

(26 November, p. 1305) in animals is of interest in view of other similar clinical reports.¹⁻⁵ However it is noteworthy that in the second case described by Dr. J. E. S. Relton and his colleagues the operation was postponed for 48 hours, suxamethonium not being used the second time, without preventing the recurrence of this combination, and that in Hogg and Renwick's³ case the suxamethonium was not given till the respiration was already embarrassed and the temperature had reached 104° F. (40° C.). In view of these two cases occurring in the absence of suxamethonium or depolarizing muscle relaxants, it would have seemed preferable to have reported their case as one of unusual reaction to anaesthetic agents. It is also worthy of note that of the seven clinical cases quoted five had some skeletal or muscular disability, and that five died.

In view of this high mortality rate it would appear that the immediate treatment would be to avoid any further relaxant or inhalation agent, to postpone the operation, and to deal energetically with the hyperpyrexia and metabolic acidosis, which would seem to be the cause of death in ventilated patients.

It would be of interest to know whether boars 1 and 3 were pyrexial at the time of their death, and also if the animals, which were litter-mates, suffered from any congenital skeletal or muscular deformities.—I am, etc.,

G. NAPIER PENLINGTON.

King's College Hospital,
London S.E.5.

REFERENCES

- 1 Relton, J. E. S., Creighton, R. E., Johnston, A. E., Pelton, D. A., and Conn, A. W., *Canad. Anaesth. Soc. J.*, 1966, **13**, 419.
- 2 Thut, W. H., and Davenport, H. T., *ibid.*, 1966, **13**, 425.
- 3 Hogg, S., and Renwick, W., *ibid.*, 1966, **13**, 429.
- 4 Lavoie, G., *ibid.*, 1966, **13**, 444.
- 5 Davies, L. E., and Graves, H. B., *ibid.*, 1966, **13**, 447.

Cephaloridine in Staphylococcal Endocarditis

SIR,—The correct role of cephaloridine in antibacterial therapy will not become apparent until more extensive experience of its use has been obtained. The value of this antibiotic in the treatment of bacterial endocarditis is especially uncertain. Dr. H. A. Burgess and Dr. R. J. Evans (19 November, p. 1244) have reported the death of a patient due to a penicillin-resistant staphylococcal endocarditis which had been treated with cephaloridine for the previous eight days. As a result of this experience they express doubts about the suitability of this drug for the treatment of severe infections due to penicillinase-producing staphylococci. Cephaloridine has been used in these hospitals for the treatment of 30 patients with staphylococcal infection of various sites. In 18 cases the organism was resistant to penicillin, as shown by the disc technique. In all except two of this latter group, which included patients with pneumonia, septicaemia, and soft-tissue infection, eradication of the staphylococcus and a satisfactory clinical response were achieved. These results were comparable with those obtained with cephaloridine in the infections due to penicillin-sensitive staphylococci. Both patients in whom the penicillin-resistant staphylococcus was not eradicated received

only one injection of cephaloridine a day—a dose which we now regard as inadequate.

While there appear to be some strains of penicillin-resistant staphylococci which are less susceptible to cephaloridine,^{1,2} this antibiotic remains valuable for many, and perhaps the majority, of infections due to penicillin-resistant staphylococci. This is particularly so when penicillin-hypersensitization is present or when treatment has to be begun before full bacteriological information is available.—I am, etc.,

H.-J. B. GALBRAITH.

Chelmsford and Essex
Hospital,
Chelmsford.

REFERENCES

- 1 Ridley, M., and Phillips, I., *Nature (Lond.)*, 1965, **208**, 1076.
- 2 Kislak, J. W., Steinhauer, B. W., and Finland, M., *Amer. J. med. Sci.*, 1966, **251**, 433.

Immunotherapy of Cancer

SIR,—The leading article "Immunotherapy of Cancer" (23 July, p. 185) and the subsequent letter by Dr. K. D. Bagshawe (20 August, p. 463) seem to be symptomatic of a failing in medicine which seems to be unworthy of the profession. Of all the debatable problems in medicine, trophoblastic disease as a whole, and post-gestational choriocarcinoma in particular, give rise to more acrimony than almost anything else. At one time, before any effective treatment was available, these arguments were the province of the pathologist, but in recent years therapists of one brand or another have been getting into the ring.^{1,2}

In the case of trophoblastic disease nobody will deny the value of energetic and sometimes heroic chemotherapy, but at the same time at the back of any honest mind is the knowledge that in this disease remissions of a "spontaneous" nature can, and do, occur, but with what frequency and probability nobody knows. It does seem curious, however, that to date chemotherapy has been successful in terms of "cure" only in "trophoblastic disease." Surely this raises two questions—(i) Is the mechanism of action of these drugs vastly different in trophoblastic disease than in other forms of cancer? (ii) Is trophoblastic disease cancer at all? Thus the argument in the leading article for concluding "that unless this tumour is susceptible to immune attack the case for using it against other tumours is weak" may well be weak, and certainly should not be used as a reason for failing to investigate possible immune mechanisms in cancer.

Since the publication of Cinader *et al.*³ we have, in a modest way, been carrying on with our attempts to treat patients suffering from trophoblastic disease by immunological methods. This work is to be reported fully in due course, but in summary four cases have been treated successfully by active and passive immunotherapy using the methods outlined in our only publication,³ and two patients have been nursed through "spontaneous remissions." Further, in one patient with recrudescence of a pulmonary metastasis soon after 10 courses of methotrexate the administration of the specific sperm anti-serum caused the disappearance of that metastasis for two years to date. In another case of "terminal drug resistant" chorio-

carcinoma the administration of the specific serum caused a dramatic fall in output of urinary chorionic gonadotrophins (from 200,000 I.U./24-hour to 20,000 I.U./24 hour-level within a few days) which was regarded as significant. Unfortunately, the patient died a few weeks later, by which time the gonadotrophin levels had returned to the same high levels as previously. We felt that it was "too little—too late."

Since malignant trophoblastic disease is all too commonly preceded by the expulsion of a "benign mole" there might well be a case for using active immunization with the consort's leucocytes prophylactically, at a time when the immune mechanisms of the patient should be in a reasonable state of repair. It seems irrational to expect an immune response from active immunization (a) in the terminal state of the disease and (b) after the administration of large quantities of drugs which are known to suppress antibody formation. For the patient unfortunate enough to be resistant to "the drugs," the preparation of a specific serum might be a life-saving measure.

The plea, therefore, is for more collaboration and less acrimony. Both methods of treatment may be complementary and need not be antagonistic, but both are best studied and practised by specialized groups or in specialized centres to which patients with trophoblastic disease may be referred.—I am, etc.,

Princess Margaret Hospital, W. D. RIDER.
Toronto, Canada.

REFERENCES

- 1 Sambrook, D. K., *Brit. med. J.*, 1960, **2**, 736.
- 2 Bagshawe, K. D., *ibid.*, 1960, **2**, 942.
- 3 Cinader, B., Hayley, M. A., Rider, W. D., and Warwick, O. H., *Canad. med. Ass. J.*, 1961, **84**, 306.

Acne

SIR,—There must be few important instances in which the recent reminder by Dr. F. F. Hellier (29 October, p. 1053) is more apposite—that in acne active treatment should always be instituted—than in the case of the schoolboy who may be directing his entire life towards a regular or short-service commission in the Army, only to find himself rejected by a medical board because of the activity of, and scarring from, this complaint.

In a situation in which volunteer supply seems always to exceed demand, the Army reasonably need not accept men with severe acne, which might well flare up badly in humid tropical conditions, and, particularly on active service, in spite of high morale, might make the sufferer a distinct liability. It seems that, by and large, the treatment of the schoolboy's acne is pursued with vigour, and that this field has on occasion proved useful for research. It is clear, too, that only in rare instances is this complaint accepted as a necessary evil which the boy must himself survive unaided. But, particularly in the case of a public schoolboy, whose dietetic problems in acne are in any event more difficult, and in whom one has a feeling that the monastic, athletic background may be a contributory factor, instances do seem to occur where treatment may fall between the two stools of the home and school doctors, with resultant difficulties all round.