Letter from . . . South Australia

Afflictions and Admonitions

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This continent has a few nasty surprises. The white pointer shark claims an occasional unwary bather, particularly on the remoter coasts. The injuries inflicted are terrible and leave little chance for the transport of the victim to adequate surgical care. At the other extreme there has been the discovery of a nasty little frog in Western Australia. His presence was not known before and he rejoices in the name of *Heleioporus*.¹ The three varieties studied have two subcutaneous glands symmetrically disposed on the dorsolateral aspect of the back. They secrete an unknown substance, which caused severe lachrymation in one person who wiped his eye after handling a dead frog. He recovered in 24 hours. Another patient had the misfortune to swallow an antacid pill after he had caught a frog, and he suffered from tightness in the chest and slowing of the heart for half an hour while he slumped in his car. He made an uneventful recovery. Extracts of these glands were investigated by injections into mice, which first became paralysed in the hind legs and died of progressive paralysis.

A possible parasite is recorded in New South Wales. It has not been previously known there, though it has made its appearance in Queensland. The patient, on this occasion, probably acquired it there while on holiday. The parasite is a worm, *Angiostrongylus cantonensis*,² which lives normally in the pulmonary arteries of rats that become infected by eating slugs. Larvae from the rats are excreted in the faeces and are taken up by the slugs and by snails. Man is infected by eating molluscs. After about two weeks the patient suffers from mild fever, nausea, vomiting, headaches, neck stiffness, and photophobia. There are also paraesthesiae and in 5% some paralysis, especially of the facial nerve. The most significant finding is of pronounced eosinophilia in the cerebrospinal fluid, amounting to 50% in the patient described. Apparently the other helminthic diseases causing C.S.F. eosinophilia such as trichinosis, cysticercosis, gnathostomiasis, and schistosomiasis do not occur in Australia, but toxocariasis and ascariasis do. The patient recovered from his meningitis in 10 days, and thiabendazole, known to cure rats, seemed to help him.

Some unpleasant things can happen to man in the mass. It seems astonishing that other forms of life should go to such trouble to get at him.

Major Affliction

Alcoholism is a major affliction of Australians, causing much ill-health and unhappiness. It is the subject of a report by the

National Health and Medical Research Council. Perhaps 4%, about 215 000, of the male work force are alcoholics and there are also more who are unemployed or otherwise on the scrap heap, while there are 43 000 women alcoholics. These are from a population of just over 13 million. As elsewhere, there is good evidence of drinking to excess increasing among the younger age group, and some estimated 10% of hospital admissions in the older group are directly or indirectly due to alcoholism. The disease runs through all social strata. The bald statistics show that the annual consumption per head of population is 28.6 gallons (130 litres) of beer, 2.2 gallons (10 litres) of wine, and 2.2 pints (1.2 litres) of spirits. Australians bid fair to be the gargantuan drinkers of the world, and this has repercussions in job absenteeism, unemployment, family breakdown, deaths from cirrhosis, pancreatic disease, and road accidents. Half the road-accident deaths are associated with a drinking driver, and in one-vehicle accidents the figure is 74%.

The problem needs some action—and not by repressive legislation, which does not work. All need education about the dangers and about how to enjoy social drinking without getting drunk. Seductive advertisements might have to be regulated and proper treatment centres set up. Social awareness is needed, too, so that alcoholism should be recognized as a disease and not therefore reprehensible and within the control of the alcoholic.

Fine Words

Two addresses have recently caught my attention. One was by a professor of Australian literature and the other by a lawyer of the Australian National University. Both had been invited speakers at medical meetings, so that the doctors cannot be accused of chauvinism. The first was Professor Leonie J. Kramer, of the University of Sydney, addressing the fifth Annual Conference of the Australian College of Medical Administrators in 1972. Her theme was "Take Physic, Pomp." The title comes from the storm scene in *King Lear*, and she skilfully and delightfully wove Shakespeare and medicine together.

Her message was to have a care with words, especially if you are an administrator. "Children, we are told by the progressive educationists, should be liberated from the drudgery of traditional learning, and from the need for demonstrating that they have mastered certain skills. That sentence is itself an example of rhetoric. What it means in plain English is that children should not have to do anything they do not want to do, and should not be asked whether they can do anything or not. If you accept the principle, it follows that you professional people should not have to learn any parts of your subject that you do not want to learn, and you must of course make that decision before you are in a position to discover what you might not want to learn. Then, having learnt what you want to learn, whatever that turns out to be, you must not be asked what it is that you have learnt. . . . And I do not know what freedom to choose can mean if one is in total ignorance—as children are—of the nature

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of the possible choices. In this situation, freedom can actually create deprivation."

Professor Kramer continued: "Administration is about people, and words are its tools. To misquote the Bible, 'By their words ye shall know them.' It is our responsibility to see that words are kept sharp, and that they are used to give an accurate representation of the facts, not to divert attention from them . . . to strip away the pomp and expose the intellectual grandstanding that, in the name of liberty and freedom of speech, offers us license to be inconsistent, misleading, muddled and evasive. The disease can be cured, if the physic is taken."

There is surely nothing to add to these two admirable statements. It would be pleasant to think that they might be heeded in the quarters where they are most needed.

The second, by Professor Douglas J. Whalan, was entitled "The Ethics and Morality of Clinical Trials in Man."³ His words, too, were strung together in fine style. He was at pains to say that he could bring nothing new to the debate, but he did it very well. There was the difficulty of drawing a line between treatment and experiment, of balancing society's good from an experiment against the potential harm to the individual, of deciding whether consent to experimentation is ever really informed and freely given. He also considered control of review procedures where "the aim is to ensure societal scrutiny without securing societal strangulation of scientific research." This probably needed at least peer review and publicity, but "I still feel that the best possible control of all in this matter of ethics and morality must be the conscience of the individual investigator."

There was an interesting recurrence of the idea of paying compensation to those injured by experiment. Professor Whalan suggested that if society was prepared to accept the beneficial results of research then it should also accept that the maleficent results should be compensated, and that that should be done as soon as there was proof of damage. It should not have to wait for the aggrieved person to prove negligence or carelessness. He called this "the concept of no-fault compensation." It has been supported in the context of drug evaluation by the World Health Organization.⁴ Such no-fault compensation should not remove the right to proceed against the experimenter for negligence, for if that right were removed it might lead to the pressing of the experiment beyond the bounds of prudence.

First in Field

There is a political will in Australia to get clinical pharmacology on the move as an academic university discipline. On 4 March

1975 the ministers for health and education announced: "Australia could soon become the first country in the world to establish departments of clinical pharmacology in all its universities." The Government will provide the funds for the new venture and the departments will be set up progressively over the next seven years. The ministers hoped that their scheme would provide students with adequate training in the safe and effective use of drugs and would help to reduce poor prescribing and overprescribing and slow down the rapid rise in the drug bill.

Clinical pharmacology as a subject is very hard to pin down and develop clear concepts about. In this it resembles clinical immunology, for both reach out so far into many related disciplines. But there can now be little doubt of the benefit of both when every journal carries something of interest in both fields. How do you plan to take on board a department of clinical pharmacology when the field is so wide and you have no idea of the talents and shortcomings of a professor of whom you have never heard and do not even know if he exists? And we are told that there is a worldwide shortage of those with the required skills. Nevertheless, it can be done and will be done, for with the smell of money in the air all things become possible.

Whenever something new like this begins there are always those who prepare a detailed brief and then expect to shop around to find some paragon who will exactly fit the template which has been designed. It is astonishing how often this happens, for it leaves utterly out of account the qualities of the incoming appointee. When every person in a senior position believes that he has moulded his job to fit in with his own talents it is odd, to say the least, that he does not think anyone else is capable of the same thing. Delegation of power seems to be one of the hardest things to do. We all seem to think that we would be able to do anyone else's job better than he can. This is a remarkable piece of arrogance.

So there will be an influx of clinical pharmacologists into Australia, since there will probably not be enough around in this country for some time. But as the importance of the subject is seen to grow these many departments should be able to spawn their own offspring and perhaps begin to export them.

References

- ¹ Softly, A., and Nairn, M. E., *Medical Journal of Australia*, 1975, 1, 560.
- ² Saltos, N., Ghosh, H. K., and Gan, A., *Medical Journal of Australia*, 1975, 1, 561.
- ³ Whalan, D. J., *Medical Journal of Australia*, 1975, 1, 491.
- ⁴ *Principles of the Clinical Evolution of Drugs*, World Health Organization Technical Report Series, No. 403. Geneva, W.H.O., 1968.

A patient experiences intense pressure and pain in both ears during take-off and landing while flying in ordinary pressurised aircraft; the resulting deafness takes up to three days to clear; the usual measures such as sucking sweets and frequent swallowing have no effect. Are there any other methods of preventing or treating this condition which may be more effective?

Pain in the ears during ascent and descent while flying is indicative of otic barotrauma; pain in the ears on ascent, however, is uncommon, and is often related to excessive scarring and fixation of the tympanic membrane. In the absence of tympanic scarring, or a previous history of chronic otitis media, a thorough search should be made for a nasal lesion—as this is the most likely predisposing factor. Look for appreciable deflection of the nasal septum, allergic rhinitis, polyposis, and any degree of nasal sinusitis. If the symptoms persist, or if no predisposing conditions are found, and the patient has to fly regularly, some symptomatic relief may be obtained by fitting a venting tube, a Shepard's grommet, to each tympanic membrane under a short general anaesthetic. This would permit pain-free flight, but would preclude swimming. If the symptoms are due to chronic tubal obstruction from oedema, a grommet may well relieve this and the

symptoms will end. An ultimate cure, however, is unlikely if there is gross tympanic scarring, although a grommet may well give relief.

A woman found to have Trichomonas vaginalis at a routine check was prescribed metronidazole though she was symptomless. Is this correct therapy? I have found that prescribing this drug leads to suspicion of unfaithfulness between partners.

It is probably justifiable to give metronidazole here because even if she has no symptoms now, they will almost certainly arise if the organism is there waiting to exploit any change in its environment. Most of us tend to gloss over the problem of how a woman becomes infected with *Trichomonas*, though it is highly likely that it is mainly a sexually transmitted disease. Presumably, therefore, when a couple is infected by *Trichomonas*, one of them has had sexual contact of some sort with someone else. Whether the doctor should try to eradicate the known infestation or try to preserve marital harmony if the couple know how the organism is usually acquired is a matter of nice individual judgment.