Complication of Podophyllin Therapy

SIR.—Since the appearance of the article by Mr. J. E. Semple entitled "Papillomata of Bladder Treated with Podophyllin" (June 26, 1948, p. 1235) a trial has been given to this form of treatment, using weekly instillations of 15 ml. of 4% podophyllin.

A woman, aged 63, was first seen in 1935, when she had three papillomata near the left ureteric orifice. During the next thirteen years she had regular treatment with perurethral diathermy. At cystoscopy on Aug. 16, 1948, a tiny seed-like recurrence high up on the left wall was seen. Five weekly instillations of 15 ml. 4% podophyllin were then given. The last instillation was on Dec. 16, 1948. Twelve days later the patient passed a mass about the size of a date stone per urethram, with considerable pain and difficulty. Analysis reports this to consist of podophyllum resin. On Jan. 5, 1949, the patient passed a further mass equal in size to the first. The weight was about 0.7 g. Each instillation of podophyllin contained 0.6 g. Approximately 50% of the podophyllin was therefore returned in the form of the calculi. Cystoscopy on Jan. 10 showed no evidence of further podophyllin. High up on the left side of the bladder three tiny papillomata were seen in a group about the size of a pin-head.

While there has been no apparent destruction of the growths by podophyllin, it was not for this reason that the treatment was adopted. It was felt that podophyllin may destroy the microscopic recurrences still not visible. It will therefore take several years to assess the ultimate value of such a course.

I should like to thank Mr. Hugh Donovan for permission to publish this case.

—I am, etc.,

Birmingham, 15.

A. G. JARRAMS.

Teaching First Aid

SIR.—At the recent conference of first-aid workers and instructors held under the auspices of the ambulance department of the National Fire Brigades Association, some 150 delegates from all parts of Great Britain and Northern Ireland attended. Many of them were emphatic that the standard and teaching of first aid in this country are seriously handicapped by the inadequate number of doctors who are prepared to spare time for this purpose.

It is true that first-aid treatment ends where medical treatment begins and that many of us know very little about first aid. Yet we rely (especially those of us on the staff of a casualty hospital) even more than the general public do upon efficient first aid for those who are brought in under our care or are transferred by ambulance at our request.

It is therefore a disservice both to the public whom we serve and to our medical colleagues if we cannot find time—busy as we may be in these days—to take an interest in and instruct those (whether St. John, Fire Service, or other ambulance workers) who seek our help and guidance in this matter. The medical background which we doctors can supply to the practical common sense of first aid makes all the difference to the enthusiasm with which the subject is approached by those who learn it.

May I therefore appeal through your columns to those doctors who are approached by any organization for first-aid lectures or examinations to do their utmost to lend a helping hand and so encourage the voluntary spirit on which this sort of work must always rely?—I am, etc.,

Redhill, Surrey.

F. J. CURTIS,
Hon. Chief Surgeon,
National Fire Brigades Association.

Approach to the Frontal Lobes

SIR.—I am amazed at Dr. Max Valentine's enthusiastic support (March 5, p. 411) of Dr. Freeman's assumption that transorbital lobotomy cuts only the thalamic connexions of areas 9 and 10. Everyone who has some experience in experimental brain surgery knows the difficulty in producing a predictable lesion even under favourable circumstances.

I certainly do not want to belittle the neurosurgical work done in the past to alleviate mental illness, but it has always been a medical practice to give a specific indication for an operational intervention. The present state of frontal-lobe psychosurgery may be compared with the procedure of an abdominal surgeon who introduces a knife through a small abdominal incision in the hope of cutting certain portions of

the intestine and thus curing constipational trouble for which no organic basis can be found. No one would defend such a procedure, even if temporary relief were obtained, yet a similar procedure within the brain cavity seems to attract many followers.

I entirely agree with Dr. Valentine that appropriate teams in excellent collaboration are working in this field in the States. An example of *critical* teamwork can be found in a paper by the Connecticut Lobotomy Committee.¹ As Dr. Valentine has misunderstood my plea for this collaboration I would like to restate the main points of my letter (Jan. 29, p. 193)—namely, that further advances in the field of lobotomy can only be hoped for if the operational route chosen allows a clear assessment of the anatomical regions which have been undercut or removed. Only if one is reasonably certain about this can a correlation of psychiatric results and the operation be attempted. The desirability of this becomes obvious if one reads Freeman and Watt's remark that "each surgeon seems to have his own preference."

Dr. Valentine quotes the favourable results of Dr. Freeman's 100 cases started in 1946. It is certainly too early yet to draw definite conclusions from this material. A surgical intervention at the highest level of human personality—the frontal lobes (cf., Halstead's *Brain and Intelligence*, 1947, Chicago)—should be done with great caution, and only very critical evaluation of the results can lead to progress and prevent disappointment in a method which raises high hopes at present. I do not want to deliver a counterblast to psychosurgery, as Dr. Valentine suggests; I only maintain that this branch of neurosurgery is still in an experimental stage and any new blind approach will delay the understanding of the underlying mechanism of mental recovery after lobotomy.—I am, etc.,

Oxford.

P. GLEES.

REFERENCE

¹*Proc. Ass. Res. nerv. ment. Dis.*, 1948, 27, Ch. 35.

Injury Caused by Ear-rings

SIR.—The following case is reported on account of its rarity.

A young lady, aged 23, complained that the lobes of both ears had been severed following the use of spring ear-rings. The photograph shows the condition of one ear. The other was similar. She stated that she had been in the habit of wearing stud ear-rings which fastened on with spring clips. She never noticed any unusual pain or discomfort, but after wearing the ear-rings for some weeks without removing them (exact time unknown) she found them difficult to take off. When they were taken off she found the ears had sloughed under the clips. Both ears healed rapidly, but she felt they were so unsightly that she did not go out in public without her head and ears being covered. Surgical repair was easily accomplished.

Ear-rings of this type are in universal use. The lobes of the ears are insensitive, and damage can occur without noticeable discomfort unless such clips are removed frequently.—I am, etc.,

Dublin.

C. SOMERVILLE-LARGE.

Diathermy Prong Forceps

SIR.—Mr. A. Wilfrid Adams (April 9, p. 631) has added a new diathermy appliance to our list of special instruments. I have always been interested in the surgical uses of diathermy, and I have described¹ how any instrument may be used for diathermy by simply soldering to a convenient spot on it a length of ordinary electric flex. (Stainless-steel instruments cannot be soldered.)

Since writing that paper I have found that it is unnecessary to solder the lead to the instrument. Two inches (5 cm.) of insulation is removed from a piece of lamp flex and the bare wire is then fixed to the instrument by winding and held in position by covering the union with surgical adhesive tape. If