of sensitivity to sulphonamides and contact dermatitis.—I am, etc.,

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