Carcinoma of Tongue

SIR,—While your leading article on carcinoma of the tongue (6 May, p. 308) draws welcome attention to the epidemiological and diagnostic aspects of this condition, the section on treatment is open to criticism. It neither points to the recent and developing aspects of management—such as reparative surgery or the use of radiotherapy in the control of lymph node metastasis, nor gives a satisfactory “conventional” picture of management. Few surgeons with experience of block dissection bilaterally would recommend its prophylactic use save in exceptional circumstances.

Perhaps the most disappointing feature of the review is the continuing attitude which regards cancer of the tongue as a single entity which may be suitably treated by a single treatment programme. Surely the time has come when every cancer must be treated as an individual problem in an individual patient. While the small or moderate sized tumour is well treated by radiation, the rare exophytic or verrucous type of cancer not only tends to be radioresistant, but radiotherapy may actually be harmful.¹ In this type of tumour the results of surgery alone are excellent. In bulky, advanced tumours both radiotherapy and surgery alone are disappointing, and the only hope of improving results lies in combination therapy.

The programme of management recommended for cervical lymph nodes differs from that used by many workers. Again the selective attitude is the only logical approach. In experience here the incidence of lymph node metastasis from small (less than 2 cm) well differentiated lesions is very low and careful follow up is adequate treatment. Where cervical metastasis is considered likely, there is mounting evidence that radiotherapy in therapeutic doses gives a high incidence of local control. This is particularly important in the many cases where bilateral spread is possible since a good measure of control can be achieved with little or no morbidity.

No review of this subject can neglect the fact that the management of advanced cases and those recurrent after radiotherapy has been revolutionized by recent reparative techniques. The use of forehead, deltopectoral, or cervical flaps to replace soft tissue defects and bring a new blood supply into the area not only aids primary healing but gives vastly improved cosmetic and functional results.

Finally, it should be stressed that many specialties besides surgery and radiotherapy have much to offer in this condition. There is little doubt that oral cancer is best treated initially by a group of people especially interested in this field, each bringing their own specific expertise to bear on this problem.—I am, etc.,

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¹ Kraus, F. T., and Perez-Mesa, C., *Cancer*, 1966, 19, 26.

Age and Anorectal Dilatation

SIR,—Mr. T. Bates describes “Rectal Prolapse after Anorectal Dilatation in the Elderly” (27 May, p. 505).

In our recently published series¹ we did

not mention age as a specific contraindication to dilatation, but our oldest patient was a man aged 66. We recommended that patients with weak perineal floors should not be subjected to forced anorectal dilatation. Such patients included those with previous pelvic floor surgery and women of high parity or over the age of 65. Mr. Bates's two elderly women, aged 85 and 78, would have been excluded by us on these grounds. In addition, both his patients had “fibrous anal stenosis” which we have described as another contraindication to forced dilatation, particularly when the fibrosis is caused by previous submucous injection of a sclerosant.

We would agree that great caution must be exercised in subjecting elderly patients to this extreme (eight finger) anorectal dilatation. Also, we would advise the exclusion of highly parous women or those with previous pelvic floor repairs.—We are, etc.,

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I. M. C. MACINTYRE

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¹ Macintyre, I. M. C., and Balfour, T. W., *Lancet*, 1972, 1, 1094.

Probenecid in Calcification of the Hands

SIR,—Professor C. E. Dent and Dr. T. C. B. Stamp (22 January, p. 216) successfully used probenecid in the treatment of troublesome superficial calcification of the hands occurring during the course of progressive systemic sclerosis. I should like to report experiences during treatment of a similar case where the patient showed initial slight improvement, marked deterioration after temporary interruption of therapy, and thereafter marked improvement when treatment recommenced. The time sequence of events in this case was striking.

A woman aged 64 has been under observation and treatment for systemic sclerosis for the past 15 years. The diagnosis is based on the typical facies with beaking of the nose and radial furrowing around the mouth, tightly bound-down skin on the hands and feet, and a creatinine clearance of 65 ml/minute. For the past six years no deterioration in her general condition has been observed, suggesting that the disease process is either quiescent or burnt out, and her main disability during this period has been pain and immobility of the joints of the hands and feet due to overlying calcium deposits. On occasions these have extruded spontaneously, and in addition some improvement has been obtained by the use of von Ebners decalcifying solution applied topically. When seen as an outpatient in January 1972 these deposits were numerous and painful and the decision was therefore made to treat the patient with systemic probenecid.

Plasma calcium level at this time was 9.2 mg/100 ml, plasma inorganic phosphate 4.0 mg/100 ml. Treatment was started with 0.5 g probenecid daily, and increased to 1 g daily after one week. No side effects were observed, and the patient was maintained on this dose until 1 May when she attended the outpatient department complaining of severe pain in her hands. On questioning it was revealed that she had discontinued probenecid therapy 48 hours previously. and on examination large bullae were observed, some over pre-existing areas of deposited

calcium, and some on previously normal skin. Culture of bulla fluid showed no growth, and microscopic examination of a smear showed amorphous material which was heavily stained by von Kossa's method for calcium. Plasma calcium was 8.3 mg, phosphorus 4.2 mg, serum uric acid 2.6 mg, and radiology of the hands showed no change by comparison with films taken in January 1972. Treatment with probenecid was started in a dose of 1 g daily, and for the following week fresh bullae requiring aspiration appeared daily on the hands. After this period new lesions ceased to appear, and as healing progressed it was observed that many of the previously solid calcium deposits had been extruded, and that mobility of the hands was greatly improved. Urinary calcium level at this time was 336 mg/24 hours.

From the time sequence it would appear that the temporary deterioration in this patient's condition can at least in part be attributed to sudden cessation of probenecid therapy, but the subsequent improvement in function is extremely striking.—I am, etc.,

RONA MACKIE

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Anticonvulsant Hypocalcaemia

SIR,—Several reports^{1,2} have confirmed the findings that calcium metabolism is disturbed by anticonvulsant therapy. It has been suggested that a drug-mediated enzyme induction may be the mechanism responsible by causing a greatly increased inactivation of vitamin D. Phenytoin is a much less potent enzyme inductor than phenobarbitone, yet the mean serum calcium was lower in patients receiving phenytoin than in those on phenobarbitone.¹ Thus, it can be assumed that other factors might also play a part.

It seems likely that phenytoin as well as other anticonvulsants may form an insoluble complex with calcium salts, as is known to happen with phenobarbitone, and the absorption of calcium and drugs from intestine in this form may be incomplete. Indeed, McQueen³ reported that when a sucrose-lactose diluent was substituted for the calcium sulphate in phenytoin capsules patients developed adverse effects with markedly elevated serum phenytoin levels. Tyrer and others⁴ made quite similar observations in Australia. They demonstrated also that patient's blood phenytoin level fell rapidly to a quarter of its former value when the phenytoin with a calcium sulphate excipient was used instead of phenytoin with a lactose excipient. The blood phenytoin concentration rose again when phenytoin-lactose excipient was reintroduced. There was no increase in faecal phenytoin loss at the time of the fall in blood phenytoin concentration. It must be emphasized, however, that this may be erroneous owing to a fault in the extraction method of faecal insoluble calcium-phenytoin complexes.

In our previous study⁵ 71% of the 120 serum calcium determinations were subnormal as well as all the mean serum calcium levels of 40 mentally subnormal epileptics on phenytoin in three serial determinations: 4.38 ± 0.20 ; 4.47 ± 0.21 and 4.27 ± 0.27 (S.D.) mEq/l. Nevertheless, only 9% of the 120 cerebrospinal fluid (C.S.F.) calcium determinations were subnormal and

all three corresponding mean C.S.F. calcium levels were normal. No significant correlation (r) could be established between either the oral phenytoin dosage or the serum phenytoin or the C.S.F. phenytoin levels and the corresponding calcium levels.

Recently, the serum calcium levels of 21 of these same epileptics who still resided in the institute have been checked. Twelve (57%) of them had subnormal serum calcium levels and their mean serum calcium value 4.37 ± 0.28 mEq/l. was again subnormal. The mean serum calcium level of 21 control patients without any drugs was 5.02 ± 0.23 mEq/l. The difference is statistically highly significant ($P < 0.001$).

Because the mean C.S.F. calcium values of the three serial determinations were normal and only 11 (9%) of the 120 samples were subnormal, in marked contrast to the serum calcium levels, it is conceivable that the anticonvulsant drugs may interfere with the protein binding of calcium (serum and tissue proteins—for example, bone matrix) rather than with the biologically active free calcium proportion. Osteomalacia has been reported to be associated with long-term anticonvulsant therapy.⁶ It has been shown experimentally that the concentration of the radiocalcium accumulated by the mitochondria was decreased by prior administration of phenobarbitone and of reserpine but increased by pentylenetetrazol.⁷ Thus, it is conceivable that the anticonvulsant action of phenobarbitone and perhaps of other anti-seizure drugs is linked with their interference with the cellular protein binding of calcium and other cations, and consequently, with ion transport. Remarkably, vitamin D enhances the activity of ATPase and pyrophosphatase enzymes.⁸—We are, etc.,

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Future of Postgraduate Medical Centres

SIR,—I was pleased to see Sir George Godber's letter (10 June, p. 654) about the future of postgraduate medical centres and to note that our views on the matter appear relatively close.

The council of our association consider that adequate accommodation should be available in multidisciplinary centres primarily for the use of medical staff and under local medical control. This medical area should be a clearly recognizable entity, and should contain certain facilities which include adequate and independent catering and common room arrangements. We had received disquietening reports from indi-

vidual clinical tutors describing actions taken or contemplated which ran counter to these views. This disquiet had not been eased by sketch plans originating from the Department itself. We believed such moves could have a most unfortunate effect upon the postgraduate medical centre movement, the results of which would be as unwelcome to the Department as ourselves. We considered it imperative to act urgently before too many irrevocable steps were taken.

Sir George's reassurances are therefore welcome and we hope that the Department's views will reach those bodies which have the actual task of putting plans for multidisciplinary centres into effect. Dr. J. Lister is abroad at present and cannot be contacted.—I am, etc.,

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SIR,—We write to take issue with you and Drs. J. Lister and D. Ferriman (3 June, p. 589) on the topic of postgraduate centres.

We would agree with you on the success of postgraduate centres and their importance in programmes of vocational and continuing education, but we feel that this is an appropriate time to take stock and see whether the role of the postgraduate centre cannot be further extended, particularly in the light of the changes in medical care which have taken place since the Christ Church conference and which are likely to continue to go on in the future.

The doctor is now one of a team of professionals, working both inside and outside the hospital, among whose members are nurses, social workers, psychologists, laboratory technicians, and administrators—that is, a multidisciplinary team in the fullest sense. We believe that the doctor is the natural person to lead the clinical team and that part of his leadership role is to take an active part in the teaching and training of all professionals. If doctors abdicate from this responsibility, and this might well be seen as such if they insisted on keeping teaching centres exclusively for their own use, then they are inviting other professionals to take over this leadership. There are clear indications in the field of mental health that this could easily happen and we cannot believe that such a take over bid is desirable.

Education is education. The needs of the medical profession are the needs of the supporting professions. The closest parallels are to be found whether one considers the need for updating knowledge, changing attitudes, arranging programmes of instruction, or making financial arrangements. Doctors are not unique in these respects. If, as we believe, the multidisciplinary approach to patient care is essential, then this further emphasizes the need for all of us involved in patient care to have some of our training together. This may not be a popular view at the present time, but we feel that it would be pertinent to ask the views on the matter of multidisciplinary education of the Nuffield Provincial Hospitals Trust and the King Edward Hospital Fund, the two bodies whose enlightened and generous action initiated the formation of postgraduate centres throughout the country. In the light of their considerable recent experience and achievements in promoting

multidisciplinary management training this would be specially relevant.

We would urge both on yourself and on the National Association of Clinical Tutors the course, not of opposing the formation of multidisciplinary centres, but of ensuring that accommodation and equipment in them is adequate to meet the needs of all their users.—We are, etc.,

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Honorary Clinical Tutor

AUBREY KEEP
Group Secretary

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SIR,—I wholeheartedly endorse the views of Sir George Godber (10 June, p. 654). As a hospital group librarian I shudder on hearing medical staffs speaking as if they are a race apart. If librarians are to provide a service to health science workers within an area authority (a policy endorsed by both the King's Fund and the Library Association) we need health education centres which accommodate ancillary staffs.

Librarianship is built on a foundation of co-operation and this attitude must be encouraged. Medicine is a discipline embraced by the health sciences. It may well be the most important one so embraced, but it must be developed in this context and not to the exclusion of other branches of the containing science. With the coming of Health Service reorganization librarians will find it impractical, and health authorities uneconomic, to have a medical library within a postgraduate medical centre and provide another elsewhere to cater for ancillary staffs. Rather, we should aim for health science information centres within the health education centres.

Only in this way can workers with a common objective—the wellbeing of the patient—develop on a personal level the interdisciplinary relationships which are currently reflected in the written word.—I am, etc.,

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SIR,—We would like to associate ourselves with your leading article and the letter from Drs. J. Lister and D. Ferriman (3 June, pp. 547 and 589). We view with grave concern the present plans of the Department of Health and Social Security which favour the development of hospital education centres rather than postgraduate medical centres.

We firmly believe that the overall control of the postgraduate medical centres should be in the hands of doctors—but entirely agree that every opportunity for multidisciplinary education should be made available. Nevertheless, the prime aim is continuing education for all doctors and dentists both in the hospital and in the surrounding district.—We are, etc.,

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Footballers' Migraine

SIR,—I was interested in the paper by Professor W. B. Matthews (6 May, p. 326).