Surgery for Rectal Prolapse

SIR,—I was dismayed to read in your leading article (14 November, p. 381) that the operation of recto-sigmoidectomy for the treatment of prolapse of the rectum "has been abandoned"—as if this were simply a matter of history—as one might say "Murphy's button has been abandoned in the performance of bowel resection."

This recto-sigmoidectomy was the operation devised by Ernest Miles. It was carefully described and illustrated by him in his book.¹ He gives his own record of the end results of rectosigmoidectomy (termed by him "Author's Operation") as follows: "These, so far as my personal experience goes, have been remarkably good. Out of 34 operations performed by myself there has been only one death. There has only been one instance of recurrence, which occurred five years after the primary operation. Amputation of the prolapsed bowel was again resorted to . . ." and the reason assigned by Miles for this recurrence is explained. In the second edition of his book in 1944, Miles makes no variation in his descriptions of the operation or of the results. He died in 1947 without ever having recanted his belief in the efficacy of this operation.

Seeking to find the reason for this "abandonment" of his operation (which is supposed to have occurred), I consulted all the references given in your leading article. The only one of them having evidence of the "failure" of Miles's operation is the report by Mr. N. Porter² in which he quotes a recurrence rate of the astonishing figure of 58%. This was from a follow-up of 110 cases of which Mr. Porter found 58% had recurred within three years; while those relieved of their prolapse still suffered incontinence—or at least only 10% had restoration of continence among those not suffering recurrence. This record of failure seems almost too bad to be true when contrasted with Miles's own statement of his personal experience. The difference is so profound that the figures of Mr. Porter must give us pause. There must surely be some explanation of this gross discrepancy, and it may well lie in the postoperative management. The first measure in after-treatment is so primitive and homely that it may seem tedious to describe it at length. It is indeed the cultivation of "perineal shrugging," which is to say the constant voluntary performance by the patient of contraction of the sphincter mechanism. I contend that this should be taught by the surgeon himself in person and not by a physiotherapist or other party. I would suggest that electrical stimulation and physiotherapy are then unnecessary, but the surgeon must supervise regularly to see that his directions are being properly carried out.

Again, in the matter of postoperative care, obesity must be reduced. A protuberant abdomen is likely to defeat all other measures of defence. Thirdly, alcohol must be forbidden entirely in the beginning. It is so well known that alcohol weakens the anal sphincter that this point needs no emphasis. Heavy beer drinkers must accept total abstinence for a period of at least a month after operation—preferably for much longer, if not permanently.

In four of my patients there had been a former procedure such as the Thiersch or the Lockhart-Mummery. The most obstinate case of my own experience was the aftermath

of an operation for fistula-in-ano. This defied efforts by at least three surgeons, myself being one (encircling a fascial strip after the manner of Thiersch on the supposition that the prolapse was merely anal). I was finally able to give relief (now for three years) by Miles's operation, reinforced by an encircling kangaroo tendon implanted in the peri-anal tissue. This man also had no less than seven operations for the final relief of a left inguinal hernia and perhaps some constitutional defect of the healing was a factor.

Of course, I shall be asked what is my own total experience and I have to acknowledge that it is really quite small. In an experience of 15 cases of prolapse of the rectum, I performed Miles's operation 13 times. One patient (aged 67) died three weeks later from cardiac asthma. There was one recurrence (after nine months) for which further operation was necessary—the Roscoe Graham procedure being performed.³ This was a woman of 81 years who had had 12 children. She remained cured after the second operation. In one case, a nursing trainee still only 20, I performed the Roscoe Graham operation as a first procedure, and likewise in another patient aged 61 years who was afflicted with scleroderma and who I judged would not heal well. These were all satisfactory, but for the frail and elderly any of the abdominal procedures is likely to be formidable. For several of my patients it would have been quite unnecessarily hazardous.

From this experience, I would consider that the advice to abandon Miles's operation is quite unjustified. I would be very sorry if this became accepted teaching. One does not doubt that there are other procedures which may be equally effective (some of them a much more severe ordeal for the patient). I remain convinced that the operation of Ernest Miles still has a place in the management of this condition and hope that you and others will be persuaded to reconsider their opinions in condemning it.—I am, etc.,

ROBERT S. LAWSON

Melbourne, Australia

¹ Miles, W. E., *Rectal Surgery*, London, Cassell, 1939.

² Porter, N., *Proceedings of the Royal Society of Medicine*, 1962, 55, 1087.

³ Graham R. R., *Annals of Surgery*, 1942, 115, 1007.

Endocrine and Metabolic Disorders in Bronchial Carcinoma

SIR,—In reply to Drs. Von Wichert and P. F. Mitchell-Heggs (6 February, p. 345) we are not unaware that "bronchial carcinoma frequently metastasizes to bone" and that "tumours which are large . . . are frequently associated with clinically undetected bony metastases". We would go further—tumours which are small are also unfortunately frequently associated with clinically undetected bone metastases. We made a special effort to exclude bone metastases in our series. The fact that 8 of our 11 cases had thorough necropsies is ignored. But even if we omit this vital fact how do they account for the association of hypercalcaemia with squamous carcinoma specifically, which even they accept. Are they suggesting that oat-cell carcinomas and bronchial adenocarcinomas metastasize to bone less frequently than squamous carcinomas?

Their statement that "there is no correlation between the size of a tumour or a metastasis and its biochemical activity" is too sweeping. The same is true of: "it is a characteristic feature of endocrine paraneoplastic syndromes that they are associated with small tumours"—the reverse is of course true in the case of hypoglycaemia. Their statement is inaccurate also as applied to hypercalcaemia. Generalizations of this nature about a whole host of distinct and complex disorders serve only to confuse.

Having questioned the cause of the hypercalcaemia in our cases, Drs. Von Wichert and Mitchell-Heggs end by stating that no such case of hypercalcaemia was seen among 300 cases of bronchial carcinoma in Hamburg. We are not told how these cases were investigated.—We are, etc.,

J. G. AZZOPARDI
G. POOLE

Department of Pathology,
Royal Postgraduate Medical School,
London W.12

Scarlet Fever

SIR,—“There was a young lady of Ealing
Whose friends had so little feeling
They refused to receive her
When she had scarlet fever
So she paid them a visit when peeling.”

The sting in the last line of this old limerick is the fact that the skin scales during the desquamation phase of the scarlet fever rash were believed in the old days to be infectious. This was certainly the teaching when I was a medical student at the end of the 19th century, as one can glean from reading the description of scarlet fever in Clifford Allbutt's *System of Medicine* (1899). I have never read of any proof that the disease known as "scarlet fever" in those days could indeed be transmitted by the desquamated skin, and I presume that it is now too late to check this old view more scientifically. Nevertheless, this widely-held belief might well have been based on careful observation, so there is a possibility that scarlet fever in the old days was a generalized virus infection which also involved the skin.

Scarlet fever was still a dreaded infection in my childhood, and the incidence of glomerulonephritis after it, often with fatal consequences, was apparently high. When my grandparents arrived in Adelaide in the 1850's, they had a family of five small children, but two little boys and one girl shortly afterwards succumbed during an epidemic of scarlatina, the cause of death being recorded on their death certificates as "oedema," which presumably means that they all had post-scarlatinal nephritis. Thus three out of a small family of five children died in infancy from this disease, and their little graves in the Walkerville Cemetery in the Adelaide suburb of that name (like so many other little graves in many cemeteries of that era) are mute reminders of the dangers to children in the good old days.

Is it a heresy to suggest that the scarlet fever in those days was due to a virus and not to a streptococcus? It is generally believed that the glomerulonephritis that may follow the initial infection is due to the remote effects of an exotoxin produced by a streptococcus in the throat, but it is now well-recognized that some

common virus infections (for example, varicella) can have identical renal complications.¹ In any event, we are forced back to the rather disturbing fact that many shrewd clinical observers earnestly believed the peeling skin to contain the infecting agent, and we are left with some doubts in our own minds about the true nature of the disease in former years. At least it is some comfort to know that the virulent scarlatina of our forefathers has apparently died out.—I am, etc.,

JOHN B. CLELAND

Beaumont,
South Australia

¹ *British Medical Journal*, 1968, 3, 264.

G.M.C.'s Functions and the B.M.A.

SIR,—I agree with Dr. I. M. Quest (17 April, p. 172) that Minute 34 of the Special Representative Meeting of 12 February 1970 listed three conditions (of acquiescence in the payment of an annual retention fee). The first two conditions were concerned with the composition of the G.M.C. and its committees, and only the third mentioned functions. Therefore it did not seem inappropriate to start with a review of the composition of the G.M.C. and its committees. I can, however, assure Dr. Quest that there was quite a lot of discussion about functions in the joint working party, and on 22 October 1970 I wrote, on behalf of the B.M.A. representatives, a long letter to the chairman, Sir Brynmor Jones, which ended as follows:

"There is one thing which I feel I should add. We have found it very difficult to consider changes in the composition of the G.M.C. without also taking into consideration possible, or even probable, changes in its functions; and we hope it will be generally agreed that a review of the functions of the G.M.C. (in whatever forum would be most appropriate) should follow immediately on the heels of the review of its composition which you and your working party are engaged in carrying out."—I am, etc.,

RONALD GIBSON

Chairman of Council, B.M.A.

London W.C.1.

G.M.C. Election

SIR,—I have received the G.M.C. voting paper with 29 names on it and an invitation to vote for eight candidates.

However, I have no information on which to base my decision on who to vote for. The B.M.A. decided not to recommend candidates (*Supplement*, 11 July, p. 46) and the candidates have not informed me of their views. Though I have attended the last four Annual Representative Meetings I know of only seven of these 29 candidates and do not wish to vote for all of these. Many doctors will know of even fewer of the candidates and will find it difficult to decide how to vote.

I hope the newly constituted G.M.C. will be able to evolve an electoral system which will allow us more information about the candidates.—I am, etc.,

STRANG MACLAY

Hambledon,
Surrey

SIR,—Dr. P. L. Loveridge (17 April, p. 172) asserts that he has received no voting paper

in the current election of members of the General Medical Council.

During the week ending on 2 April voting papers were posted to 81,661 doctors, who were fully registered as on 26 February, at the addresses which appeared against their names in the *Register* at that date. If Dr. Loveridge had not received a voting paper, there are (apart from the possibility of miscarriage in the post) two possible reasons. The first is that his letter was written before the voting papers were issued. (As announced on p. 60 of your issue of 3 April, the issue of voting papers, originally scheduled for 26 March, was delayed because of the effects of the postal strike). The second is that his voting paper had not been forwarded to him from his registered address. This address was a hospital, but not the hospital from which he wrote to you. The second reason could equally have prevented him from receiving voting papers in the by-election last autumn.

As announced in the notice of the election (9 January, p. xxxi) and on other occasions, any person who is entitled to vote but does not receive a voting paper may obtain one by writing to the Registrar and signing an undertaking that he has not marked and will not mark more than one voting paper in the election. This was brought to Dr. Loveridge's attention when he wrote to the G.M.C. on 30 March to notify a change of address. The last day for the return of voting papers was 21 April.—I am, etc.,

M. R. DRAPER

Registrar,
General Medical Council

London, W.1.

Keeping on the "Medical Register"

SIR,—In order that there shall be no misunderstanding of my letter (27 March, p. 725) I would explain that the doctors to whom I referred in the second paragraph as having been removed from the *Register* are those who have applied to the G.M.C. to have their names removed.—I am, etc.,

JEAN LAWRIE

Honorary Secretary,
Medical Women's Federation

London W.C.1

Future of the Consultant Grade

SIR,—I would be grateful for the opportunity to correct two errors in a speech which I made at a meeting of the Central Committee for Hospital Medical Services on 4 February and reported in the *B.M.J.* (*Supplement*, 20 February, p. 50). I am on record as saying that "Mr. Grabham reported that the C.M.O. had asked the Regional Hospital Consultants and Specialists Association about the immediate expansion of the consultant grade, and he had asked for that in isolation."

In fact the C.M.O.'s discussions were with the Joint Consultants Committee, and as far as I know the views of the Regional Hospital Consultants Association have never been sought—the wish was obviously master to the thought.

I also note that "Mr. Grabham asked whether at the same time there would be a freezing of registrar grades, but he did not get any assurance from the C.M.O." In fact, I

asked for a "relaxation of the registrar freeze." I regret to say, however, that the report is all too accurate when it records the lack of an assurance from the C.M.O.

I apologize to those concerned and can only plead temporary emotional distress caused by my real and sincere fears for the future of the consultant grade, which at that moment appeared to be in danger.—I am, etc.,

A. H. GRABHAM

General Hospital,
Kettering

Female Medical Practice

SIR,—With reference to the letter entitled "Female Medical Practice" (13 February, p. 406) it is unfortunate that the inference was made that general practice is an inferior career for women in medicine.

The quality of the Health Service depends on the highest possible standard of care from the patient's first medical consultant—the general practitioner. Women are well suited to this work, which involves a sympathetic relationship with the community and industrious application of their acquired skills. Many women are able to give full-time service in general practice.

It is to be hoped that basic practice allowances on a part-time basis will be granted by all executive councils to women who have completed a suitable training period in practice, either in the immediate post-registration period or following the retraining scheme for married women returning to professional work after having a family. This would offer a satisfactory career to women able to undertake part-time service only. Medical officers in the family planning service also find their useful work satisfying.

The social structure of this country has changed radically during the last 100 years, resulting in the disappearance of the household of domestic servants. This, rather than lack of advance in the profession, has been largely responsible for the fact that many married women with families have been unable to take full advantage of the increasing opportunities available to them since the days of Elizabeth Garret Anderson.—I am, etc.,

AGNES VÉREL

President, Sheffield Association of
the Medical Women's Federation
Sheffield, Yorks

Tropical Diseases Unit, Edinburgh

SIR,—It is to be hoped that readers in Scotland of Dr. C. C. Draper's article (10 April, p. 93) on the laboratory diagnosis of malaria will also have read my letter (5 September, 1970, p. 590) in which I pointed out that the Tropical Diseases Unit moved from the Eastern General Hospital, Edinburgh, in 1963 to its present location in the City Hospital, Greenbank Drive, Edinburgh EH10 5SB.

Patients are more expeditiously diagnosed by being referred to the correct address than by the sending of blood slides to the wrong hospital. An analysis of 50 cases of malaria treated in this unit has been accepted for publication in the *Scottish Medical Journal*.—I am, etc.,

FREDERICK J. WRIGHT

Tropical Diseases Unit,
City Hospital,
Greenbank Drive,
Edinburgh EH10 5SB