Correspondence

Specialists in Physical Medicine

SIR,—Lord Horder (November 15, p. 1095) makes a plea for additions to the establishment of consultants and registrars in physical medicine. His reasons for this recommendation are based on assumptions from some of the evidence available on the subject. These assumptions will not, I think, be accepted by some who are acquainted with the practical working of physiotherapeutic clinics. It is true that the increase in the last few years of treatment given is of the measure of 75% in most hospitals in the south. I have not seen an analysis of the relevant figures, but I have noticed in my experience with the Metropolitan Police that there is an increasing tendency to prescribe relatively long courses of physiotherapy for men suffering from minor injuries or the secondary effects of early osteoarthritis. Often enough I doubt whether these courses are really necessary or in the best interest of the patient and community. I cannot but think that, certainly for minor injuries, the result is to prolong the period of disability and to encourage an undesirably passive attitude towards the process of recovery.

The following quotation from Lorenz Böhler expresses the idea I have in mind: "The physiotherapeutist (*Medico-mechanik*) should take an honoured place in the service of medicine, but he should be used in the right place at the right time and not be regarded as a universal healer."

It is doubtful if the appointment of more consultants in physical medicine will improve the present state of affairs, for the specialist in any branch tends to magnify the importance of his own subject and to enlarge his department. There are men in charge of the larger clinics with the clinical experience and the attitude of mind which are desirable, but they are a select group. I do not think the method of training suggested in Lord Horder's letter will necessarily reproduce their kind. The possession of the diploma in physical medicine will ensure that a man has an understanding of the various methods of therapy which may be in use, but a great deal more than this is required if he is to form a sound judgment of the value and limitations of these methods for the individual case. I would suggest that, in the small units, economy and efficiency of effort is more likely to be achieved by the closer supervision of treatment by the practitioner primarily responsible for the care and diagnosis of the case.—I am, etc.,

Faversham, Kent. MAX PAGE.

Rubella in Pregnancy

SIR,—In 1940 and subsequently, Gregg, Swan, and others in Australia pointed out the very definite danger to the foetus, leading to deafness, blindness, and sometimes a cardiac lesion, of a rubella infection in the first three months of pregnancy. As an otologist and a member of the Committee of the Deaf Children's Society, I was very perturbed to learn recently from the relative of a deaf child that a general practitioner had questioned the accuracy of the diagnosis of rubella in these reported cases.

If it is thought by many doctors that the infection was not true rubella, and "that other cases have not occurred since," this is a very dangerous as well as an erroneous supposition. There is no doubt whatsoever that children are still being seen with these tragic defects as the result of infection in their mothers by a "simple" illness indistinguishable from typical rubella, often of a very mild nature. Pregnant women should still be extremely careful to avoid contact with rubella—in fact there seems every justification to recommend that all girls should be exposed to rubella before leaving school.—I am, etc.,

London, W.1. IAN G. ROBIN.

Tuberculin Tests

SIR,—Dr. J. D. Lendrum (September 20, p. 649) outlined a practical routine procedure which leads to a rational and quite accurate "jelly method" of testing sensibility to tuberculin. Here in the Province of Quebec those tuberculin tests are made almost entirely in connexion with vaccination by B.C.G. Until recent years the general routine used by the Ministry of Health's "Unités Sanitaires" consisted mainly in the Vollmer's patch test, followed, if proved negative, by an intradermal injection of purified protein derivative (P.P.D.). The negative were vaccinated with B.C.G. scarifications.

In 1950 Frappier and Guy, of the University of Montreal's Institut de Microbiologie et d'Hygiène, published a "New and Practical B.C.G. Skin Test (the B.C.G. Scarification Test) for the Detection of the Total Tuberculous Allergy" (*Canad. J. publ. Hlth*, **41**, 72) which is now extensively employed in our country. This test joins the practical usefulness to the impressive accuracy of the reaction. Broadly it consists of a scarification made through one drop of B.C.G. in the concentration of 10 to 25 mg. of B.C.G. per ml. At the same time a scratch is made with a needle only on the opposite side, generally the lumbar region, as a control. The results are observed after 24 hours. The "negatives" show merely the trace of the needle scratch; the "positives" show marked oedema and an intense redness which persists for more than 72 hours. This test enables even a residual allergy (infra-tuberculous allergy) to be detected.

So from a practical point of view it seems that the B.C.G. scarification test is one of the simplest and most accurate reactions for the detection of tuberculous allergy. Furthermore, it makes it possible within 24 hours to choose those who are to receive B.C.G. immediately. One is in favour of, or is against, B.C.G. for active prevention of tuberculosis. But if we are in favour of this vaccine we must use the most sensitive and practical test as time is concerned, and we consider that the B.C.G. scarification test of Frappier and Guy is the best available to-day.—I am, etc.,

Beauport, Quebec. GUY MARCOUX.

Abscess in Femoral Hernial Sac

SIR,—An encysted abscess of a femoral hernial sac resulting from peritonitis due to a perforated appendix is a rare complication. The following case occurred at the Royal Halifax Infirmary.

A woman, aged 75, was admitted to the Infirmary with a history of onset of lower abdominal pain three days previously, with diarrhoea on the day of onset. Her own doctor had diagnosed appendicitis and had been treating her conservatively for it. On the day of admission to the Infirmary her pain had got worse and she had started to vomit. Her bowels had not been open for two days, but she had passed a little flatus on the morning of admission.

On examination, the relative findings were a moist but thickly coated tongue, a tense, tender, irreducible swelling present over the right femoral ring, and some generalized tenderness over the lower abdomen. The general practitioner reported that the hernial swelling had not been present on the previous two days. Nevertheless a diagnosis of strangulated right femoral hernia was made and the patient was operated on under a general anaesthetic.

A right inguinal incision was made and the femoral hernial sac was dissected out and opened. It was found to be full of pus, and the neck of the sac was found closed. This was opened with a finger and pus was seen to pour from within the abdomen. The incision was then extended, and the peritoneum opened. The peritoneal cavity was found to contain purulent fluid and a perforated gangrenous appendix was found and removed. The hernia was repaired and the peritoneal cavity drained.

The patient was treated with intravenous fluids and chemotherapy and made an uneventful recovery. She was discharged home sixteen days after the operation.

Two other similar cases have occurred in this hospital in the last two years. A search of the literature reveals abscesses of the hernial sac to be rare, only a few cases having been described.[1–5] But the fact that three cases have occurred in this hospital in the last two years would suggest

that the condition cannot be as uncommon as the literature suggests and therefore should be kept in mind.

My thanks are due to Mr. H. I. Deitch, consultant surgeon at the Infirmary, for permission to publish this case and help in doing so.—I am, etc.,

Halifax J. S. MEHTA.

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Treatment of Acute Poliomyelitis

SIR,—There has been some correspondence recently in your columns on whether cases of acute poliomyelitis should be treated in infectious-disease or general hospitals. What is even more important, however, is that the doctors in charge, whoever they are, should make sure that their knowledge is up to date, that the nursing staff are properly trained, and that the best possible equipment is available. For example, the evil reputation of the bulbar type of the disease is still notorious, whereas in fact the prognosis is generally very favourable provided that the "airway" is kept clear for a few days by means of postural drainage in the prone posture. This posture also assists breathing in many cases in which the abdominal muscles are paralysed and coughing is impossible, as it enables the weight of the abdominal viscera to raise the diaphragm during expiration.

The skilled exploitation of postural drainage saves many lives, but the problems involved are probably understood best by chest surgeons, brain surgeons, and anaesthetists, who may with advantage be consulted by any not fully familiar with the nursing methods. In regard to equipment it seems desirable that all units should be equipped with special beds for postural drainage which can be raised in the centre to form an inverted "V." Other equipment, including respirators, suckers, and oximeters, should also be the best on the market.—I am, etc.,

Oxford. W. RITCHIE RUSSELL.

Treatment by Radioactive Tantalum Wire

SIR,—It is not of much importance to establish who did what for the first time. Perhaps you will, however, allow me space to add to Mr. Anthony Green's letter (November 1, p. 994) recording "one of the first cases of malignant disease other than the bladder treated by radioactive tantalum wire," since he has raised the matter.

The first use of radioactive tantalum wire in this country was not for the bladder. Walton and Wallace discussed its use in the form of beads, wire, and foil in 1950.[1] It was used by Dr. M. Lederman for orbital implant, and by Mr. Michael Harmer for implants in the buccal cavity as reported by me at the International Radiological Congress in London in July, 1950.[2] The first report on the use of this material in the bladder was also given in 1951.[3] Mr. Michael Harmer has used tantalum wire for implants of the palate, tongue, buccal mucosa, and skin, and it has also been used at the Royal Cancer Hospital for surface applicators.

It is still too soon to say whether this technique offers material advantages over those previously available. A full account of the use of Ta^{182}, as well as radioactive Au^{198} wire, has been given.[4 5 6]—I am, etc.,

London, S.W.3. D. W. SMITHERS.

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Treatment of Pernicious Anaemia

SIR,—During recent months many articles have been written stressing the value of vitamin B_{12} injections in the treatment of pernicious anaemia. Blackburn *et al.* published an article (August 2, p. 245) stating that they can confidently recommend physicians and general practitioners to change their patients' treatment from liver extract to vitamin B_{12}. They also go on to say that there seems little justification for the continuation of the relatively expensive form of treatment unless better evidence than that now available can be brought forward to suggest it.

During the past four years I have treated over a hundred cases of pernicious anaemia with vitamin B_{12} injections, parenteral liver extract, and proteolysed liver, and from the results I have obtained with these various preparations I am sure that in some patients the injection of the cruder preparations or proteolysed liver have definite advantages over the refined vitamin preparations. I should like to report a case which illustrates the great value of proteolysed liver.

A male patient, aged 40 years, was admitted to hospital on September 26, 1951, suffering from a severe anaemia. Apart from the pallor due to the anaemia the physical examination was negative, but the more specialized investigations revealed severe macrocytic anaemia, with a red-cell count of 1,720,000 per c.mm. and a haemoglobin of 48%. The white-blood-cell count was 2,400 per c.mm., with a normal differential count. When some marrow taken from the sternum was examined many primitive red cells were seen which were maturing into megaloblasts. Many giant band cells were present in the maturation of the white cells. A barium meal was negative. There was a histamine-fast achlorhydria and the serum bilirubin was slightly raised. The red-cell fragility was within normal limits and a direct Coombe's test was negative. A fat-balance test revealed results within normal limits. A barium enema was negative. The liver-function tests were all normal. A diagnosis of pernicious anaemia in relapse was made.

Two ml. of a well-known parenteral liver extract was given at weekly intervals and this produced a reticulocyte count of 39% on the fourth day after commencement of treatment. The red-cell count and haemoglobin concentration gradually returned to normal. The megaloblastic cells in the marrow were changed back to normoblasts. The patient was discharged and kept under constant observation in the follow-up clinic, and after three months his red-cell count and haemoglobin concentration gradually began to fall. The bone marrow became megaloblastic. The parenteral liver extract was changed to another liver extract reputed to be of high concentration. This produced no effect on the red-cell count, the haemoglobin concentration, or the marrow pictures. After a month on this treatment, vitamin B_{12} was given parenterally in doses of 50 μg. weekly, and this failed to influence the relapse. He was readmitted to hospital and a clinical state similar to the one already described was discovered. The special investigations were repeated with the same results.

A diagnosis of pernicious anaemia in relapse refractory to parenteral liver extract and vitamin B_{12} injections was made. 30 g. of a well-known proteolysed liver preparation was given daily and this produced a reticulocyte response of 20.4% within seven days of commencement of this treatment. Within two days the marrow had reverted to a normoblastic picture and the red-cell count and haemoglobin concentration gradually returned to normal. Since then he has remained well with this treatment.

This must have been a case of pernicious anaemia, as special investigations ruled out the other causes of megaloblastic anaemia, such as neoplasms of stomach, idiopathic steatorrhoea, and liver disease. A diagnosis of a severe haemolytic condition associated with a megaloblastic anaemia count could not be supported by a normal red-cell fragility and a negative direct Coombe's test, so that improvement in the blood count could not be attributed to regeneration of the haemopoietic system after a haemolytic episode. Without treatment with proteolysed liver the patient would have died.

Proteolysed liver is also useful in the treatment of pernicious anaemia in pregnancy and in those remoter parts of the country where injections are difficult to give and laboratory control of the anaemia impossible. When injections of liver and vitamin B_{12} have failed to maintain the blood count satisfactorily, I have on six occasions substituted proteolysed liver, with an immediate return of the blood count to normal. I am convinced that there is a place for all three of these preparations in the routine control of pernicious anaemia.—I am, etc.,

Birmingham, 18. R. O. GILLHESPY.

Operative Method of Thrombosing Varicose Veins

SIR,—It is not clear why Mr. A. Johnston Abraham (August 2, p. 260) and Mr. F. D. Murphy (September 27, p. 725) do not just extract the veins when the Babcock's extractor probe (not his original vein-stripper) has been