Kingdom asking about the legal position of medical practitioners travelling on an airline other than their provincial flag-carrier, or British Airways in my case.

The deputy registrar replied:

The Council has no information about the requirements for obtaining a temporary registration, or licensure, in the circumstances you describe. . . . As you will have appreciated, questions relating to registration, or licensure, of medical practitioners in countries overseas is a matter for the appropriate authorities in the countries concerned. I can only suggest, therefore, that you should seek further information from those authorities.

There are arrangements within the European Economic Community which permit persons who are established for registration in one of the Member States to render medical services temporarily in another Member State, without relinquishing registration in their country of origin or establishment.

I understand that the airlines were to discuss licensing at one of their regular international meetings, such as the congress in Montreal held in September 1980. The head steward was certainly comforting to Dr. Handa at that time, but legally he may not have been on strong ground. Can this issue not be resolved by "global agreement"?

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Plantar fibromatosis

To the editor: Plantar fibromatosis is a curious entity probably related to palmar fibromatosis or Dupuytren's contracture. The lesion usually starts as a tender subcutaneous nodule, and other nodules subsequently appear, usually in the medial half of the plantar fascia. Plantar fibromatosis rarely causes a contracture. Microscopically, it is a proliferative fibroblastic lesion, the nodules usually blending gradually with the surrounding fascia.

This is probably a rare condition; I have seen only two cases. In both patients the nodules recurred following excision of the plantar fascia in one foot. In one patient the local tenderness settled slowly over a 2-year period. In the other patient both the recurrent nodules and the nodules on the other foot remained very tender. There was no response to physical therapy or to various anti-inflammatory drugs, such as naproxen, fenoprofen calcium and phenylbutazone. However, when the patient started taking Orudis (ketoprofen), 50 mg twice a day, for low back pain, the tenderness was immediately relieved. When the Orudis therapy was stopped the tenderness returned, and it was again relieved when the Orudis therapy was restarted. She has been taking Orudis with complete relief of symptoms for 4 months.

It is not clear if this is an idiosyncratic reaction or if Orudis has some hitherto undescribed effect on plantar fibromatosis. One swallow does not make a summer, and, unfortunately, I have been unable to find any other swallows with painful plantar fibromatosis.

I ask that readers of the Journal who have such patients try Orudis and let me know the results, be they good, bad or indifferent.

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"Anatomy of an Illness as Perceived by the Patient"

To the editor: In his review of Norman Cousins' book entitled "Anatomy of an Illness as Perceived by the Patient" (Can Med Assoc J 123: 38, 1980) CMA Director of Publications David Woods admits a rather tongue-in-cheek, but only mildly critical, attitude. A similar tone was evident in the critique by the late editor of the New England Journal of Medicine, Franz J. Ingelfinger, in 1976, when that journal published most of the book's pertinent material. Much of the deference accorded to Cousins accrues to his eminence as a man of letters and as a supporter of many worthwhile liberal causes.

However, important questions are being asked about the medical profession's essentially uncritical support and appreciation of Cousins' views. As an example, I recommend the article by Ruderman.
The scientific, social, medical and ethical issues involved in Cousins’ book are important. Ruderman suggests that approbation of Cousins’ views may well stem from the needs of doctors “to escape from the complexities and frustrations of medical diagnosis and treatment; they, too, want the cheerful certainties of a pseudo-philosophy in place of the unending search of science.” Furthermore, she states that “medicine must bear a responsibility for creating ‘heroes’, ‘experts’, and ‘therapies’ with such morally and intellectually dubious foundations.”

It occurred to me that Ruderman could just as easily have been talking about Sigmund Freud. Despite dwindling numbers, there are still many psychoanalysts who hold fast to Freudian theory, despite debatable corroboration and much devastating criticism, replete though it is with subjectivism and inconsistencies and with logical and empirical mistakes. For these psychoanalysts, abandoning the myth of Dr. Freud as a guru would mean forsaking the notion that they can perceive their patients as categorized in an all-encompassing, albeit ambiguous, metapsychologic theory. This is not to suggest that we should not continue to honour individuals whose beliefs we can no longer consider bowel involvement than advanced disease.3,4

Whenever new theories arise, whether from laypersons or from within the medical profession, what are required are fewer heroes and more science.

References


Warning against products containing bismuth subsalicylate

To the editor: For many years bismuth subsalicylate has been an ingredient in products for the treatment of minor gastric and intestinal complaints and diarrhea. It was considered that bismuth subsalicylate was not absorbed from the gastrointestinal tract. However, in the July 25, 1980 issue of the Medical Letter on Drugs and Therapeutics it was reported that in six fasted men given a dose of a proprietary product containing bismuth subsalicylate approximated those following an analgesic dose of acetylsalicylic acid.

Products containing bismuth subsalicylate are sold in Canada under the following brand names: Pepto-Bismol liquid and tablets, Rawleigh Pleasant Relief and Watkins Settelz. A product called Stress Liquid may soon appear on the market. These products should be avoided by patients undergoing oral therapy with anticoagulants, sulfipyrazone, probenecid, methotrexate or medications with high levels of salicylate; patients with gastrointestinal ulceration or hemophilia; young children; persons sensitive to salicylates; and others in whom salicylate may be hazardous. Manufacturers will henceforth be required to include an informative and precautionary statement on the labels of these products.

Large doses of Pepto-Bismol have been advocated by DuPont and colleagues5 for the prevention of travelers’ diarrhea. For patients in whom salicylate may be hazardous, prophylaxis or treatment with an alternative preparation is suggested.

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References


Use of carcinoembryonic antigen in follow-up of patients with ovarian carcinoma

To the editor: About 20% of patients with ovarian carcinoma have high levels of carcinoembryonic antigen,1 and in most of them histologic specimens show a mucinous tumour and advanced disease.2-4

Of 132 patients with ovarian cancer the levels of carcinoembryonic antigen were high (5 ng/ml or more) in 29 (22%) — 15 of the 20 with mucinous ovarian cancer and 14 of the 112 with nonmucinous ovarian cancer. Of the 20 patients with mucinous ovarian cancer the level of carcinoembryonic antigen correlated with the clinical status in 16. On the other hand, among the patients with nonmucinous ovarian cancer, levels greater than 5 ng/ml were often associated with bowel disease, such as diverticulosis (in two patients), intestinal obstruction (in four) and a second primary carcinoma (in one, in the colon).

Thus, increasing levels of carcinoembryonic antigen in patients with nonmucinous ovarian cancer, which is not usually associated with high levels, more commonly indicate bowel involvement than advancing disease.

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