was this March, when a friend staying with her had a relapse in her home.

I hope that this case will help further in stressing the fact that primary malaria can be a factor in diagnosis in this country at the present time, where malarial carriers are more numerous and the Anopheles maculipennis is known to be present.—I am, etc.,


DAVID A. FERMONT.

Congenital Hepatic-duct Malformation

Sir,—The case of congenital hepatic-duct malformation recorded by Dr. Frank Riggal (June 7, p. 824) emphasizes the fact that children born without bile ducts, or with the bile ducts so malformed that they do not communicate with the intestine, survive much longer than one would expect. In Riggal's case the child lived for ten months, and in a large series of cases reviewed by Holm there was one where the child survived for 15 months. The question of operation is worth while considering in cases of atresia, for it may be found that sufficient of the common duct is present to allow of anastomosis to the duodenum. In these cases jaundice usually present at birth or shortly afterwards, but according to Ladd and Gross2 2-3 weeks may elapse before the icteric tinge appears, “whereas the stools are always clay coloured or white from birth.” Further, they state that if operation is delayed for 4-6 weeks there is little chance of error in differential diagnosis.

Anastomosis of the duct to the duodenum is carried out over a small piece of tubing—somewhat after the method of Sir James Walton—and silk is used for suturing. Vitamin K and ox bile salts are administered beforehand in the hope of diminishing oozing.

Ladd and Gross emphasize the danger of post-operative disruption of the wound, and advise the use of silk and silkworm gut for stitching the abdominal wall. In 45 of their cases nine patients were found to have a patent hepatic or common bile duct connected with the intrahepatic ductal system but not with the duodenum; 6 out of 9 cases survived the operation and were in excellent health 12, 8, 7, 5, 4, and 3 years respectively after operation.

Dr. Frank Riggal is to be congratulated on taking the trouble of publishing his interesting case in the British Medical Journal.

I am, etc.,


Michael J. Smyth.

References


E.C.T.

Sir,—Your correspondent who explains (June 14, p. 858) his reactions to E.C.T. is to be highly congratulated for the enlightening description of his experience, and his article should do much towards alleviating the acrimony at present being expressed on the subject. His important contribution lies in the cognizance that the treatment produced a psychosomatic reaction which he himself “identified as the physical reactions to fear,” as it is likely that it is through such identity that he escaped from his troubles. His “memory images” are obviously symbolic expression, which would have been better to have undergone elucidation at the time.

I hope I conflict with neither physician nor psychiatrist when I understand that E.C.T. in this particular case acted by bringing wholly repressed material to a nearer level to conscious appreciation, and that it is probable that it is through such measures that benefit is obtained in all cases that respond to such treatment. Your correspondent’s observations emphasize the further benefit to be obtained by the attendance of a psychiatrist to take advantage of the probability of such response.—I am, etc.,

Tipton, Staffs.

Causalgia of the Face

Sir,—I read with interest Mr. J. A. W. Bingham’s report of two patients suffering from causalgia of the face (June 7, p. 804). Our knowledge of this condition is so incomplete that individual experience is well worth recording. I cannot agree, however, with his conclusion, “that when sympathectomy relieves causalgic pain and tenderness it does so by interrupting the sensory pathway.” It is not proved that sensory (afferent) fibres travel to the spinal cord by way of the sympathetic chain, and secondly one can see that pressure on the superior cervical ganglion can stimulate effenter fibres passing through. “Novocain” block of these fibres at a lower level would produce a temporary paralysis in their peripheral course and distribution and so prevent the occurrence of pain as noted.—I am, etc.,

Salt, Cheshire.

C. H. Cullen.

Reiter’s Disease

Sir,—The annotation on Reiter’s disease (Dec. 7, 1946, p. 865) summarizes the present state of the knowledge of this condition very well. A few points noted in four cases by me (subject of communication elsewhere) are worth mentioning. Though you have quoted several writers as correlating the disease with bacillary dysentery, Jackson’s contrary opinion, which has also been quoted by you, seems to be confirmed by my four cases, none of which had any bacillary dysentery. Further, in India we see bacillary dysentery cases literally by thousands, and yet there are no authentic records of Reiter’s disease. Had the two conditions been aetiologically related there would surely have been more cases of Reiter’s disease in this country.

The categorical statement made by you that “...there is no E.C.T. to sexual intercourse” is not wholly correct. Kristjansen1 described his case in detail in 1930 where the infection was traced to a girl of 16 who for two years had had a yellow vaginal discharge. This girl had also infected another man at about the same time, and the second victim developed only an uncomplicated urethritis lasting three months. In neither man was the gonococcus or any other organism found. The girl herself was examined for a year and was found to have had only an inflamed vagina, but gonococci were not demonstrated in her either. The sexual relationship in these two cases is clear. One of my cases also developed the condition after extramarital coitus.

Neutrophil leucocytosis has been reported in all the cases, but one of my cases had an eosinophilia of 4 to 7% in a total leucocyte count of 11,000 to 13,000. This may mean that allergy is a factor in the disease. This case went through the gamut of bilateral conjunctivitis and arthritis, and the eosinophilia persisted over the earlier part of the illness. The patient did not have any parasitic infection or infestation. The possibility of allergy being aetiologically responsible is strengthened by the observation of Forbes2 that his case was associated with dental sepsis. Junghans3 tells about a case in conjunction with a furuncle in the upper lip, while Fruhwald4 described two cases, in one of which the first sign was urethritis, and in the other, joint pain in the left foot. The example of erythema nodosum being the result of a variety of infective processes may be mentioned as a possible parallel to the incidence of Reiter’s disease following upon non-specific infections.

In none of the four cases observed was the complement fixation test for gonococci done, but gonococci were not found in any of the exudates by the usual staining methods. The tests were repeated many times and under varying clinical conditions.

—I am, etc.,

Bangalore.

P. N. Bardhan.

References


Physical Therapy of Mental Disorder

Sir,—It seems to the mind of an ordinary physician a great pity that there should be a need for bitter and violent controversies on the subject of psychiatry; I refer to the article written by Dr. D. W. Winnicott (May 17, p. 688) and to the replies by Drs. W. Malcolm Miller, Dr. A. Spencer Paterson, Dr. A. Lionel Rowson, Dr. A. N. Hardcastle, and Dr. E. E. Feldmesser (June 14, pp. 861 and 862). Whatever the rights and wrongs of it all may be, it seems to me that always should we be able safely to look to, and to accept, the findings and dicta of fully recognized and really experienced psychiatrists.

Michael J. Smyth.
In my opinion, for what it is worth (I am not a psychiatrist), Dr. Winnicott's article is full of flaws, of wishful thinking, and of aggression. He condemns absolutely the modern physical methods of psychological medicine and is severely taken to task for it, as he should be. If I, practising my own methods of care with the emotional problems and upssets in children and in their parents, do not accept the principles of child guidance, and if I disagree in the main, as I certainly do, with most child psychiatrists and do not recognize the need for many of these, I am entitled to my opinion and quite free to say so. But if out of hand I condemn the whole movement and paint it as quite absurd, I think I should expect to be regarded as aggressive and, in all probability, somewhat frustrated; and I should certainly be incredibly foolish.

I scarcely think that Dr. Winnicott would be prepared to accept without retract my own condemnation (which, however, I do not offer) of the use of psycho-analysis in children, save in those cases which I personally would regard as uncommon. I think I should expect him automatically to express the view that I knew nothing about it—I am, etc.,


MAURICE L. YOUNG.

After-care of Psychiatric Casualties

SIR,—Most doctors are aware of the establishment about three years ago of the official after-care scheme for men and women discharged from the Services for psychiatric reasons. This scheme has been organized by the National Association for Mental Health at the request of the Ministry of Health with the co-operation of the Service Departments, and has provided social supervision for psychiatric casualties as part of their after-care. In them there is no obligation to come in, but in 11,500 patients up to date. The original procedure was that the Service hospitals notified the after-care scheme of those patients who agreed to accept after-care, at the same time informing the patient's own civilian doctor. Subsequently many discharged ex-Service men and women have been brought into the scheme from a wide variety of hospitals and have not asked for admission. In recent months, in response to many requests from other social agencies, Ministry of Labour, Pensions, and Health officials the scheme has accepted responsibility for a number of civilians who are in difficulties in ordinary life because of psychiatric disabilities. It is hoped that the experience gained in this social service will eventually be integrated into the official medical services of the State.

Whereas in 1943 it has been claimed that the general practitioner has been fully aware of the interest of the social workers in his patient, this has not always proved possible. For instance, many patients on discharge from the service have moved to new districts and have not arranged for medical attention for many months after moving; some belong to that floating population which never remains for long with any individual doctor; others belong to the predatory fringe hostile to any form of medical attention, yet nevertheless much in need of help. It has occasionally happened that doctors have felt that their relationship with a patient has been encroached upon by the social worker, of whose credentials they have not always been aware. In the great majority of cases doctors have been happy to use the services of our psychiatric social workers and have co-operated actively, but misunderstandings have occurred.

May I emphasize that this service is intended as an ancillary to medical measures, to aid in the patients' readjustment to life; and we regard it as of the utmost importance that good relationships should be maintained with general practitioners. Clearly, if misunderstandings occur, it hampers the efforts of both parties, and it is the patients who suffer. We have therefore arranged that each new patient referred to the scheme will be the subject of a letter written by the social worker to the doctor concerned. If the doctor has any comment to make or objection to raise he can do so at the outset, bearing in mind that after-care is a voluntary arrangement entered into by the patient himself. If doctors feel any doubts or questions about the validity of the work which the social workers are undertaking, we should be glad if they would ask the social worker concerned to call on them at their convenience to give a full explanation of what the service can offer. If further explanation is needed, I and others of my medical colleagues who are active in this Association will be only too glad to get in touch with the doctors concerned.—I am, etc.,

KENNETH SODDY,
Medical Director,
National Association for Mental Health.

Factors in the Aetiology of Skin Cancer

SIR,—I should like to ask Prof. J. A. Ryle and Dr. W. Russell whether the conclusions drawn from their interesting and instructive paper (June 21, p. 873) which is to be tendered to certain qualifications. Their figures refer to deaths from skin cancer, but the mortality rate from that disease is very low, probably less than 2%, while the disease itself is very common and accounts for a high proportion of all primary cancers.

Prognosis in skin cancer depends largely upon the size of the lesion, and negligence is probably an important factor in relation to death from this cause. I should, in the ordinary course of events, expect neglect of a symptomless lesion to be higher in unskilled workers and labourers (IV and V of the Registrar General's social classes) than in the other groups. Do the figures therefore reveal a fair sample from which to assess the social factors or occupational factors in the aetiology of skin cancer?—I am, etc.,


JOHN T. INGRAM.

Ulcereated Nasal Septum

SIR,—As medical officer to a large engineering firm, and during routine examinations of men who were working on picking vat containing sulphuric acid, I found that eight men were suffering from the nasal septum. After treatment I tried petroleum jelly and lanolin, but the result was far from satisfactory. I changed the treatment after four days to creomor penicillin with "phenoexol," and within forty-eight hours there was a definite improvement, and in twelve days with the exception of one case, the other cases were completely cured.—I am, etc.,

Leeds.

JOSEPH RADNOR.

Calculation of the Colour Index

SIR,—It was certainly the publication of Dr. R. Elsdon Dew's paper (May 24, p. 723) which would lead to your receipt of a rather long letter asking for the help of the colour index. Admirable and well-meaning though Dr. H. Levy's intentions may be, the widespread adoption of his suggestions (June 21, p. 903) in routine haematology would be regrettable, as not only does the use of the haemacrit involve vein puncture in a case where the life of the patient may later depend on the integrity of that vein for blood transfusion, but it tends to confound the haematologist, who, noticing for example marked polychromasia, "ghost-cells," spongy platelets, and other abnormalities in a routine blood count, then proceeds to carry out reticulocyte counts, fragility and haemacrit determinations, and on the whole as his judgment backed by his clinical findings may dictate.

During the war years, when the country was flooded with innumerable varieties of lend-lease colour standards, each with its own level of normality, the use of the term "grammes %" was probably justifiable and even desirable. The colour index of the Haldane scale is ideally suited for routine purposes, and with certain well-known exceptions normality is represented by unity and the patient referred to the rank 0.9 to 1.05 as retaining an accurate counting—probably pathological and certainly worthy of further investigation. The colour index is also a valuable guide to treatment of anaemias, where to subject the repeated vein punctures would be wholly unjustifiable. Any improvements in the science of haematology should follow the lines of establishing specialist haematology departments in hospital laboratories, where the worker recognizes the abnormal by reason of his or her wide experience of the limits of normality.

W.1.

JOHN T. INGRAM.