tographers of whom Emil Kraepelin and Eugen Bleuler are the outstanding examples. In 1898 Kraepelin, misguided as it happens, coined the term “dementia praecox” in an attempt to separate those mental illnesses leading inexorably to an irreversible mental deterioration from the affective psychoses, which did not. Bleuler, in 1911, corrected this misconception, and in his monumental work¹ spoke of “the group of schizophrasias,” admittedly including dementia praecox, but also other varieties of the symptom complex in which dementia in the true sense of the word did not of necessity take place.

With succeeding decades the plurality of Bleuler's nosological concept has tended to be forgotten and psychiatrists have used, or misused, the term as though it were a single, specific disease-entity lending itself to rigorous definition, to a precise catalogue of symptoms, and with a known aetiology, life history, and prognosis. Were these data in fact available, the road to a rational form of treatment would have been laid long ago. Unfortunately, as is well known, this happy state of affairs is still awaited. The agony of the situation is increased by the fact that despite acres of publications on the subject of “schizophrenia” there is no single interpretation of the term, not only among psychiatrists in different countries but among those in the same country. Something approaching the same lack of precision applies also to other psychiatric diagnoses.

It is important, therefore, before real progress can be made to attempt to measure the gap in the understanding by psychiatrists both at home and abroad of diagnostic and technical terms by which they purport to communicate with each other. To what extent, in other words, do they all call a spade a spade? Do some, merely as a matter of linguistic nuance call a spade a shovel? Or do others see a spade as a spade but call it a pick-axe? It is encouraging to learn that efforts are being made to sort out the mess. Foremost in this field of research is the conjoint U.S.—U.K. Diagnosis Project located at the Maudsley Hospital, London, whose workers have recently published two papers which complement each other closely. The first² compares the differences in the use made of diagnostic labels and in the rating of symptoms between some 200 psychiatrists in seven centres in the United Kingdom and Eire, using their observations on three video-taped psychiatric interviews. Diagnostic agreement between the United Kingdom and Eire psychiatrists was quite good when they were grouped by their place of training. Even so, Glasgow stood out in that psychiatrists who trained there had “a significant tendency to make a diagnosis of affective illness in one of the tapes where the choice of diagnosis was between affective illness and schizophrenia.”

The second³ investigation was again confined to psychiatrists working in centres in the United Kingdom and Eire using the same method of video-taped psychiatric interviews. The uniformity of language and culture between the 200 and more participants is, rightly or wrongly, assumed. The purpose of the investigation was to study the similarity or otherwise of the provisional diagnosis made and also the degree to which psychiatrists can communicate with each other in their own technical language. The results show that “though differences in rating habits among British [sic] psychiatrists are not alarming, some differences do exist between centres of training, and they suggest areas for further study.”

As a corollary of these conclusions the authors stress the practical implications of obtaining information on the behaviour and diagnostic habits of psychiatrists “both because of the increasing effectiveness of therapeutic methods requiring adequate descriptions of patients for their assessment, and because of the basic importance of epidemiological studies needing accurate and repeatable methods of symptom rating and diagnosis”. This is a tough assignment, but until it is completed psychiatry will continue to lurk from one empirical method of treatment to the next.


Brachial Cysts

Brachial cysts arise from time to time as a result of budding from the bronchial pathways during the process of development. Most of the bronchial branches are already formed by the fifteenth week of fetal life, but they continue to divide, reaching completion in about the eighth year of life. Though bronchial cysts have been observed in stillbirths and are well recognized in babies and infants, they may not be detected until adult life. Hence the term congenital, implying that they existed at birth, would seem to be inappropriate despite common usage. They may safely be regarded as developmental in origin. The term bronchogenic is erroneous in describing these cysts.

The cysts measure up to about 10 cm in diameter. Their walls are sometimes thin, comprising little more than connective tissue and bundles of smooth muscle. They may contain cartilage, mucous glands, and fibrous tissue. The existence of cartilage often distinguishes them from other simple mediastinal cysts. Uninfected cysts are filled with clear, yellowish, or opalescent fluid containing epithelial debris. In the mediastinum the cysts are almost always solitary. In the lungs they are occasionally multilocular or multiple, and multiple cysts may occupy a segment of a lobe, a lobe, or even the whole of a lung.

Cysts of the mediastinum are commonest in the middle third of its length and may be predominantly paratracheal, carinal, hilar, or paraoesophageal. Wherever they are situated they tend to adhere to adjacent structures. As they enlarge, they may cause symptoms of compression. A few become infected and rupture into a bronchus, causing a mucopurulent sputum, haemoptysis, and fever. Clinical features vary from none to rapidly progressive respiratory distress. In early childhood, anorexia, dysphagia, cough, and noisy breathing may be quickly followed by extreme dyspnoea as a main or lobar bronchus becomes compressed, with distal hyperinflation or collapse of the lung. In such circumstances emergency thoracotomy with removal of the cyst may save life. An extension of the cyst upwards between the trachea and oesophagus may cause progressive dysphagia. Later in childhood and in early adult life the presenting symptoms are similar in kind but are usually less dramatic. They respond equally well to surgery.

The diagnosis of mediastinal bronchial cysts may be greatly facilitated by radiology. While small cysts are invisible, they may be inferred by associated pulmonary hyperinflation or collapse. Larger cysts appear as smooth, round, or oval opacities; tomograms may assist in delineating them. Bron-
Chorophy and barium swallow may show pressure defects. An infected cyst with a bronchial fistula may show a fluid level. Calcification is not a feature. Bronchoscopy does little more than confirm external bronchial compression, but is a necessary investigation when the diagnosis is in doubt.

Bronchial cysts within the lungs tend to have thin walls and to lie peripherally. They are sometimes discovered on routine chest radiography. They often have a bronchial communication and most of them become infected sooner or later, typically in early adult life. When this happens, the clinical features are those of a lung abscess, with cough, mucopurulent sputum, haemoptysis, and fever; radiographs may show a fluid level. Appropriate antibiotic therapy will lessen the extent of the inflammation but is most unlikely to effect cavity closure. The cysts should be surgically removed, if possible by segmental resection.

While the description of bronchial cysts is comparatively simple, preoperative diagnosis can rarely be made with certainty. In the mediastinum a small radiologically invisible cyst should be suspected, at least in early childhood, when respiratory distress is associated with unilateral pulmonary hyperinflation or collapse. Larger radiologically visible cysts rank rather low in the long list of causes of rounded opacities in that region. Fortunately, the means of differentiating most of them is available; when doubt exists, a thoracotomy is ordinarily indicated. Pulmonary cysts also cause diagnostic difficulties. The possibility that a solitary rounded opacity is malignant cannot always be eliminated. Chronic lung abscesses which do not give positive proof of their identity or respond fully to medical treatment may provide evidence of their bronchial origin only on microscopy after resection.


Tests of Acupuncture

Scratching is giving place to astonished incredulity at some of the demonstrations of acupuncture analgesia. How many English patients sip China tea, exchange pleasantries with the bystanders, and then climb off the table unaired after a thoracotomy?

It is as a system of treatment that acupuncture has been developed in China over the past 3,000 years. There are held to be certain points on the body surface where penetrating stimulation or irritation may influence disease in a distant viscus. These points are termed meridian points and they bear no obvious neuroanatomical relationship to a particular viscus. For example, a “gastric meridian” of connected points goes across the right side of the face and neck, perpendicularly down an approximately mid-clavicular line, down the right leg to the second toe. The identification of these points and their relevance to treatment is an esoteric and far-fetched exercise, especially when the diagnostic evidence of disease is so unconvincing. Stimulation comprises the deep insertion of a fine needle, which in the traditional fashion is twisted manually. Electrical stimulation is claimed to be as effective and more convenient, since the process may take 30 minutes or more.

Clearly it is tempting to dismiss the technique along with the intuitive nonsense that formed the basis of mediaeval medicine in Europe. Nevertheless, insistent reports about the success of, for example, acupuncture analgesia suggest that it deserves more serious study. One recent attempt to identify meridian points electrically in animals has been reported from the Hahmemann Medical College, Philadelphia.1 The investigators used a galvanometer to identify points of increased skin resistance on the abdominal skin of rabbits, believing them to be meridian points. They identified similar points in the gluteal region and applied a small electrical current (12 V and 200 μA) for 30 minutes through an acupuncture needle (0.24 mm diameter) inserted 1 cm into a gluteal point. They report not only that the electrical resistance increased at meridian points on the abdomen after vagotomy, but also that acupuncture stimulation postoperatively caused a reduction in this resistance. Their report also suggests that bowel atony was relieved more quickly and mesenteric circulation improved. Unfortunately this study had a number of methodological deficiencies: the observations were not made “blind,” the effect of randomly inserted needles was not studied, and the numbers were too few (four groups of six rabbits) and raw data too scanty to allow scientifically valid conclusions.

Doubtless the acupuncturist is as skilled at exploiting the credulity and suggestibility of his patients as many orthodox medical practitioners, and this may be the basis of some of the success claimed in treatment. Conceivably acupuncture analgesia may in certain circumstances have a similar derivation, but this seems unlikely to be an invariant feature. An alternative explanation is that there are neurophysiological mechanisms whereby peripheral stimulation has distant effects at either a thalamic or a subthalamic level. Analgesic applications deserve study by both neurophysiologists and anaesthetists, and it would be a pity if it were inhibited in Britain by its unorthodoxy. Perhaps the Medical Research Council might initiate a preliminary scientific investigation.


Glove Powder: A Surgical Hazard

In 1947 the modern commercially available surgical glove powder came into widespread use after a paper suggesting it was biologically inert.1 Experiments on dogs showed that it produced little or no reaction when introduced into the peritoneal cavity, and it compared very favourably with talc, which was in general clinical use at that time. Not only did talc produce experimental peritoneal lesions but there was ample evidence which showed it to be responsible for wound granulomas, intestinal fistulae, and peritoneal adhesions and nodules in patients.2-3

Unfortunately the initial hopes that the new glove lubricant would prove inert in clinical use have proved wrong. The main constituents of this powder are corn starch and magnesium oxide. In 1955 two patients were reported in whom corn starch powder was undoubtedly responsible for wound granulomas,4 and in 1956 there appeared the first report of starch granuloma peritonitis.5 By 1965 the sixteenth case of starch granuloma peritonitis had been reported.6 Most of the original observations appeared in the U.S.A. but recently reports have appeared in the British journals with increasing frequency.7-9