the risk of thrombosis at the suture lines is held to be less than the risk of massive haematomata in the wounds.

Although the retrograde removal of an aortic embolism following the bilateral exposure of the femoral arteries has been advocated (Griffiths, 1938), it is extremely difficult in many cases to dislodge the clot from below, and the intimal trauma it involves readily leads to further thrombosis. Retroperitoneal exposure of the aorta is more difficult and has no particular advantage.

The results of conservative therapy in iliac or common femoral embolism where the femoral artery pulsation, when palpable, terminates within 2.5 cm. below the inguinal ligament are not impressive (Haimovici, 1950), many patients dying of the effects of limb gangrene or suffering the troublesome complications of chronic ischaemia. The exposure of this region is simple, and can, if necessary, be performed under local analgesia. Probably the number of patients saved by femoral embolectomy will not be great. Many will succumb, as under the non-operative regime, to the complications of the cardiac lesions or further embolisms. Strömbeck (1935) reported a 63% mortality following embolectomy in the lower extremities. The results, however, for limb survival are vastly improved and the sequelae of chronic ischaemia largely avoided.

Distal emboli in the leg or emboli involving the arm are probably most suitable for the conservative regime, as the dissection necessary to expose the smaller vessels destroys collateral vessels and closure of the incision severely narrows the arterial lumen.

The two limiting factors to embolectomy are the general condition of the patient and the time interval between the embolic impaction and operation. The former often excludes surgery, and the non-operative regime is perforce adopted. Although many embolectomies have been successfully reported where the interval is longer than 24 hours, the extension of the retrograde thrombosis is so rapid and soft-tissue necrosis so developed that operations beyond 12–16 hours are apt to be unsuccessful (Pearse, 1933). It is a sad reflection that only 20 out of the 72 patients reported in this series were admitted to hospital within 12 hours of the onset of symptoms. It is probable, therefore, that in any large group of peripheral emboli the majority of the patients will be most satisfactorily managed by non-operative regime. There are, however, some patients whose general condition permits the removal of emboli arrested at the common femoral and aortic sites. The eventual prognosis for such patients who are saved is not good. Strömbeck (1935) has shown that of 61 patients discharged from hospital after successful embolectomy one-half are dead from heart failure or further emboli within two years. Many surgical lesions, however, carry an equally grave prognosis, and by prompt intervention the surgeon can save many limbs and some lives and, as is his duty, relieve much suffering.

Many of the cases reported in this paper were seen in the Manchester Royal Infirmary, and I am grateful to Professor A. M. Boyd for stressing the importance of the conservative regime. Mr. W. Metcalfe has kindly allowed me to use some of his material, and the Department of Medical Illustrations provided the diagram.

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OCULAR NERVE PALSY WITH SEVERE HEADACHE IN DIABETICS

BY

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A diabetic patient presents with the complaints of double vision and of extremely severe headache behind the left eye and in the left frontal region. Examination reveals an isolated left-ocular-nerve palsy. No cause is found and the condition clears spontaneously. Is it a diabetic complication, pure and simple?

Isolated cranial-nerve palsies, especially of the third and sixth nerves, are known to occur in diabetics, either at the inception of the disease or later in its course.^{1–12} That these palsies are in fact true instances of “diabetic neuritis” seems likely where no other cause can be found and where the paralysis is only temporary. According to Joslin and his group⁷ the condition clears up as the diabetes is brought under good control, while Collier¹ reports total cure in all of his 30 cases.

Association of Ocular Palsy and Pain

We have seen several instances of diabetic cranial-nerve palsy in the past years, but have recently run into diagnostic difficulties over diabetic patients who present with severe headache in addition to their ocular palsies. Pain does not normally accompany such palsies; it is rarely mentioned in the literature. Groenouw⁴ remarks upon the occasional association of “neuralgia of the fifth nerve” with diabetic ocular paresis, and Larson and Auchincloss⁸ mention “numbness of the face” (presumably fifth nerve) without pain. Goodman *et al.*³ report one case of “widespread neuropathy, including an attack of pain in the distribution of the right trigeminal nerve,” and Herson⁵ reports a case of internal and external ophthalmoplegia preceded by three weeks’ bilateral frontal headache. Apart from these skimpy references all other authors either state that pain in head or face does not occur or else they are silent in this regard. In each of the present cases there was a strong suspicion of intracranial aneurysm (or similar localized lesion), but this could not be proved, and it was eventually believed that the syndrome was purely diabetic.

Case Reports

Case 1.—A coloured woman aged 48, known to have had diabetes for 18 months, not obese, and poorly controlled on around 30 units of zinc-protamine insulin daily, experienced very severe right hemicranial headache of sudden onset which was continuous and unrelieved by salicylates. There was no nausea, vomiting, or vertigo. The next morning her right eye was closed. Examination the same day revealed a complete right third- and sixth-nerve palsy and also hypoaesthesia to touch and pin, with mild paraesthesia in the distribution of the first division of the fifth nerve on the right side. She had no diabetic “complications” of vascular or other type; she neither drank nor smoked. Her past history and further examination were unrevealing. Radiographs and cerebrospinal fluid were normal; W.R. was negative in the blood and C.S.F. A right carotid angiogram was adequate and entirely normal. The headaches slowly abated; the neurological features were improving in three weeks, and had completely cleared within two months.

Case 2.—A coloured obese woman aged 50, with very mild diabetes of some nine months’ duration (fasting blood sugar, 150 mg. per 100 ml.), who was controlled on diet only, suddenly developed an extremely severe right frontal

headache which spread to involve the hemicranium. This gradually improved over the next 14 days, but just when she felt quite well she became suddenly dizzy and saw double. She had a complete right sixth-nerve palsy. The past history and further examination were unhelpful. She "had never had a headache before." Her blood pressure was 150/110. Radiographs, C.S.F., and the W.R. were normal; permission to take an angiogram was refused. Improvement started after six weeks, and slowly the sixth nerve function became fully restored.

Case 3.—A coloured woman aged 50, of slim build, had had diabetes for four years. She was poorly controlled; in fact, she had omitted insulin for the past year, though actually needing some 30–45 units a day. She suddenly felt an intense right retro-orbital pain and right-sided headache, constant in nature and not relieved by ordinary analgesics. At the same time her vision became blurred, and the right eyelid closed two days later. We saw her after four weeks, when a partial right third- and fourth-nerve palsy was found with normal pupils and hypoaesthesia in the area supplied by the first and second division of the fifth nerve. Nothing else transpired, except for the later appearance of angina pectoris of effort. Radiographs, C.S.F., and the W.R. were normal; a carotid angiogram was adequate and normal. The condition was actually improving when first seen (some four weeks from the onset), and restitution was complete in 10 weeks.

Case 4.—An undersized white boy aged 14, with severe poorly controlled diabetes of three years' duration, taking around 60 units of insulin daily with no definite diet, had had recurrent attacks of headache occurring above the left eye for two years, unaccompanied by nausea or vomiting. A complete left sixth-nerve palsy suddenly appeared, not definitely related to a bout of head pain. Other diabetic complications had already begun to appear, evidenced by retinal micro-aneurysms and sluggish tendon reflexes. Radiographs were normal; the W.R. was negative. Angiography was not performed. The paresis completely disappeared within three months, during which time no further headaches occurred.

Comment

It is admitted that in each of these patients, taken individually, the possibility of a non-diabetic local intracranial lesion has not been completely excluded. Even a normal angiogram does not afford total certainty in this regard. Taken together, however, I believe that these histories make a reasonable case for the existence of the syndrome of ocular palsy plus severe localized headache, caused by diabetes. I must admit that the fourth case is less convincing than the others. The combination of definite third- and fifth-nerve involvement in two cases suggests that it may be the latter lesion which produces the headache in the syndrome under discussion. Perhaps both nerves are involved by the "neuropathic process" where they run close together in the cavernous sinus.

It would appear that, as with other diabetic "complications," the severity of the diabetes bears no obvious relation to the emergence of this syndrome. In all cases it was temporary, although it might be argued that it cleared up as the diabetes was brought under better control.

Summary

Four cases are reported of severe localized headache with ocular-nerve palsies occurring in diabetic patients. In each case a "congenital" intracranial supraclinoid aneurysm (or similar local lesion) was suspected, but was not found, and the condition always disappeared within a few weeks. I believe it to be a variety of diabetic neuropathy, although I do not claim to have proved this.

I wish to thank Dr. S. Berman for allowing me to use the record of Case 1, which was under his care. I am indebted to Professors F. Forman, J. F. Brock, and G. C. Linder for their interest and advice.

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NEUROSIS IN GENERAL PRACTICE

BY

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This paper forms an attempt to analyse the incidence, symptomatology, causes, and treatment of neurosis in a general practice. This practice is of medium size, consisting mainly of working-class patients in a town of 38,000 people.

Few papers dealing with the analysis of neurosis in general practice are available for reference, and nearly all are American. Klapman (1945), Bowman (1946), and Waggoner (1947) have written at length on the significance of psychoneurosis in general practice, and have estimated that it constitutes some 50% of the practitioner's work. Denker (1946) reviewed 500 cases of all types of neurosis treated by general practitioners; his paper is referred to later. O'Neill *et al.* (1954) however, made an analysis of "stress disorders" seen in three London area practices, and found that each day some 20% of patients seen were suffering from some type of neurosis, the figures for the rural practice being somewhat lower (10–15%). They emphasized the importance of diagnosing these patients in the practice and devoting enough time to treatment, and presented a number of examples.

Material

In order to avoid special selection, the first 500 consecutive patients from a given date (August 28, 1953), who sought consultation, whether at the surgery or in the home, were taken. Their names were entered in a book, together with their age and sex. Careful histories were taken, and all were examined thoroughly as soon as possible. A note was made if neurotic symptoms were present, and each case was regularly reviewed at intervals over the period of one year.

The 500 patients in the survey consisted of 273 females and 227 males. Evidence of neurosis was found in 50 (22%) males and in 131 (48%) females, making a total of 181 patients, or 36.2% of the whole. The ratio of 50 males to 131 females compares with Denker's analysis, in which he found a ratio of roughly 1:3.

An estimation carried out during the survey showed that in one month 47.6% of all consultations were sought by patients with some form of neurosis. Since many of these patients take up more time than those with physical illness it is clear that the neurosis is the biggest problem facing the general practitioner.

Table I shows the incidence of neurosis in these 500 cases. It will be seen that the greatest incidence of neurosis in