would be detected at a very early stage and the appropriate treatment could be instituted. In general, the earlier the diagnosis the more effective the treatment. The approach seems at the moment to stand a better chance of improving recurrence and survival rates than is likely to be accomplished by any foreseeable changes in treatment. If used on a national scale, with the original methods, this scheme of early detection would require vast resources. The new simplification may overcome this difficulty and make a development of this nature more probable.

Imported Tropical Disease

"When and where were you last abroad?" is increasingly a question that a doctor must ask his patient. International travel is becoming commonplace, whether on business or holiday, and immigrants also swell the numbers coming to Great Britain from overseas. As a result tropical disease is something for which doctors here must constantly be on the look-out if it is to be detected and tragedies averted. The list of such tragedies is formidable, and letters in this issue of the B.M.J. (page 496) draw attention to the matter again.

Malaria heads the list of tropical diseases to be suspected as a cause of the patient's symptoms. There can be no disease which passes so readily as *Plasmodium falciparum* infection from a condition easy to treat into one that may be hopeless. The point is exemplified by the series of such patients with severe renal failure reported by R. C. Jackson and A. W. Woodruff. It is believed that one or two patients die every year in Britain of malaria which had been unsuspected, and several others have severe illnesses which could be prevented.

Trypanosomiasis is being increasingly encountered here and is seldom diagnosed till late in its course. A recent report described a patient who had been in hospital for four months before the disease was suspected, the illness being ascribed to tuberculosis meningitis. The diverse manifestations of leprosy provide a further source of difficulty, aggravated by the tendency of some patients with the disease to conceal it. Amoebic and bacillary dysentery are both commonly contracted by travellers, and amoebic abscesses of the liver is a frequently overlooked cause of fever and abdominal discomfort. Schistosomiasis with its insidious onset and long latent period is often a cause of obscure genito-urinary and alimentary symptoms. Smallpox, and even cholera, must be kept in mind as possibilities in some cases.

Thus it is most important to bear tropical disease in mind and to ask all patients, as an essential part of history-taking, where and when they were last abroad. B. G. Maegraith has recently given a useful synopsis in a pamphlet distributed by Ciba Ltd. of tropical diseases likely to be imported into Britain. The series of articles appearing at monthly intervals in the B.M.J. may also be of help, even though they are intended primarily for our many readers in tropical countries. A textbook on the subject, such as those admirable volumes by Adams and Maegraith and by Hargreaves and Morrison, finds a useful place on the shelf. But the most important thing is to think of tropical diseases and refer to a specialized centre patients possibly suffering from them. Of these special centres there are three in Britain—the Hospital for Tropical Diseases, London; the Liverpool School of Tropical Medicine; and the Tropical Disease Unit at the City Hospital, Edinburgh.

**Bronchial Neoplasms and Hormonal Secretions**

Neoplasms of the lung may secrete hormone-like substances. Patients with lung tumours may show some of the features of adrenal cortical excess, but the florid clinical picture does not develop, probably because these patients do not survive long enough. C. K. Meadon and colleagues have shown that tumour cells from these patients contain a material identical with or very like adrenocorticotrophic hormone, and the cells may in fact secrete this material. Water retention may occasionally be associated with bronchial carcinoma. J. Lee and colleagues suggested that the water retention is due to the secretion of an antidiuretic material by the tumour cells. Subsequently, Lee and his co-workers extended their investigation and concluded that the antidiuretic material, if not antidiuretic hormone, must be a closely related substance. The evidence is less certain that hypercalcaemia may be due to the secretion of a substance resembling parathyroid hormone by the tumour. The carcinoid syndrome has been described in association with bronchial neoplasms.

True gynaecomastia in males with lung tumours is well recognized, and removal of the tumour leads to a reduction in size of the breasts. Recently F. D. Fusco and S. W. Rosen found that lung tumour tissue removed from patients with gynaecomastia contained large quantities of gonadotropins. These authors considered that the large quantities of gonadotropins released by the tumour cells stimulated the testes to secrete the excess oestrogens which induce the development of the gynaecomastia. Chorionic gonadotropins can induce secretion of oestrogen by the human testes, but the assay preparation used by Fusco and Rosen would respond to any of the gonadotropins. Their conclusion does not take account of the finding that high levels of oestrogen and gynaecomastia can occur separately. As well as lung tumours, neoplasms in other situations are also known to produce hormone-like substances.

Thus a new but rare syndrome has appeared. The rare has always excited the clinician, though an awareness of a new condition may show it to be less unusual than originally supposed. It has already been possible to anticipate the presence of a lung tumour on the evidence of hormonal disturbance. Moreover, the finding that neoplasms may secrete hormone-like substances provides a new avenue of approach in cancer research.


---

1 See *Brit. med. J.*, 1965, 1, 4.