In many cases this ankylosis can be avoided by suitable foot and ankle exercises, preferably taught, and in some cases supervised, by a physiotherapist. Obviously, common sense is required in avoiding friction of the ulcer against bandages, etc., and in the initial stages the exercises should not be vigorous. With patients lying in bed regular exercises may also play a part in improving the circulation, and so accelerate healing. Paste and supportive bandages have a very important place in the treatment of gravitational ulcers and are used extensively. However, it must be weighed against the undoubted value of these measures that a degree of ankylosis with its attendant disadvantages will be more likely to occur following their prolonged use.—I am, etc.,

Bristol, 8. ROBERT P. WARIN.

Essential Hypertension in Pregnancy

SIR,—Professor J. Trueta's misrepresentation of my view (September 17, p. 650) is due either to a misapprehension or to other causes. He attributes to me the opinion that anuria "is not the result of a decreased intrarenal blood flow, but on the contrary that it is due to an increased blood flow to the renal medulla, which maintains the 'obstruction' of the uriniferous tubules"—as though I supposed an increased blood flow to and through the medulla is primary. Had Professor Trueta read my paper on eclampsia and its lesion (*J. Obstet. Gynaec. Brit. Emp.*, 1929, **36**, 341)—not mentioned in the 16 pages of the bibliography of his book—he would have found that I hold a very different picture.—I am, etc.,

Rugby. R. H. PARAMORE.

Parturition after Pneumonectomy

SIR,—As we cannot find in the literature any other case of a woman going to full term and parturition after a total pneumonectomy, we thought that it may be worth while to have the following case on record.

The patient is a 23-year-old primipara in good general condition (weight 8 st. 2 lb.—51.3 kg.). In 1942 Mr. T. Holmes Sellors performed a left pneumonectomy for gross bronchiectasis. In August, 1948, the patient became pregnant, and apart from slight oedema of the feet at the end of the day the pregnancy was uneventful. She went into labour in the early hours of May 3, 1949; the cervix was fully dilated by the evening of the 5th, but, as the patient was unable to push, medical aid was sought. She was delivered under chloroform anaesthesia by a high forceps manœuvre, preceded by an episiotomy. The episiotomy was repaired immediately after delivery. The child, a male weighing 6 lb. 3 oz. (2.8 kg.), was very shocked at first but recovered quickly on clearing the air passages.

—We are, etc.,

F. KELLERMAN.
R. SAUVAN SMITH.

Colchester.

Memorial to Charles John Bond

SIR,—In the letter from Dr. Joan B. Walker and Mr. N. I. Spriggs (September 17, p. 655) referring to the fund which is being raised in Leicester to provide a memorial to the late Mr. C. J. Bond no reference is made to what was undoubtedly one of his great interests in the later years of his life—the question of voluntary euthanasia. He took a leading part in the formation of the Voluntary Euthanasia Legalization Society, and was the first chairman of its executive committee, a position he held until his death. It was at his personal invitation that the late Lord Moynihan became the first president of the new society, and doubtless it was largely due to the great prestige attaching to Bond's and Moynihan's names that the society made the rapid progress it did in securing the adherence and support of so many other distinguished members of the medical profession.

No review of Bond's life and work would be complete which did not include a reference to this aspect, and it is possible that in the years to come the great part he played in the initiation of this reform will be what he will be chiefly remembered and honoured for.—I am, etc.,

Leicester. C. KILLICK MILLARD,
Honorary Secretary,
Voluntary Euthanasia Legalization Society.

Old Age

SIR,—With increase in the numbers of those who have grown old, there arises the question, Can anything be done about it? If the majority of these had grown wiser, and kinder, and less selfish, one would not mind so much. But so many apparently live only for themselves. Daughters, and even sons, are kept at home to minister to the old people's wants, and these offspring are often prevented from marrying. I wonder, do they ever ask themselves, "What use am I in the world?"

The resources of the public, or private persons, have often to be expended on them; they take up the time and labour of many; they consume food, and occupy space that is badly needed for the younger. Why encumber they the ground? Segregation may be one remedy, or, more brutally, they might be induced to agree to voluntary euthanasia. But I doubt—even if it were allowed—that many would agree to this. What, Sir, is your suggestion?—I am, etc.,

Portsmouth. J. RUSHWORTH LUND.

Syringes

SIR,—I regret that my letter on the advantages of the Luer syringe fitting (August 13, p. 387) has led to a little misunderstanding. The type of fitting which I have found so useful in ophthalmic surgery (as it enables the injection to be made with one hand whilst withdrawing the needle, and without any risk of leakage) is the Luer-Lok fitting. After correspondence, I find that this is not yet available in this country, though it may become available in the next year or so. I hope that the production of this type of bayonet-joint fitting for hypodermic syringes will be accelerated, as it has great advantages for ophthalmic surgery and is even less likely to be obtainable from America now than it was.—I am, etc.,

Leeds, 1. JOHN FOSTER.

Local Analgesia

SIR,—In the *Journal* of July 16 (p. 139) there appears a review of the book *A Surgeon's Guide to Local Anaesthesia.* But why, oh why, do you have it reviewed by a specialist anaesthetist? The result is just what one would expect—namely, a half-hearted, brief, non-committal statement which does scant justice to the book. It may interest your readers to learn that this book has now reached its third edition, though the two previous editions appeared in Australia only, where they were issued by the author in typescript form owing to wartime difficulty in publishing. The volume is intended to be a guide not only for the practising surgeon but for all who have perforce to do operative work where trained assistance is not available, perhaps in villages far in the country, and who want to learn safe methods that will work and will not fail.

I may say that I am writing this letter because to-day I was proposing to perform an operation for haemorrhoids using caudal analgesia, but having read Mr. C. E. Corlette's strictures upon this somewhat dangerous method of local analgesia I decided to employ the ordinary infiltration method around the anal canal, using 1% procaine with adrenaline solution, $2\frac{1}{2}$ minims to the ounce (0.53 ml. per 100 ml.), and all went well. The point that Mr. Corlette brings out in his book is that the infiltration method is a safe method, whereas the caudal injection is unsafe; it has led to deaths, as can be found in the literature if one takes the trouble to look it up. It is highly probable that a professional anaesthetist does not look with any favour upon a book which shows surgeons how to perform operations safely and reliably, and without troubling the general anaesthetist at all.

The main theme of the book is the author's unique premedication system, which puts the patient in a state of quiet relaxation, physically and mentally, and this enables operations to be performed without producing any mental or nervous strain. The patient either dozes off to sleep, or remains quiet and calm but awake. I have used his method in hundreds of cases, and with great success. Altogether the book is the most complete practical guide that exists at the present time, and the

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200 illustrations make it a pleasure to read. What is most valuable is that the author assumes responsibility for every method that he recommends; he has tested all his methods thoroughly, and he speaks from the standpoint of an immense experience of surgery under local analgesia. Furthermore, general practitioners who look into this book will find in it much which they can put to use in their daily work.—I am, etc.,

Dunedin, N.Z. ROLAND A. H. FULTON.

Penicillin in Emergency

SIR,—The extreme value of penicillin in an acute medical emergency due to a penicillin-sensitive organism is illustrated by the following case.

At 2 p.m. I was summoned to a man aged 81 by his daughter, who stated that her father had developed a shivering attack during the morning and now she did not like the look of him. On arrival, the patient was delirious and restless, trying to sit up in bed. Temperature 104.5° F. (40.25° C.), pulse 100, respirations 40. Patient was oblivious of his surroundings and difficult to examine, and there were few physical signs. A provisional diagnosis of septicaemic pneumonia was made. 500,000 units of penicillin were injected intramuscularly. At 4.30 p.m. the patient was rational, knew his family and myself. Temperature 100.5° F. (38.5° C.). Sulphathiazole, 1 g. 4-hourly, by mouth. At 7.30 p.m. the patient was much improved. Temperature 99° F. (37.2° C.), pulse 80. 100,000 units penicillin. The next morning the patient was quite recovered, but somewhat weak. Temperature 97.5° F. (36.35° C.), pulse 70, respirations 16. No abnormal physical signs in lungs or elsewhere.

—I am, etc.,

Leigh-on-Sea. THOMAS REES.

Antiseptics for Minor Dressings

SIR,—With reference to the answer to the question on antiseptics for minor dressings ("Any Questions?" September 17, p. 661), I should like to take your anonymous authority to task for advising the use of proflavine sulphathiazole powder for application to the wounds from minor accidents. I have pointed out previously the dangers of this preparation.[1] Although the incidence of sulphonamide dermatitis due to its local application is not very high in this country, it is an avoidable risk, as sulphonamide is not an essential wound dressing. Sulphonamide dermatitis, particularly the light-sensitive variety, is such a distressing dermatosis that it should be avoided at all costs.

Acriflavine and proflavine have the property of increasing the severity of sulphonamide dermatitis, and Russell and Beck[2] showed that proflavine and sulphonamide mixtures were more lethal to tissues than either substance singly. There is, therefore, even more reason for avoiding proflavine and sulphathiazole mixtures.

As I am afraid that this is so far purely destructive criticism I would like to advise that antiseptics should be avoided as much as possible. The trauma unit at the Royal Infirmary, Sheffield, now uses only "cetavlon" and spirit as pre-operation preparations, and saline and tulle gras as local applications, and there has been a considerable drop in the incidence of contact dermatitis in wounds without noticeable increase in wound sepsis. One still sees, however, a regular supply of cases of sulphonamide dermatitis from those enthusiastic house-surgeons who forget that penicillin powder is 99% sulphathiazole.—I am, etc.,

Sheffield. I. B. SNEDDON.

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1 Sneddon, I. B., *Proc. R. Soc. Med.*, 1947, **14**, 883.
2 Russell, D. S., and Beck, D. J. K., *British Medical Journal*, 1944, **1**, 112.

Myxoedematous Madness

SIR,—I feel I would like to state my opinion that Dr. R. Asher's paper on this subject (September 10, p. 555) is an exceedingly valuable clinical contribution, the importance of which is in no way minimized by the qualifications put forward (September 24) by Drs. E. B. Davies (p. 706) and J. Douglas Robertson (p. 707). Dr. Davies wishes to emphasize that where a psychosis is associated with myxoedema or another endocrinopathy it is not necessarily the result of the endocrine disturbance. This will be readily agreed to, and I do not think that Dr. Asher's article or your annotation intended to indicate otherwise.

However, changes in behaviour pattern, psychoneuroses, and psychoses are not infrequently associated with a major endocrine disturbance—e.g., thyrotoxicosis, myxoedema, adrenogenital syndrome, Cushing's syndrome, Addison's disease, Simmonds's disease, and hypoparathyroidism. When the cure of these disorders or correction of the resulting metabolic disorders is achieved by substitution therapy, operation, or radiation and, following this, the psychoses, etc., disappear, it would seem justifiable to conclude that the endocrinopathy was the immediate cause of the psychoses, the psychoneuroses, or the altered behaviour pattern. This view would not be vitiated by the fact that the psychosis, for example, associated with an endocrine disorder varied in its character and was not constant, because the pattern of the psychotic disorder might well be determined by genetic factors.

I have been particularly impressed by the change in behaviour pattern in patients with hypopituitarism following pregnancy (Simmonds's disease). Whereas hypoglycaemia is an important factor it does not appear to be the sole or constant factor in causing such changes. Of a series of such cases, I have in mind in particular one woman who was a loving wife and mother and who, after the onset of the disease, ceased to have the slightest interest in the well-being of the children or husband, in her own clothes, or in the cleanliness of the household, which deteriorated dramatically. I also recall a woman with Addison's disease whose relatives wrote me after she had been correctly diagnosed and treated that they were deeply grateful for the change in her behaviour and outlook in the home and the return of her normal, kindly, and interested nature. I can hardly consider these features, as well as the major psychoses, chance coincidences.

On the other side of the picture, and in support of Dr. Davies's views, the number of cases one is asked to see of mental disturbances, mental retardations, and delinquencies which have been thought without justification to be of endocrine origin is surprising, although an awareness of the possibility should not be discouraged. Considerable interest has recently been aroused in the general well-being and euphoria produced in patients with rheumatoid arthritis by the use of the pituitary adrenocorticotropic hormone and, on similar lines, by the finding of an increased secretion of adrenocorticotropic hormone after electroconvulsive therapy. It would be prudent, I think, to await further elucidation before becoming excessively enthusiastic about the application of these discoveries to the therapy of psychoses not associated with major endocrine disorders.

As regards the basal metabolism in myxoedema, my experience coincides with that of Dr. Douglas Robertson, and I intimated to Dr. Asher, when he kindly asked me to consider his findings, that uncomplicated myxoedema was usually, if not invariably, associated with a decreased B.M.R.—I am, etc.,

London, W.1. S. LEONARD SIMPSON.

SIR,—The article by Dr. R. Asher (September 10, p. 555) should lead to the more frequent recognition of "myxoedema madness," but in the patient whose condition deteriorates when thyroid extract is administered it should be recognized that it may be dangerous to persist in this form of treatment, as the following short case history displays.

A woman of 58 was admitted to hospital under my care in January, 1949, suffering from confusion and delusions; she appeared to be an obvious case of myxoedema. Treatment with thyroid was commenced (30 mg. thrice daily), but as her confusion increased the dose was doubled. She then became violent and maniacal, refusing to take anything by mouth. This violence alternated with almost complete collapse, when she seemed on the verge of death.

This combination of symptoms suggested that she might be a case of Simmonds's disease, and treatment with testosterone-propionate and desoxycorticosterone was commenced immediately. The improvement was dramatic, and within a few hours she was demanding food. Her condition steadily improved from that date, and her mentality is now almost normal. Her electrocardiograph taken before treatment commenced showed characteristic inversion of the T waves

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