the food used (a sandwich) produced sensations of hunger, a tight sensation in the epigastrium, and increased salivation—all symptoms of increased vagal activity.

Many appetite-depressing drugs are sympathomimetic, and may well prevent the fall in free fatty acids which apparently occurs at the sight of food. Hence if appetite is partly dependent on a fall in the free fatty-acid concentration in the serum a more precise method of depressing appetite might be to prevent this fall from occurring. Moreover, if it was found possible to achieve this by increased mobilization of fatty acids from adipose tissue the patient would lose weight this way as well.

Heart Failure in the Newborn

Cyanosis at birth or shortly after is not uncommon and may have a variety of causes. Occasionally respiratory distress is associated with obvious signs of heart failure. The presumptive diagnosis of congenital heart disease is likely to be correct, but rarely there may be other explanations.

Describing three cases of heart failure in newborn babies (all girls) with anatomically normal hearts, O. P. Gray and R. Prosser⁴ consider the condition to be secondary to brain damage. Their first patient was cyanosed and hypotonic, with an enlarged heart, hepatomegaly, rapid respirations, central cyanosis, and bilateral crepitations. With treatment the baby made a gradual recovery, but was still hypotonic at eight months. The second child was anoxic and stuporose, with absent Moro, sucking, and grasp reflexes, and again with an enlarged heart and liver. There is no mention of hypotonia. This child also made a gradual recovery on treatment of the heart failure. The third infant was the younger sister of the second and showed cyanosis, respiratory distress, and an enlarged heart and liver. She was hypotonic, with absent reflexes. The child died at 45 hours, and necropsy showed cerebral oedema, subarachnoid haemorrhage, and coning of the brain, with a very large heart but no anatomical abnormality.

The first two babies had had normal spontaneous vertex births, but the one that died had been a breech delivery and forceps had been applied to the aftercoming head.

It is tempting to accept that the cerebral findings at necropsy were the cause and not the result of the heart failure. In adults, rapidly progressive intracranial lesions, and particularly cerebral haemorrhage, may be associated with pulmonary oedema, heart failure, and grossly abnormal electrocardiograms, but with a normal heart and no evidence of coronary occlusion.⁴ On the other hand heart failure in association with anoxia may give rise to cerebral oedema and haemorrhage.⁵ It has also been shown that asphyxia can lead to an increase in heart size.⁶

Two of the children described by Gray and Prosser were noted to be hypotonic. Congenital non-progressive myopathy, or "benign congenital hypotonia," or occasionally dystrophy myotonica and Werndig-Hoffmann disease may present in the neonatal period; indeed intraterine movements may be noted to be diminished. Difficulty with


Malignant Melanoma

The recent adoption of a more optimistic attitude about the prognosis in malignant melanoma has led to a critical reappraisal of the results of therapy. Most recent published series⁷ of 100 or more patients quote a five-year survival rate of over 50%, but if treatment is delayed or inadequate this falls to 20%. Clearly it is important that the best treatment is started as soon as the diagnosis is made.

About 40%,⁸ of malignant melanomata arise in a pre-existing lesion which has undergone a definite change. For example, the lesion may have become larger, darker, lighter, or mottled; it may have developed a halo of pigment, bled, ulcerated, or become crustose. Both trauma⁹ and sunlight¹⁰ have been incriminated as causes of this change. Pigmented lesions on the palm, sole, and face should also be suspected of being malignant. Nevertheless, misdiagnosis on clinical grounds may occur in half of all cases,¹¹ and in particular melanoma may be confused with pigmented types of basal cell carcinoma, seborrhoeic wart, and cellular naevus, as well as pyogenic granuloma, cysts, and whitlow. Hence radical surgery should be delayed until the diagnosis is proved, but the latter should be done using excision-biopsy and not a biopsy that entails cutting through the tumour.²³

With the diagnosis proved histologically—and this is not always easy—an excision wide enough to require a skin graft is essential, and this should follow the excision-biopsy with the minimum of delay. If enlarged lymph nodes cannot be felt and histological examination shows that the melanoma is confined to the cutis and has not penetrated below the level of the sweat glands, block dissection of the draining nodes is unnecessary—since the five-year prognosis is not improved by this procedure.²⁴ It is hoped that on the other hand lymph nodes are palpable, or histologically the infiltration is found to have

occurred deep into the dermis, a block dissection is often performed—though it has been found that the prognosis is not greatly improved. Some believe that all metastases should be tackled vigorously, but both primary and secondary tumours may disappear spontaneously, a feature that may explain the occasional remarkable results of radical surgery in apparently hopeless cases. Moreover, survival for five years is no guarantee of cure, for in this disease possibly more than in any other the metastases may appear after a long delay.

A better guide to prognosis in those receiving early and adequate treatment is probably the clinical appearance when first seen. Melanomas on the trunk, foot, and hand; those that have ulcerated; and those with palpable and histologically affected lymph nodes, all carry a poor prognosis. Women in general have a better prognosis than men because most of the lesions in the former are on the face and leg. Those patients with a history of over a year and lesions less than 2 cm. in diameter have a good prognosis. Pregnancy is now discounted as having an adverse effect on the prognosis.

Most published reports about the prognosis of malignant melanoma have included malignant lentigo, which has a very good prognosis, so that the overall survival rate is improved according to the proportion of this type of melanoma in the individual series. Malignant lentigo appears in people over 50. In 70% of cases it is on the face, starting as a brown macule which spreads peripherally and irregularly and becomes mottled. The appearance of an indurated area, nodule, horn, or crust—which may take from 2 to 40 years—suggests the development of a malignant melanoma. Hence the patient should be kept under observation, though extensive excision is probably unnecessary. The macule including the malignant melanoma should be excised, but the size and site of the lesion and the age of the patient often preclude the recommended wide excision.

The incidence of malignant melanoma is about three per 100,000 people per year, making it a relatively rare tumour. Nevertheless, a high degree of suspicion by all doctors should improve the prognosis even more, and possibly permit it to approach the figure of 100% survival at 5 years recently quoted for stage-I tumours.

Phenobarbitone and the Shoulder-Hand Syndrome

The total amount of phenobarbitone that has been consumed by anxious, sleepless, or epileptic patients must be formidable, and it would have seemed improbable that any undesirable side-effects of the drug remained to come to light. Yet an association between barbiturate treatment and the shoulder-hand syndrome has recently been suggested.

The authors were struck by the spontaneous development of severe bilateral shoulder pain and diffuse swelling and atrophy of the soft tissues of the hands in three epileptic patients on phenobarbitone. This unusual finding prompted an analysis of 75 patients with the shoulder-hand syndrome attending the University Hospital in Leiden. It unexpectedly showed that 33 patients had received phenobarbitone before or during the development of this curious syndrome. In most of them the syndrome was bilateral. Duration of treatment had varied from a few weeks to more than 20 years and was longer in cases of bilateral than unilateral disease. The acute symptoms—burning pain and stiffness, oedema, and hyperhidrosis—lasted from three to nine months and were followed by atrophic changes in the hands with finger contractures.

The authors state that continuation of phenobarbitone after the onset of the syndrome did not appear to alter the prognosis.

Arthralgia during barbiturate treatment was first described over forty years ago but is not commonly seen. Perhaps this recent clinical observation associating barbiturate medication with the shoulder-hand syndrome will provoke wider recognition of it.

Public Health Dispute

On 1 March the Minister of Health was asked to intervene in the dispute between the two sides of Whitley Committee C over the failure to review the pay of public health medical officers. He has refused to do so, and at an emergency meeting on 7 April the Public Health Committee asked the B.M.A. Council to take action to support it in this dispute. (See Supplement, p. 17.)

Public health medical officers form the third branch of the N.H.S. Their pay and terms of service are decided in the Medical Whitley Council Committee C, which was set up for this purpose. Ever since their exclusion from the terms of reference of the Royal Commission on Doctors' and Dentists' Remuneration ten years ago doctors in the public health service have asserted that they should be treated like other doctors in the N.H.S., and that their pay should be reviewed whenever the Review Body reports. Mr. Dennis Vosper, Minister of Health at the time of the Royal Commission, promised them as much—as we pointed out last month—but Mr. Robinson denies this in a letter we print at p. 18 of the Supplement. Public health doctors are now the only sizable group of doctors in Britain who have had no review of pay since the Seventh Report of the Review Body in May 1966.

Doctors in all branches of medicine will wish to support their public health colleagues at this time, for two very good reasons. Firstly, if the profession as a whole fails to look after its minorities, these will always be in danger of being sacrificed to Government expediency. Secondly, unless all practising doctors are treated as such—and not just as employees of local authorities or industry—then good doctors will not be attracted into these fields.

Recruitment in public health is already difficult because of uncertainty about the future. The Royal Commission on Local Government is sitting; the reports of the Kilbrandon and Mallaby Committees and the published evidence to the Seebom Committee all suggest that widespread changes are going to be made in local government services in the '70s. In the last two years doctors in the two major branches of the N.H.S. have demanded a fresh look at their conditions, and have got some reforms. Doctors in public health feel that they too need a new deal, with a fresh career structure and scope for the practice of modern preventive medicine.

2 Maillard, G., and Renard, G., Presse méd., 1925, 33, 315.
3 ibid., Supplement, 1966, 1, 237.
4 ibid., Supplement, 1966, 1, 60.
5 ibid., Supplement, 1967, 2, 10.