Manual Methods in General Practice

SIR,—I would like to reply to the very helpful letters on manual methods in general practice (*Journal*, July 25, p. 222).

Dr. P. Hopkins mentioned the psychogenic backache. This is quite a common trouble, as explained by Dr. J. P. Spillane at the Cardiff Plenary Session on "Fibrositis," and I agree with him, and mentioned the method of examination in my article (*Journal*, July 4, p. 18). I strongly endorse Dr. Hopkins's last sentence referring to examination of the "whole patient and not just the part that hurts." Examination for backache is carried out literally from "head to toe," and for armache from head to finger-tips. This is essential to avoid missing tuberculous caries or secondary deposits in the spine, or a cervical disk protrusion giving rise to pain in the arm. I cannot, however, agree with Dr. Hopkins's estimate that the proportion of total patients seen who require physiotherapy is 5%. First, he has omitted any cases of arthritis of the hip, shoulder, or knee, cases of strain of the coronary or lateral ligaments of the knee, or the chronic sprained ankle. Secondly, he has seen eight cases diagnosed as prolapsed disk in six months. This is hard to believe, since I see many more than that number every week. I note that 50% of his eight cases had operative treatment or plaster-jacket treatment. I can only remark that during the past three years I have not had one case operated on or encased in plaster.

Dr. R. Howard raised the one big snag—namely, payment. A great deal of work is done free by me and my physiotherapist. Not being recognized as a consultant in the National Health Service, I cannot be paid by the executive council and I cannot charge my patients (N.H.S.). I feel the treatment is so necessary that I am content with giving something for nothing.

Dr. T. Hambly's letter points out the weakness in our medical education. I am sure that before this work can be successfully carried out by general practitioners many courses will have to be arranged at St. Thomas's Hospital, under the guidance of Dr. Cyriax, and one general practitioner from every partnership should attend. We owe it to the patients who trust us to give them the best and earliest treatment practicable.—I am, etc.,

Hoddesdon, Herts.

R. BARBOR.

Cerebellar Dysfunction

SIR,—I must thank Dr. J. O. Newman (*Journal*, July 25, p. 223) for his interest in my medical memorandum (*Journal*, July 11, p. 83). I have to inform him that the ataxia so noted in the case report was indeed cerebellar ataxia, which was, of course, what made the case so unusual.—I am, etc.,

Glasgow.

BASIL SELTZER.

Three Testicles

SIR,—I can appreciate the gentle jest of my very old friend Mr. McNeill Love in resurrecting an anonymous mediaeval Pope and recording his alleged reaction to an anatomical conundrum (*Journal*, July 18, p. 145); but it is a pity to let the doctor who certified that the applicant had three testicles remain unhonoured. Medical history would be brightened if my friend could look up the original documents for an addendum to his admirable article on scrotal swellings.—I am, etc.,

London, W.1.

W. J. O'DONOVAN.

Regional Service for Diabetics

SIR,—It will no doubt be of great interest to those concerned with the care and welfare of diabetics to read (*Journal*, July 18, p. 160) that the Central Health Services Council has drawn up plans for a regional service for diabetics, and that the proposed centres will amongst other activities provide for "the training of patients in how to live with their disability."

The British Red Cross Society will be particularly glad to know of this development, for in 1946 the Society, in conjunction with the Diabetic Association, set aside 50 beds for that very purpose in part of the British Red Cross

Society's Auxiliary Hospital, Burley-on-the-Hill, Rutland, which I think I am correct in saying was the first undertaking of its kind in this country. Patients who had but recently been diagnosed as suffering from diabetes were there taught the diabetic way of life, as well as the use and administration of insulin and the preparation of suitable food. In addition to this instruction they had the benefit of meeting others suffering from the same complaint and were helped to regard the unusual as almost the usual, thus conditioning them for an altered life in the outside world and raising their morale. Burley-on-the-Hill was taken over on the appointed day in 1948 by the Ministry of Health, but it continues to give the same encouragement and help to diabetics as was provided originally by the British Red Cross Society.—I am, etc.,

London, S.W.1.

H. A. HEWAT.

Primary Biliary Cirrhosis

SIR,—We would like to comment on the article by Drs. H. G. H. Richards and C. B. S. Fuller on "Primary Biliary Cirrhosis" (*Journal*, July 4, p. 23). The following case report emphasizes the importance of awaiting post-mortem proof before accepting the diagnosis of primary biliary cirrhosis.

A married woman became jaundiced in July, 1951, at the age of 55. There was no relevant previous history. Investigation showed that the jaundice was of obstructive type. Mr. J. D. T. Jones performed a laparotomy, but could find no evidence of extra-hepatic obstruction. Liver biopsy showed biliary cirrhosis. The histological picture was the same as that described by Drs. Richards and Fuller. The patient remained intensely jaundiced until her death ten months after the beginning of the illness. Latterly both liver and spleen were enlarged together with ascites and a haemorrhagic state. Despite her extraordinary colour she felt well until the terminal phase of her illness. Post-mortem examination carried out by one of us (P. S. T.) revealed bile-duct carcinoma involving the hepatic duct in the porta hepatis. The tumour was only 2 by 1 cm. in dimension. There was also a small nodule 4 mm. in diameter in the cystic duct at its junction with the hepatic duct. The common bile duct was normal.

It is evident, therefore, that biopsy proof of biliary cirrhosis in combination with negative laparotomy findings does not exclude the presence of a small tumour of the hepatic duct.

We are grateful to Mr. J. D. T. Jones and Dr. H. A. Dewar, who had this patient under their care, for permission to publish this case.—We are, etc.,

J. W. PLATT.

P. S. TWEEDY.

Newcastle-upon-Tyne

Dr. Johnson as Scientist and Patient

SIR,—Your report of the B.M.A. Popular Lecture given by Sir Russell Brain on Dr. Samuel Johnson (*Supplement*, July 25, p. 62) prompts me to suggest that the truth behind the odd behaviour of the great lexicographer is to be found in the pages of *Lavengro*, by George Borrow. In chapters 64–7 is a most vivid account, obviously based on fact, of the author's brief sojourn with a country gentleman afflicted with compulsive neurosis. The sufferer confides in Borrow as follows: "Suddenly, I found myself doing that which even at the time struck me as being highly singular; I found myself touching particular objects that were near me, and to which my fingers seemed to be attracted by an irresistible impulse . . . a mysterious dread hanging over me till I had given way to it." As Borrow sympathetically observed to his host, it was the warding off of the "evil chance." I myself well remember an unfortunate school contemporary who, when walking in the street, was frequently compelled to turn round and round—top fashion—to the no small embarrassment of any chance companion. In the same way Dr. Johnson, when escorting poor blind Mrs. Williams, was obliged to leave her floundering while he carried out the gyrations imposed upon him by that dread, inexorable power.—I am, etc.,

London, E.1.

J. P. ENTRACT.