Myiasis of Palpebral Conjunctiva

SIR.—The following record of a case of myiasis of the palpebral conjunctiva is of interest.

CASE REPORT

A negro oilfield metal turner aged 32 presented himself at the dispensary, saying that a piece of cast iron had got in his right eye in the course of his work that day. He complained of the usual irritation, but there was no infection of the cornea. After a search a minute foreign body was removed from the upper palpebral conjunctiva. The eye was washed out with boric lotion and he returned to work. Two days later he returned saying he still felt something in his eye.

On examination the conjunctiva was slightly infected, and there was a small area of inflammation in the centre of the upper palpebral conjunctiva. As this appeared to be a focus of sepsis following removal of the foreign body, hot spoonings and irrigations with boric lotion were prescribed. A week later the man was seen again. There was a large swelling below the upper lid, which raised the lid off the eye, and he complained of frequent attacks of severe pain and inability to sleep for several nights.

The appearance was that of a large styte pointing on the underside of the eye, so 4% cocaine was instilled preparatory to incising it. When the lid was everted as much as possible there appeared to be two openings, and owing to the pressure a white object could just be seen in one of these openings. Increased pressure disclosed more of this object, and it was seen to be segmented with a row of bristles between each segment. Slowly a large larva of *Cordylobia anthropophaga* (tumbu fly) was extruded from the swelling, greatly to the amazement of all present. The larva was 3/4 in. (1.9 cm.) long and as thick as a cigarette. The patient was immediately relieved of his symptoms, and within two days the eye was to all appearances normal.

Infestation of various fleshy parts of the body is commonly seen, but this is the only case I have heard of in which it occurred in the orbital cavity.—I am, etc.,

Santa Flora, Trinidad.

T. E. M. WARDILL.

The Label of Psychoneurosis

SIR.—During the last year I have been able to survey a large number of persons invalided from the Services with psychoneurosis. A great number of them complain bitterly that the label prevents them obtaining suitable employment. It is becoming evident that many employers, without proper consideration, look upon them as defective in character and mentality and as unfit for steady employment.

To my mind from an employment point of view there are two classes of psychoneurotics: (1) Those with a history of neurosis from childhood, with a bad occupational record, and who rapidly became useless in the Service because of "black-outs," headache, apathy, and general poor morale. The employers quite rightly are rather chary of taking them on, for they cannot be relied upon to continue at steady work. Incidentally, I estimate not less than 15% of the total population belong to this class of ineffective unemployables, and it is they who ruin the harmonious working of many social services. (2) Those with a good employment record, who have done a fair amount of service but have eventually broken down under stress the severity of which they are unlikely to encounter in civil life. It is these men who suffer so unjustly from the label of psychoneurosis. Sometimes they have done over five years' service, or been through the Battle of Alamein, or Salerno, or Caen, or been on submarine service, or completed 20 operational tours over Germany. Given a chance and a considerate employer they regain their confidence and return to normal—though they can never lose the stigma of psychoneurosis.

Solely on behalf of this latter group I would like to suggest: (a) That invaliding medical boards, when considering a man who has *served his country well*, avoid the term psychoneurosis, and prefer terms such as battle exhaustion, tropical debility, flying stress, etc. (b) That employers look more fully into a man's war service and the stress he has sustained before classifying him as a constitutional psychoneurotic.

Until laymen appreciate the difference between the above groups some very good men will continue to resent the label of psychoneurosis, and it is to bring this matter to light that I am writing this letter.—I am, etc.,

London, W.1.

KENNETH HAZELL.

Quinine and a Resistance Factor

SIR.—I read with interest Dr. E. O. Blake's letter (April 12, p. 506) on the treatment of early cases of influenza and the common cold by the intravenous administration of quinine bi-hydrochloride. In fact the use of small doses of quinine by mouth by laymen in many countries to abort such attacks has stood the test of time. At first sight such a procedure seems quite irrational in view of the accepted idea that quinine is a drug with specific antimalarial action. But is it so?

It is generally held that quinine *in vitro* is ineffective unless large concentrations are used which are not tolerated by macrophages. This immediately suggests an indirect mode of action. Recently Black (*Trans. roy. Soc. trop. Med. Hyg.*, 1946, 40, 163) reported that serum from a patient treated with quinine arrested the development of trophozoites of *Plasmodium falciparum* when cultured *in vitro*. He had excluded the specific immune properties of sera used in the culture as an influence detrimental to the parasite, since the parasites were taken from patients with a primary attack, while the drugs were given to donors who had not had falciparum malaria. He had also excluded phagocytosis, since leucocytes were removed before cultivation was begun. This suggests that this indirect mode of action is humoral and non-specific. Of great interest is his finding that most of the parasites undergo schizogony in a control culture, using serum from healthy donors containing no drug, and that the second generation does not progress so readily. He comments that this method of cultivation does not provide ideal conditions for the development of the parasites. But why should serum from normal volunteers offer a handicap for the growth of these parasites?

At the last laboratory meeting of the Royal Society of Tropical Medicine I demonstrated the mechanism of action of two antimalarial drugs studied—quinine and atebrian—with reference to a new *resistance factor* found in the albumin residue and revealed by the serial cephalin flocculation curves. This resistance factor proved to be of great significance in determining the course and outcome of this struggle between host and parasite: a decrease in this resistance factor shifts the balance in favour of the parasite, and when marked is associated with clinical manifestations of disease, while an increase in this resistance factor shifts the balance in favour of the host, tending to re-establish a condition of health. This latter effect is obtained by the administration of quinine to healthy volunteers as well as to malarial patients, thus explaining its non-specific and indirect mode of action as an antimalarial and possibly also as an antiviral and antibacterial agent. Since this resistance factor is also present in healthy persons to a less extent than in healthy persons treated with quinine, it is apparent why normal serum should offer a handicap to the growth of *P. falciparum* when cultured *in vitro*. A more detailed account is in the press.—I am, etc.,

London, W.2.

J. G. MAKARI.

d-Tubocurarine in Caesarean Section

SIR.—I was most interested to read Dr. T. Cecil Gray's excellent article on this subject (April 5, p. 444), particularly as the choice of anaesthetic for caesarean section is such a controversial matter. The questions that seem to arise are: (1) If the combination "kemithal"—cyclopropane-oxygen is to be used, is it necessary to use d-tubocurarine at all? (2) If d-tubocurarine is used, do the advantages obtained definitely override the possible dangers dependent upon its use?

It seems that, using cyclopropane-oxygen alone on the closed circuit, adequate anaesthesia can be obtained for caesarean section without using harmful doses of the anaesthetic agent; little relaxation is required, and the babies seldom cause anxiety. Anaesthesia is usually light and, after delivery, not below deep plane one or upper plane two of the third stage. The patients in the great majority of cases recover their reflexes in the theatre. Post-operatively their condition is satisfactory and vomiting not a regular feature. True, intubation is no doubt facilitated if it should become necessary, and uterine tone good if d-tubocurarine is used with the above combination, but, as Dr. Gray reports, this latter fact caused a temporary embarrassment to the surgeon on two occasions,

If *d*-tubocurarine is to be used as an aid to anaesthesia for caesarean section, its powers would perhaps be even more fully appreciated if combined with kemithal—gas-and-oxygen provided suboxygenation did not occur, for here the unpremedicated patient strains and resists anaesthesia, is more liable to vomit during induction, and usually requires the addition of trilene or ether.

In the future, as reports come in, perhaps all parties will be satisfied and the advantages of Dr. Gray's method obtained with "myanesis" in combination with general anaesthesia, but with a wider margin of safety and no respiratory depression.

There seems a tendency at present for anaesthetists to use *d*-tubocurarine indiscriminately as the solution to all their problems; in the hands of one as experienced as Dr. Gray it can only be an advantage, but no one will deny that in the hands of the occasional anaesthetist its potential dangers may become real.—I am, etc.,

Cambridge.

ROBERT I. W. BALLANTINE.

Child Guidance

SIR,—Dr. J. A. McCluskie's letter (April 12, p. 508) illustrates the unnecessary confusion that there is on this subject. I suspect that, like many current misunderstandings, it is largely due to people failing to read, or comprehend, the documents that they criticize. Since he refers—although not by its correct title—to a recent memorandum produced by a subcommittee of which I happen to be the convener, I should be glad of an opportunity to correct the misleading impression that may result from his interpretation of the subcommittee's views; although I do so as an individual. The subcommittee is part of the Medical Advisory Committee of the Berks, Bucks, and Oxon Regional Hospitals Council, not that of the Nuffield Trust, although it was set up by virtue of the activities of the latter body; and the memorandum refers to psychological medical services in the Oxford region only. It is appended to the council's report on the planning of hospital services in that region (January, 1947). Dr. McCluskie implies—para (c)—that the subcommittee advocate "double administration clinics." On the contrary, this is the very thing that they deprecate. What they advocate is an arrangement very similar to that which Dr. McCluskie describes and so obscurely calls "the dual scheme . . . under one administration." Why introduce an element of contentiousness where none exists?

Most of the authorities that he quotes—and one notable one that he omits, namely, the joint memorandum of the R.C.P., the B.M.A., and the R.M.P.A. (*Supplement*, 1945, 1, 111)—are agreed that the psychiatrist, with his essential technical assistants in psychometry and sociology, is the man to deal with mental illness and defect in children; and that it were better that this team should be integral with the health services, although they will probably do some of their work in *ad hoc* school clinics and some in the psychiatric department of a general hospital or in a special hospital. Thus they can deal with any patient in the place that is best suited to his needs, whatever may have been the point of first contact. It would ease relationships with education authorities if the distinction were more clearly recognized between an educational psychologist with a university training and degree in his subject on the one hand, and the more humble psychometrist, or mental tester, on the other; the latter may be an auxiliary technician in the psychiatrist's team or in the educational psychologist's department. But no realist would deny the educational psychologist his place, in his own right, within the framework of the educational service, for most of his work is far closer to education than it is to medicine. Psychiatrists, having rightly objected to a tendency, here and there, in the early days of this work, on the part of lay psychologists to undertake, often in ignorance, the treatment of an ill child, should take care that they do not themselves commit a similar kind of offence by encroaching too far into the territory of the professional educationist.

At some points in some cases the two fields will overlap; symptoms may be scholastic, treatment medical, or vice versa. In the children's interests, therefore, the administration system, however designated, must be such as to provide smooth continuity from provisional diagnosis to investigation, to final diagnosis, to treatment; no matter in what field symptoms arise, no matter through what channel help is sought (teacher and school M.O., or parent and family doctor, or juvenile court and probation officer), and no matter whether the prepotent therapeutic factor lies in the tutorial skill of the educational psychologist, in the clinical techniques of the psychiatrist or the paediatrician, or in the activities of the social worker. The

only way to achieve this is to have an easily worked interconsultative arrangement of people who know their jobs and their limitations, and who, while remaining masters in their own houses, have a pretty sound conception of the relevance of the other man's work and are big enough to refer appropriate cases to him and let him get on with his own job in his own way.

I should like to dispel the doubts that Dr. McCluskie has about the subcommittee's experience of psychiatric disorders in children. All of its members have done a considerable amount of work in this field, and among them are two former and one present director of psychiatric clinics for children. The latter is actively engaged in the work of clinics—managed on lines similar to those advocated—in a predominantly rural county. This work has been going on for five years and it has not yet broken down as a result of geographical considerations in the way that Dr. McCluskie so confidently predicts—he must be very far indeed ahead of the planners.

I hope that controversy on this subject will not be rekindled. The great majority of the authorities that have given it consideration and are versed in its practice are agreed on the fundamental principles; clearly their detailed implementations must be moulded by the peculiarities of diversely circumstanced localities; can't we leave the matter there?

And if I may be allowed a personal tail-piece: can't we stop, once and for all, using this ridiculous expression "child psychiatrist"? If the words bear their correct meaning they suggest a bespectacled prodigy in a school cap rushing hither and thither to treat disordered patients. Who ever heard of a "child surgeon," a "child ophthalmologist," or a "child dentist"? Must we always be different?—I am, etc.,

Aylesbury, Bucks.

IAN SKOTTOWE.

Medical Ration Book

SIR,—The size of the medical profession, its geographical distribution, and the proportion of its parts are not fortuitous things, but have arisen, rightly or wrongly, in response not to needs in a general way but to "effective demand" in the special economic sense. The first result of making all demand effective by taking medicine out of the market will therefore be similar to that observed with other commodities in short supply—namely, there will not be enough to go round. The number of medical items of service necessary to ensure theoretical perfection in practice (and to avoid future questions in Parliament) is limitless and therefore, until the majority of the brains of the country can be mobilized and applied to the problem of keeping healthy people well and making sick people more introspective, some form of rationing will have to be devised.

It would appear that the simplest and fairest system, and one which is already familiar and highly esteemed, would be some form of medical ration book. With the assistance of officials from the B.O.T. and the M.O.F. an estimate should be made from the supply side (there would obviously be no point in estimating demand as the limiting factor is supply) of the number of items of medical service available from year to year, and these should be divided up among the total population with special weighting for infants and the aged. A number of general coupons would be provided in the book, and also pages of coupons for the various specialties, hospital beds, surgical operations, drugs, and appliances. One page could contain photograph, finger-prints, blood pressure, identity number, height, weight, chest expansion, size of collar and shoes, blood-type, number of moles on the body, and other information likely to be helpful in diagnosis.

The patient would register with a general practitioner for the basic ration as it were, but the specialist coupons could be used freely (like "personal points") as taste or necessity indicated. As the total available services had been accurately estimated, there would be no need to insist that coupons should be non-transferable, though the possibility of a "black market" developing among hypochondriacs might require certain restrictive measures. The healthier members of the community could hand in coupons which they were not likely to require during the current period of, say, six months to a central pool controlled by a panel of consultants, so that there would be no shortage of, say, "barbiturate coupons" for patients consulting psychiatrists or of "dental coupons" for orthopaedic