

110 mm. Hg. She was confused with paranoid trends and exhibited hallucinations at times. Depression had also been noted by her relatives before she was admitted to hospital.

Physical examination showed osteoarthritis of both knee joints and small joints of the hands, confirmed by x-ray. Intravenous pyelogram showed normal appearance of both kidneys. Her haemoglobin was 6 g./100 ml. and the blood picture was hypochromic and microcytic, which improved after iron therapy. Blood sugar, electrolytes, proteins, and cholesterol were normal. There was no glycosuria, and urinary 17-ketosteroid estimation was within normal limits. X-ray of the skull showed well-marked hyperostosis frontalis interna (Fig. 1). As seen in Figs. 2 and 3, obesity was mainly limited to the upper arms and thighs.

Association of hirsutism, obesity, and hyperostosis frontalis interna has been observed under the title of "Stewart-Morel Syndrome" or "Morgagni-Morel Syndrome." Morel reported 17 cases and Stewart reported a few cases.<sup>1</sup> Michaux described a case in 1959 presenting mental symptoms along with this syndrome.<sup>2</sup> Aubertin described a patient with arterial hypertension.<sup>3</sup> All say that the case is obscure. The newly formed bone is deposited in the inner aspect of the frontal bones with considerable thicken-

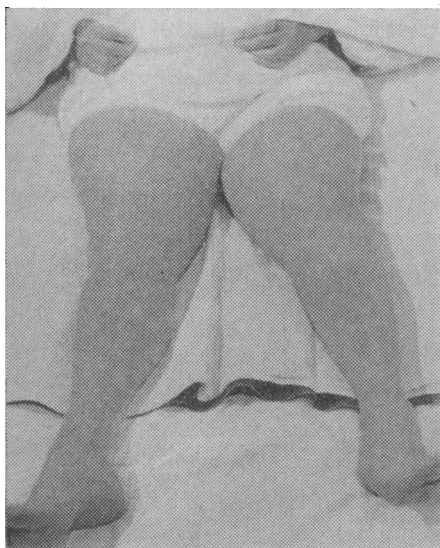


FIG. 3

ing—resulting in atrophy of frontal lobes and pituitary dysfunction—and has almost always been recorded in women.

Our patient presented all features of the syndrome—that is, hyperostosis frontalis interna, hirsutism, obesity, mental and nervous symptoms, and hypertension.—We are, etc.,

I. P. ROWLANDS.

B. C. DAS.

General Hospital,  
Warrington, Lancs.

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#### Hypogammaglobulinaemia in Adults

SIR,—Your special correspondent's account of my lecture on hypogammaglobulinaemia in adults (5 August, p. 362), given at the conference on disorders of protein metabolism

at the Royal College of Physicians, London, contains some misquotations.

Hypogammaglobulinaemia in adults is of two types: primary, in which the deficiency of gammaglobulin is of unknown origin, and secondary, in which it is due to protein loss from the gut or kidneys or results from the effect of neoplasms upon immunoglobulin production. I did not say that the disease could be due to the toxic effects of drugs, and there is no evidence that hypogammaglobulinaemia can be caused in this way.

The eighteen patients whom I reported had all been diagnosed as having hypogammaglobulinaemia in adult life. The onset of the disease as judged by the history of recurrent infections was not, as stated in your report, always in adult life. In four of these adults the first onset of recurrent infections had occurred in childhood.—I am, etc.,

Brompton Hospital,  
London S.W.3.

K. M. CITRON.

#### Cardiac Resuscitation

SIR,—As a lecturer and examiner in first aid for both Red Cross and St. John Ambulance Societies over the past nine years, I can substantiate Dr. J. D. Barrett's feelings (12 August, p. 437) that the indications for external cardiac compression are not understood by the majority of first-aiders who have only attended one or two courses. Often candidates state at examination that if the casualty does not respond by spontaneous breathing after the first four to six inflations of the lungs then external cardiac compression should be started. There is no thought of palpating the neck for pulsation, of observing the colour of the lips, or of noting the condition of the pupils. I feel that many casualties would be better with only basic first aid—that is, arrest of haemorrhage, ventilation of the lungs, and the treatment of cuts, burns, and fractures. I suggest that external cardiac compression should be taught to recognized "life-savers" who have passed at least two first-aid examinations and have shown aptitude in diagnosis, and not to those who have only just started.—I am, etc.,

Public Health Office,  
Swanage, Dorset.

W. E. HADDEN.

#### Insulinotropic Action of Secretin

SIR,—Drs. D. R. Boyns, R. J. Jarrett, and H. Keen (10 June, p. 676) have confirmed the insulin releasing action of secretin in man but report evidence which they suggest throws doubt on the possible physiological role of this hormone in the regulation of insulin secretion. Some of our observations in studies related to this question and in studies of the effects of pancreozymin are at variance with theirs. In the earlier experiments of Boyns, Jarrett, and Keen with intraduodenal infusions of citric acid hypertonic solutions of glucose were delivered into the duodenum as a means of raising the blood glucose concentration.<sup>1</sup> With this procedure possible effects of the hypertonic solution on secretin release might obscure further effects of acidification of the mucosa. However, it is clear from the results of the three experiments reported in their recent paper that the infusion of 2.5 mEq of citric acid into the duodenum did not significantly modify the

response to intravenous infusion of glucose.

We are in the course of a series of experiments in which hydrochloric acid is infused in the duodenum for a period of 20–40 minutes to a total dose of 30 mEq while glucose is given intravenously. This dose of acid does not exceed estimates of the normal acid secretion in response to a mixed meal.<sup>2</sup> In two out of three experiments distinctly higher levels of serum immunoreactive insulin were observed while the acid was infused into the duodenum; and in the third a difference in the same direction was recorded. Moreover, we have found that the intravenous infusion of synthetic human gastrin in six normal subjects modifies the response to intravenous glucose in the same manner as secretin, and it seems that this effect may be mediated by stimulation of acid secretion.

Our findings with a highly purified preparation of pancreozymin of verified exocrine activity differ from those of Boyns, Jarrett, and Keen. This preparation administered to eight subjects in doses of 25 to 50  $\mu$ g. has consistently enhanced the rise in serum insulin associated with intravenous infusion of glucose and has accelerated glucose disposal. In fasting subjects little or no change in peripheral serum immunoreactive insulin is obtained when pancreozymin is administered intravenously, but a large transient rise in portal serum immunoreactive insulin has been observed. The same preparation of pancreozymin enhanced the change in serum insulin concentration associated with intravenous infusion of arginine in eight normal subjects. We believe that all preparations of secretin or pancreozymin must be tested for exocrine activity after use in experiments yielding negative results. Our findings will be presented at the forthcoming meeting of the International Diabetes Federation.

It is unlikely that duodenal infusion of isotonic glucose causes secretion of pancreozymin in man, and it has been shown by Dr. R. Preshaw at McGill<sup>3</sup> that such infusions do not produce exocrine effects of secretin in man. This procedure was used by McIntyre and his colleagues<sup>4</sup> to demonstrate enhanced insulin secretion in man during intestinal absorption of glucose. It appears, therefore, that an insulinotropic hormone other than secretin or pancreozymin is secreted when glucose is absorbed from the small intestine. However, the response to ingestion of protein together with carbohydrate suggests to us that stimulation of the endocrine pancreas is further potentiated to an extent not fully accounted for by the direct effect of circulating nutrients. The digestive secretagogues may be responsible for this potentiation.—We are, etc.,

J. DUPRÉ.

J. D. CURTIS.

J. C. BECK.

Fraser Laboratory for  
Research in Diabetes,  
Royal Victoria Hospital,  
Montreal, Canada.

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#### Mortality of the Ambulance Ride

SIR,—The letter from Mr. C. H. Cullen and others (12 August, p. 438) inadvertently underlines the great importance of taking seriously injured patients to the proper centre

even if it does mean a rather longer ambulance journey initially. Only in this way can the problem Mr. Cullen pinpoints be avoided. It is no use resuscitating a patient if he then has to travel to receive the necessary subsequent treatment. And, far from relating only to transfers between hospitals, this applies with great force within the hospital in the siting of x-ray departments and operating theatres in relation to the resuscitation room.

Those who have much experience of accident surgery know that in the critical phase, when a patient has just been resuscitated sufficiently for the anaesthetist to dare accept him for surgery, he must be transferred to the theatre *on tiptoe*. Trundling such a patient along a hundred yards of corridor will do the same as the ambulance journey did to Mr. Cullen's patient. A journey on a trolley stationary in a lift, however many floors are traversed, will affect him far less.

The place for resuscitation is the place which can supply the whole treatment. Staging patients for resuscitation en route can only increase the mortality.—I am, etc.,

Canterbury. F. G. ST. CLAIR STRANGE.

### Fulminating Ulcerative Colitis

SIR,—I must take issue with your correspondent Mr. T. A. Boxall (5 August, p. 368).

In the large majority of cases Professor Goligher and his team carried out a total proctocolectomy and not simply a subtotal colectomy (22 July, p. 193), although your leading article in that issue perhaps tended towards the less radical view.

Any surgeon who has had the experience of dealing with a rectal remnant which has continued to bleed severely, to perforate and to form abscesses and massive adhesions to bladder, urethra, and small intestine—requiring a second operation of great technical difficulty and severity—must surely hesitate to leave behind the rectum at the primary operation unless it can be clearly shown to be not more than slightly diseased.—I am, etc.,

Glasgow. D. M. SINCLAIR.

### Casualty Department—or G.P. Service?

SIR,—Mr. R. S. Murley (22 July, p. 245) rightly criticizes your previous correspondents' (1 July, p. 46) defeatist attitude to the abuse of the hospital casualty service. This abuse is not only typical of the larger city centres but is becoming increasingly common in smaller hospitals serving a "well-registered" population since more and more general practitioners are adopting appointment systems. "I can't get an appointment at the surgery till Wednesday" is a familiar excuse to many a casualty officer on Monday mornings.

I would not agree, however, that the doctors' efforts to educate the public are "largely doomed to failure." Much can be done if the casualty staff are prepared to establish the department's reputation locally as a place where only genuine emergencies will receive attention. This entails close co-operation with the general practitioners, asking them to be firm with their patients who attend unnecessarily, making sure that local works first-aid personnel know this attitude, and so on.

Because casualty work is not recognized as a specialty in its own right, this venture may prove difficult. Support at management committee and medical staff committee levels is often lacking, and much of the out-of-hours work may be done by junior doctors from other departments who have no enthusiasm to help solve a problem which is not theirs to begin with. Only the creation of a proper career structure in this work will give casualty departments the type of staff they need to function to their best advantage and eliminate this abuse.—I am, etc.,

Stockton-on-Tees. J. H. JENNINGS.

### Health of Students and Soldiers

SIR,—I would entirely agree with Colonel H. G. Skinner's comments on planning a health service (15 July, p. 178).

Some 15 years ago, when I was a post-graduate student at the London School of Hygiene and Tropical Medicine, I attended an elective course of lectures on what was to me a new subject—"Industrial Psychology." As the content of the course unfolded, it was interesting to note that we were covering the principles of man-management which had earlier been instilled into me as a very junior regimental medical officer by the more senior regimental officers of the battalion in which I was privileged to serve.—I am, etc.,

Eastern Command, Hounslow, Middx. F. G. NEILD.

### Consultants' Views of G.P.

SIR,—Perhaps one should not take too seriously remarks made in the heat of debate, but some words ascribed to Dr. B. D. Morgan Williams (*Supplement*, 12 August, p. 115) call for comment.

He is reported as saying that "Teaching-hospital consultants saw only the worst side of general practice: they did not see the successes." I should like to record that in my own experience this is complete nonsense. Neither in private practice nor in outpatient clinics did I see only the worst side of general practice, and I cannot believe that my experience was unique. This kind of remark is to be deplored, and I feel someone ought to say so.—I am, etc.,

London, N.1. CECIL FLEMMING.

### Radio Communication and the G.P.

SIR,—Referring to the letter from Dr. K. A. Harden, of Glasgow (5 August, p. 374), in this practice we do indeed have an arrangement whereby the hospital can hear our report radioed direct from the car.

This is done through a commercial organization—Air Call, of Hitchin—who on receipt of our message contacts the hospital by telephone, and by leaving the switch open in the control office allows the hospital doctor to hear our message. This saves many a letter in the wee small hours, and we can vouch for the great saving in time.—We are, etc.,

R. A. BRIGGS. D. G. WRAY.  
J. MCN. FULLERTON. E. V. JONES.

Houghton Regis, Dunstable, Beds.

### B.M.A. Department of Audio-visual Communication

SIR,—The pressure of urgent business at the Annual Representative Meeting at Bristol prevented me from presenting the report of the Film Committee and informing members about the future plans of the Association's new department of audio-visual communication. Briefly, for the immediate future, these are:

(1) To hold a three-day founding conference entitled "Educational Technology in Further Medical Education" at the University of Sussex on 3, 4, and 5 January 1968. (Full details will be published early this autumn.)

(2) To create an advisory service covering the content, availability, and suitability of audio-visual source material of all kinds and the advantages and disadvantages of recording and presentational apparatus in all media.

(3) To serve as a co-ordinating centre for individual effort in the whole field of audio-visual communication in medicine.

(4) To upgrade and recatalogue the present film library and to enlarge the library of audio tapes in order to increase its usefulness to doctors and others both at home and abroad. (Modern apparatus for the servicing of films returned by borrowers has now been installed.)

(5) To promote the making of clinical and health education films by bringing together medical men with ideas, film makers, and potential sponsors and to encourage the setting up of trust funds to sponsor specific projects.

Eventually it is hoped that a hallmarking system for medical films can be introduced which will enable a prospective user to identify titles whose professional and ethical standards are acceptable to the Association. The provision of training courses for medical teachers in the use of apparatus appropriate to the newer media of communication is also under consideration.

I am also happy to report that shooting has actually started on a film dealing with the problem of juvenile obesity that is being sponsored jointly with the British Life Assurance Trust. The newly appointed head of department, Mr. Charles Engel, will be taking up his duties in September.—I am, etc.,

T. A. QUILLIAM,

Chairman,

Film Committee of the B.M.A.

University College, London W.C.1.

### Points from Letters

#### Aversion Therapy of Homosexuals

Dr. C. E. ALLEN (Mold, Flintshire) writes: It is unfortunate that Dr. B. Kalcev (12 August, p. 436) claims that homosexuality is not a disease, because the dictionaries I have consulted suggest that a disease is merely an abnormal condition. The fact that it has a psychological basis does not make it any less a disease.

This is not to suggest that I feel that treatment should be forced on those who do not wish it. Since I have treated a very large number of homosexuals I know that anyone who tries to treat a patient who does not wish it is wasting his time. It should be appreciated that homosexuality leads to unhappiness. The homosexual is never able to fit comfortably into a society adjusted for heterosexuality. He is often unhappy during his youth because he feels different from others, and when old age comes is intolerably lonely. For these facts alone it is worth urging him to accept treatment, and, if he can respond, to be cured.