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,