Correspondence

Because of heavy pressure on our space, correspondents are asked to keep their letters short.

Vaccine Against Poliomyelitis

SIR,—Your issue of June 1 may be kept in gilded covers, for in it the report of the Poliomyelitis Vaccines Committee of the Medical Research Council is published (p. 1271), and, with the cool objectivity of a scientific survey of this nature, the dawn is announced of the day which will see new epidemics of paralytic poliomyelitis no more. Among the 148,684 children from 1 to 9 years of age who received two injections of the British-prepared (Glaxo) vaccine within less than three weeks 2.7 per 100,000 suffered from paralytic poliomyelitis, whereas among the non-vaccinated over 14 per 100,000 were affected.

These figures from the well-planned trial may be compared with those included in the report on the 1956 poliomyelitis outbreak in Chicago¹ submitted by the Chicago Board of Health. Both the British and the Chicago analyses show that no paralytic poliomyelitis occurring in vaccinated children had any connexion with the vaccination, as paralysis did not occur in the inoculated limb. From June 28 to October 4, 1956, Chicago had 1,111 cases of confirmed poliomyelitis of which 835 were paralytic. During the spreading of the epidemic vaccination was intensified, and by the first week of October, of the 1,150,000 children in Chicago up to 19½ years of age, 125,000 had had no inoculations of Salk vaccine, 125,000 had received but one inoculation, 600,000 had had two inoculations, and 300,000 children had received three inoculations. It is impressively convincing of the effectiveness of the vaccine that in the non-vaccinated group of children the paralysis attack rate per 100,000 population was 358.4, in the children who had had one inoculation 154.4, in those who had received two inoculations 14.2, and in the children who had obtained the full course of three injections 0. Even though if not absolutely certain it also appears that the intensive inoculation during the epidemic contributed to the unexpected short duration of the outbreak.

On the basis of these two experiences we seem to be well on the way, given sufficient vaccine, to eradicate the outbreak of the most severe, extensive, and expensive of the crippling diseases. But a serious effort must be made at the present to rescue as many as possible of those who, like the hero in Remarque's famous novel *All Quiet on the Western Front*, may be struck the day the war ended.

As you well said in your leading article of May 25 (p. 1229), until our production of vaccine is sufficient to cover all the urgent requirements, there is certainly a strong argument for importing the best brands of American vaccine if that is possible. If such vaccine was available in sufficient quantity—and I am told that it is—only an unsound financial reason may prevent its importation, but this should not deter the authorities, as if this year we were to have, say, 5,000 paralytic cases without vaccine and only 1,000 after appropriate inoculation, the reduction in expenditure for hospital bed occupation, treatment, and instrumentation will be a profitable investment, as many of these patients cost the taxpayer more than £1,000 each year until they are—if they ever are—beyond the responsibility of the Health Service. After nearly 100,000,000 inoculations without mishap in America and Canada of the Salk vaccine since the Cutter incident, no one could object as to the safety of the American vaccine as prepared by the best drug firms. I do not see any other reason which could be adduced against the immediate use of the American Salk vaccine, as in matters such as these national pride is not involved, the virus being an international aggressor and the vaccine being prepared with the same virus. The only thing which here would be national would be the victims.

Being in daily contact with the present ravages of the disease I have had my grandchildren vaccinated with three inoculations of the American (Parke, Davis) vaccine sent to me by a kind American colleague. It would be dishonest that we, the medical men who know, protected our families and that the bulk of the population was left waiting until enough vaccine is produced in our laboratories. If that was to occur the National Health Service would not be a service but a liability.—I am, etc.,

Oxford.

J. TRUETA.

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- ¹ Bundesen, H. N., Graning, H. M., Goldberg, E. L., and Bauer, F. C., *J. Amer. med. Ass.*, 1957, 163, 1604.

Choledochoduodenostomy

SIR,—The paper on this subject by Mr. J. P. Hosford (*Journal*, May 25, p. 1202) will be of considerable interest to all those who have to carry out bile duct surgery. It may not be inappropriate, therefore, to consider the history of this operation, and previous experiences of its results. This may serve to emphasize some of the points raised in the paper.

Riedel was probably the first to do the operation (1890). Finsterer¹⁻⁴ in 1952 reported 233 cases where the operation had been carried out, largely for a suppurative cholangitis, or where white bile was present. His immediate mortality was 8%. No ascending infection was observed in any of his cases when followed up from 5 to 25 years. Three were reported not cured and eight had continued "slight" symptoms. In two of the three cases which were not cured, the stoma had become closed. He insisted that troubles arising after this operation were due to a small stoma, which *must be bigger than 2 cm.* Plenk⁵ reported on 95 cases he had treated privately, with one post-operative death. Seventy-one of these cases had a frankly purulent cholangitis. He also described 293 hospital cases and he states that no case of ascending cholangitis had been encountered in any of these. He said that purulent cholangitis would be cured if the stoma was large enough, as the most important thing was drainage. Becker,⁷ in reporting a number of other cases, put forward the theory that purulent cholangitis is not an ascending infection, but descending, and that all such cases were rapidly improved when the bile could escape freely into the duodenal lumen. Waltman Walters⁸ states that in choledochoduodenal anastomosis cholangitis is *not* the result of duodenal reflux into the biliary tract. Recurring pain, with or without jaundice, chills, or fever are the result of varying degrees of obstruction at the anastomosis. Kjaergaard⁹ carried out the operation for 12 cases of the "post-cholecystectomy syndrome," where severe colic, in the absence of common duct stone, occurred after cholecystectomy. Six of them were much improved, and none had any complications from the operation.

Professor Milnes Walker first called my attention to the possibilities of this operation in 1947, since when I have carried it out in 31 cases. I have followed up another 19 cases, with the kind permission of surgeons in this area. The only case where there has been evidence of cholangitis is one where a stoma of 1 cm. in size was made. Apart from this case, all have a patent stoma as shown by barium meal, or by gas in the biliary tree. In some cases considerable pressure has to be exerted in order to get the barium up the duct. Three cases have persisted with what appears to be biliary pain, and in one of these a small filling defect can be seen on the skiagram—presumably a stone just above the ampulla of Vater. The patient does not wish any further surgery to be done, as the attacks of pain are infrequent and do not seriously inconvenience her.

I have found the results following this operation to be better than those after dilatation of the ampulla, or of transduodenal section of the sphincter—i.e., internal choledochoduodenostomy. The anastomosis should never be done unless the common bile duct is obviously dilated, and the best results will occur where the wall is thickened and white in colour. It has been my practice to fold back the duodenum covering the common bile duct until pancreatic tissue is

reached, in order to divide the common bile duct as low as possible. The stoma should be at least an inch (2.5 cm.) in size, and so far I have not had any biliary leak. The gall-bladder, of course, must always be removed. The pressure in the common bile duct even after cholecystectomy is much higher than that in the duodenum, and it is probable that there is no reflux of food through the stoma under ordinary conditions. This is in contradistinction to a cholecysto-gastrostomy, where pieces of food debris have not infrequently been found in the gallbladder at a later operation. A small but definite percentage of these biliary cases have an achlorhydria,¹⁰ so it must not be presumed that the duodenal contents are necessarily sterile. One of my cases developed a severe infective hepatitis; it is problematical whether this was due to the degree of ascending infection or was merely fortuitous.

In any biliary operation it is impossible to draw firm conclusions until many years have passed, but from my observations it does appear that the operation may be of real value in cases of common duct stones, especially if a purulent cholangitis or any degree of stenosis is present, or if the pancreas is harder than normal. The convalescence in these cases is surprisingly rapid. I must thank a number of surgeons in this area who have permitted me to review their cases.—I am, etc.,

Bristol.

W. M. CAPPER.

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- ² — *Zbl. Chir.*, 1942, 69, 1290.
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- ⁶ Hartl, H., and Rindl, W., *Wien. med. Wschr.*, 1951, 101, 444.
- ⁷ Becker, B., *Brun's Beitr. klin. Chir.*, 1950, 180, 45.
- ⁸ Walters, W., *A.M.A. Arch. Surg.*, 1954, 68, 12.
- ⁹ Kjaergaard, S., *Acta chir. scand.*, 1952, 104, 97.
- ¹⁰ Butler, T. J., personal communication.

SIR.—Mr. John Hosford (*Journal*, May 25, p. 1202) advocates this operation for stones in the common bile duct under certain circumstances, and records his experience in 21 cases. Some years ago I took a similar view, and I expressed it in a Hunterian lecture at the Royal College of Surgeons in 1940, by which time I had carried out the operation 17 times. I also thought that the regurgitation of duodenal contents into the biliary tree, which could be demonstrated by x-ray examination, was a matter of no importance in the presence of free drainage through the choledochoduodenostomy. As time went on I began to see these patients returning with attacks of fever, rigors, and transient jaundice, and I came to the conclusion that recurrent cholangitis occurred too frequently to make the operation one to carry out except under very exceptional circumstances. I also think that a widespread adoption of this procedure would result in an increased operative mortality, although the rate is low in Mr. Hosford's capable hands. If the operation is to be done I agree that the opening should be reasonably large, and to achieve this I made an oblique opening in the duct.

In the last five years I have performed this operation only once, and I have relied on careful exploration, washing out the duct, and drainage as a routine for stones whether multiple, recurrent, or associated with infection.—I am, etc.,

Leeds.

DIGBY CHAMBERLAIN.

Examination of Immigrants

SIR,—I regret that my work often entails delayed contact with the *Journal*. In "Medical Notes in Parliament" (*Journal*, April 6, p. 826) under the heading "Tuberculosis Among Immigrants," it is reported that Mr. T. Iremonger (Ilford, North) asked what examination of immigrants into the United Kingdom was made to determine whether they were suffering from tuberculosis or other communicable diseases. I was astonished at the reply as reported in the paragraph.

Mr. J. K. Vaughan-Morgan, Parliamentary Secretary, replied (I quote the *Journal*) that "any alien immigrant might be subjected to a general medical examination before

he was permitted to land. Where tuberculosis was suspected in any person, British or alien, coming to this country the port medical officer notified the medical officer of health of the district to which the person was proceeding, so that he might be brought under observation. The port medical officer had power to examine any person if he had reason to think he was suffering from any other infectious disease, apart from venereal disease."

It is impossible to accept such a reply, for, although each statement may be theoretically true, it has no relation whatever to actual practice. The port medical officer receives from the ship surgeon a notification of all readily diagnosable infectious diseases, and an occasional doubtful one, but when it is considered that the ship surgeon sees only a small proportion of the passengers, and the port health officer none at all (other than those above drawn to his attention), there can be no reason for suspicion, and indeed no chance of it. As a surgeon for more than eight years on ships bringing to one of our largest ports thousands of passengers annually, I have, to the best of my recollection, called attention to one case only, that of an Indian woman who had phthisis, and knew it. The surgeon, and through him the port officer, were the last persons she would wish to see but that she became afraid of continued and serious haemoptysis. One crew member also had a haemoptysis, and was sent home at the beginning of the voyage. In effect, as I have seen it, there is no check whatever.

Many countries, including Commonwealth countries, insist that, for certain types of immigrant at least, there must be produced a chest x-ray film and report before they will be at all considered as immigrants. There can be no doubt that, while we are attempting to stamp out the disease, we are allowing into the country fresh centres of infection; we have been informed also that in certain parts of the country, probably due to immigration, there has been a remarkable increase in venereal diseases.

All this tempts one to a comment on a broader situation with which every ship surgeon of experience will be familiar. A considerable number of visitors, often from countries better off financially than our own, and however welcome, "save up" operations, chronic ailments, dentures, appliances, etc., for payment, in whole or in part, by the British taxpayer. This same taxpayer is informed on high authority that he cannot afford luxuries; he can see also for himself that he can scarcely afford the present, even underpaid, Health Service. In the light of this it might be well to consider that, while liberality is a fine quality, a man whose family is on the verge of want deserves no credit for scattering largesse on the broad highway.—I am, etc.,

Sutton, Surrey.

JNO. CRAWFORD.

Thrombocytopenic Purpura Following Quinidine

SIR,—The report of a case of thrombocytopenia due to quinidine by Drs. Stanford Bourne and Denis J. O'Sullivan (*Journal*, May 4, p. 1046) prompts us to place on record a further case.

A man of 55 had been suffering for many years from occasional attacks of paroxysmal auricular fibrillation. He had taken quinidine intermittently for six years. An attack developed on April 8, 1957, and clinically he appeared to have auricular fibrillation. He was given phenobarbitone 1 gr. (65 mg.) that night and the attack had subsided by morning. He was advised to take regular prophylactic quinidine, and on April 10 he took quinidine hydrochloride 3 gr. (0.2 g.) at 9 a.m. Later that morning he went by car to Cambridge, where he became ill with nausea and shivering. At 1 p.m. his temperature was 101° F. (38.3° C.) and he was admitted to hospital. No abnormal physical signs were found. His temperature was normal the next day and he was discharged. It was considered possible that this attack was due to quinidine, and he took no further dose until April 15, when he was given ½ gr. (32 mg.). He took the same dose the next morning with no ill effect. He took nothing on April 17, but on April 18 took 1 gr. (65 mg.). He was well in the morning and played golf, but developed