BONE-GRAFTING IN TUBERCULOUS SPINAL CARIES.

SIR,—Among Sir Henry M. W. Gray's most interesting remarks in favour of bone-grafting in tuberculous spinal caries occur several statements open to serious criticism, to which I feel bound to call attention.

1. He states that "fixation is essential to success"; and then that "all are agreed on the difficulty of fixing the spinal column efficiently by external splinting so that movement is entirely prohibited." Let me say at once that fixation in the sense in which he uses it here is not essential to success, and that therefore the difficulty he alleges does not arise. Dr. Rollier at Leysin, between the years 1903 and 1913, treated 198 cases of Pott's disease, of whom 171 were cured, and in no case did he attempt such fixation; what he did try to obtain was physiological rest, which is prevented by absolute fixation.

2. Sir Henry Gray states that in six to twelve months after the operation the patient may be leading a normal life except for the slight restriction imposed upon him by the stiffness of the part operated upon, and that therefore by operative fixation much time is gained for the patient when compared with fixation by external splinting. At first glance he does seem to have found here a valuable argument in favour of the operation, for the average period of treatment by heliotherapy is twelve to eighteen months, but he ruins it at the end of the same paragraph by excluding from his statement all cases with abscess. He says:

"If abscess has developed the time taken in the process of cure largely depends on the behaviour of the abscess, which is uncertain. Until the abscess in connexion with the vertebral bodies is cured no relaxation of treatment ('that is, fixation by external splints') should be allowed."

Now, if any large number of cases of Pott's disease be investigated it will be found that abscess is present in a very large percentage; thus in Rollier's 198 cases there was abscess in 96, or 48 per cent; so that on Sir Henry's own showing, even if he is right, nearly half the cases would not be cured any quicker by operative methods.

3. He states that in his experience the operation has not proved dangerous, as only one death which can be directly attributed to the operation occurred in his series of 28 cases. He then quotes Hibbs (against himself it seems to me), with 31 deaths in 210 cases; and, not quite so bad, Meyerding, with 8 deaths in 100 cases. If we add these three sets together, 23 with 1 death, 210 with 31 deaths, and 100 with 8 deaths, we get 238 cases with 40 deaths, or 16.8 per cent. Does Sir Henry consider that an operation with such a mortality can be rightly described as not dangerous? As a contrast to the small mortality following operation he quotes (1) a statement made by Royal Whitman in 1901 that "at least 20 per cent. of all patients die during the progress of the disease"; and (2) a statement made by Lovett in 1907 that "the mortality is probably not under 33 per cent. if ultimate results are considered." Could he have not quoted from a more up-to-date book, as, for example, Rendle Short's *Index of Prognosis*, 1918, second edition, where we are told that we may take it that the mortality is about 5 to 10 per cent.?

4. He states that operation should be done before deformity occurs, but he surely must know that it is usually the onset of deformity which first draws attention to the presence of disease. If deformity be present he tries "by postural methods to bring about gradual straightening." "If these fail, and they frequently do," he deliberately breaks the grafts to adapt them accurately to the curvature. It is not surprising that the postural methods frequently fail, for how can he give them any chance when his advice is: Perform the operation "as soon as possible after the disease is diagnosed"? As regards leaving the deformity alone, is not this absolutely a retrograde step? Rollier has shown that in all active cases the deformity can be entirely reduced except in the cervical and lower lumbar regions. Can we then advise patients to have an operation to cure (*sic!*) them, and thereby force them to remain humpbacked for life, when another form of treatment can make them perfectly straight?

5. He states that by reason of the bony fixation the patient is less likely to suffer from local recurrence of the disease than after "conservative" treatment. This gives the impression that under "conservative" treatment relapse is frequent. Yet if we turn to Dr. Rollier's published statistics we find that between the years of 1903 and 1913, out of 171 cases of Pott's disease cured, there were only 2 relapses.

From the foregoing remarks, I think I have made it clear that there is everything to be said against this operation, in spite of Sir Henry Gray's optimism. If anything more were needed to open your readers' eyes to the real state of affairs, let them turn to the paragraph headed "Results of Operative Treatment," where occur the following sentences:

(*a*) "One patient, a young weakly child, 4 years of age, died on the third day after operation."
(*b*) "One adult died within two months of operation from progressive disease in the spinal cord and canal."
(*c*) "In another adult psoas abscess continued to increase."
(*d*) "In one child operated on when 6 years of age the disease has apparently been cured, but deformity has increased."

Many years ago an operation was invented for curing microcephalic idiots. The idea of the operation, called craniectomy, was that the brain could not expand because of the smallness of the cranial cavity, and so large portions of the cranium were cut away to give the brain room. Although it soon became known that many of the children died under the operation, that those who survived it ended up in asylums, and that the operation had been wrongly conceived—the size of the skull depending upon the size of the brain, and not vice versa—yet surgeons went on performing this dangerous and useless operation in ever-increasing numbers, and it was not until Dr. W. W. Keen wrote his famous paper entitled "Noli Nocere" that their eyes were opened and they were able to perceive the error of their ways. Is it too much to hope that this history may soon repeat itself?—I am, etc.,

PAUL BERNARD ROTH,
Orthopaedic Surgeon, Miller Hospital, etc.

London, W.1, July 25th.

"DOCTORS IN COUNCIL."

SIR,—The *Manchester Guardian* had a leader last week under the above title dealing with the deliberations of the Representative Meeting at Glasgow. Part of the leader dealt with the future of voluntaryism at hospitals and the position of the doctor in relation to any new arrangement of hospital affairs, and in this part it expressed the opinion that the discussion at the Representative Meeting was "unsatisfactory . . . because so much of it draws a kind of formal veil between us and realities." It went on to say that:

"Appointments on the staff of a great hospital are nominally honorary, but not really so, for, though they are unpaid, they are the recognized entrance gates to the most lucrative fields of private practice."

This view, which is, I believe, common to the laity, deserves more attention from the profession that it has yet received, for it will seriously interfere with the carrying through of hospital reform, and with the status of the staff of the hospital when reform is carried.

I wrote the enclosed letter to the *Manchester Guardian*, and it was published on July 28th; but as it pertains to matters which I believe are of still more importance to the medical profession than to the laity, and as it will become more and more necessary for the profession to educate the laity on this question, I am in hopes that you will consent to publish it along with this letter.—I am, etc.,

York, Aug. 1st. PETER MACDONALD.

THE VALUE OF HOSPITAL STAFF APPOINTMENTS.

To the Editor of the Manchester Guardian.

SIR,—In your generally well-informed leader of the 24th on "Doctors in Council" there runs through that part of it concerned with the position of voluntaryism the thought that the position of the honorary staff in voluntary hospitals is not essentially honorary, inasmuch as indirectly it is a source of emolument. In your own words "appointments on the staff . . . are the recognized entrance gates to the most lucrative fields of private practice." As this view, which is a common one, interferes largely with what I am convinced is the sound line for hospital reform, I trust you will allow me to comment upon it.

While there is a large although varying amount of truth in it, varying with the hospital concerned, it is on the whole misleading and indicative of confused thinking, especially on two chief lines. The first is that it confuses hospitals generally with the relatively few, although, of course, relatively very important, hospitals in the large centres, and especially those at which there are teaching schools. Here positions on the honorary staff are exceedingly valuable and indirectly lucrative, and far more than repay the services given in these positions. This relationship, however, between value of position to the member of the staff and value of his services to the community is not a constant one, but varies with the geographical position of the hospital, and the more peripheral (so to speak) the hospital is the lower becomes the value of the position on the staff relatively to the service—this even in the same city—until in the small hospitals in the smaller centres of population the value of the services far and away outweighs the indirect value of position on the staff. Now these smaller hospitals are