Correspondence

Limits of Certification

SIR,—I was asked by the Civil Service Commissioners to examine from the psychiatric standpoint candidates for the Civil Service "in which there is some doubt or in which candidates appeal against the findings of the medical examiner." They asked for a full and detailed report and stated in a letter that they felt that an opinion of this kind would place them in a better position to decide on each candidate. I objected and said that I would be willing to certify only that there was no medical reason why a man should not be accepted, or that there was some medical reason why he should not be accepted. The Commissioners then wrote a long letter outlining exactly what they did and why they wanted such a full opinion on each candidate referred to me. I asked for their permission to show this letter to my colleagues. I received a very dusty answer: "You will kindly regard as strictly confidential to yourself the information concerning their practice conveyed to you in their letter of Feb. 19. . . ." "As the Commissioners apprehend that you still feel reluctant to oblige them. . . ." Since then I have not been asked to see any case for them, and presumably somebody else is doing so.

To my mind this raises an important point of principle. Surely as medical men we are not expected to select candidates or to say that candidates would be suitable for the Civil Service. We can say in certain cases that for medical, psychological, or psychiatric reasons a man would not be suitable, but I do not see that we should be called upon to do more than this. Briefly the medical role, as I see it, is not to choose the First XV but to pass men simply as fit or unfit to play. In making this limited decision, which I think does fall within the medical province, it would be much easier to form an opinion if the candidate knew that anything he said confidentially would not be passed on to the Civil Service Commissioners, although of course he would know that an opinion in general terms would be given as to whether he was or was not fit for the Service; for in these circumstances candidates would surely speak more freely. This would not be the case if candidates knew that a detailed report of what they said was to be put away in a Government file and perhaps seen by numbers of laymen.

It seems that there is no medical man on the Civil Service Commission. Reports of this kind, perhaps dealing with complicated technical points, would therefore be considered by a lay body and might well be misinterpreted. I doubt if anybody would object to sending a full report confidentially to a suitable Ministry medical officer, who would then have the duty of interpreting it to the appropriate lay body. I dislike, however, the whole idea of passing on confidential and perhaps intimate information obtained in a professional capacity to lay people.

At the moment this apparently minor problem concerns only candidates for the Civil Service. With the steady extension of Government control in industry and in our own profession the principle is one which may well concern many more people in the near future than it does at present. What is needed, it seems to me, is an authoritative ruling on the limits of certification intended for the use of lay bodies.—I am, etc.,

London, W.1.

DESMOND CURRAN.

Reporting of Deaths to Coroners

SIR,—Many practitioners are seriously disturbed by public comment, recently expressed by the coroner who conducted the inquest in the Clements case, on the subject of the conduct of post-mortem examinations of persons who have died from unknown causes. Since such doubts are prone to cause confusion and irregularity of action among practitioners generally it is thought desirable to recite afresh in an abbreviated form an authoritative opinion obtained from Mr. (now Sir) Roland Burrows, K.C., dealing with the questions that are raised. He maintained in his opinion:

(1) That there is no legally enforceable duty resting on a medical practitioner *qua* medical practitioner to report any death to a coroner.

(2) That a coroner is not vested with any power to require a practitioner to report any death.

(3) That the registrar of deaths is vested with a duty to report deaths in certain circumstances to the coroner.

(4) That a practitioner must not do anything to obstruct a coroner in the discharge of his office.

(5) That a practitioner may make a post-mortem examination of a person deceased with the consent of the deceased's relatives whether or not he knows the cause of death, unless, by so doing, he knowingly hinders the coroner in carrying out his duties; but, as soon as it comes to the knowledge of a practitioner that a coroner has been informed from any source touching the death of the person involved, an examination of the body by that practitioner should not be made in these circumstances without an instruction from the coroner concerned.

These are the legal duties of medical practitioners, but, of course, like other members of the community they have social, public, and moral obligations to discharge which are not enforceable by law, and such duties may include one to assist a coroner in certain special circumstances. It is desirable that practitioners and coroners should collaborate harmoniously for the public good, and it is hoped that every practitioner whether engaged in hospital or private practice will refer to the coroner any death respecting which he entertains any doubt as to his responsibility or obligation.

It may perhaps be not inappropriate to remind your readers that at the moment a Committee of the British Medical Association is examining and will report upon the operation of the Coroners Acts where they impinge upon the work of medical practitioners. This committee contains among its personnel several distinguished coroners whose opinions in discussion are greatly valued. It is hoped to furnish a report towards the end of the year for consideration eventually by the Representative Body of the British Medical Association, and it is believed that this report will cover adequately many of the problems that arise in the course of medical practice affecting jointly medical practitioners and coroners in the discharge of their legal and professional duties.—I am, etc.,

ROBERT FORBES,

Secretary, Medical Defence Union.

London, W.C.1.

The Thalamic Dysfunction Syndrome

SIR,—The dys-symbolic effusion of Dr. B. H. Kirman (July 19, p. 109), criticizing my article on the use of euphorants in depressive states, is a masterpiece of prejudice, mis-statement, and inaccuracy. In the first place the term "thalamic syndrome" used by Dr. Kirman is a gross terminological error, the term used to denote the condition in my paper being "thalamic dysfunction syndrome." The former expression is already in general use by neurologists to describe an entirely different disorder, namely, a unilateral gross lesion of the cortico-thalamic fibres accompanied by a definite sensorimotor syndrome. In this connexion it may be pointed out that, contrary to Dr. Kirman's assertion, motor symptoms are a recognized feature of lesions of the thalamic-basal ganglia complex.

With regard to the question of what constitutes a "higher centre," it is now well known that the thalamic centres and their cortical connexions are concerned in some of the most complex cerebral functions, particularly in the sphere of emotional expression and feeling tone. This is demonstrated by the personality and affective changes following prefrontal leucotomy, in which operation the principal tracts severed are the fronto-thalamic connexions, and by the characteristic mental changes found in post-encephalitis and other diseases of the basal ganglia. Dr. Kirman attributes to me two statements which were certainly not made in my article. These are that tremors, obsessional thoughts, pseudo-hallucinations, etc., are thalamic and not cortical in origin, and that the various psychic functions can be strictly localized to individual parts of the central nervous system.

Dr. Kirman refers in his letter to "the clumsy attempt to divide off 'neurotic depression' artificially from psychotic depression." My experience with a large series of treated cases has shown that the two conditions can, in fact, be so differentiated by the specific response to anoxic therapy, which differs radically in the two types of affective disorder. Again,

he states that I have attempted "to divorce it (the thalamic dysfunction syndrome) . . . from environmental factors"; whereas in my paper I stated clearly that "the thalamic dysfunction state may be regarded as a response of the organism to stresses of various kinds" (i.e., environmental stress, conflicts, toxins, and so on).

With regard to his remarks about the morphine and cocaine addiction syndromes, if Dr. Kirman were to go to the trouble of consulting any of the standard psychiatric textbooks dealing with the subject, he would find it stated that alkaloid addiction differs in a number of important respects from alcoholism. This last-named toxin, incidentally, is a cortical depressant rather than a true euphoriant of the type described in my article, in addition to being chemically and pharmacologically unrelated to the agents under consideration. Finally, while admitting "the limited value of present methods" (i.e., of psychiatric treatment), he is apparently unable to suggest any alternative or more effective form of treatment than that suggested in my article. In other words, his criticism is the purely destructive kind which questions everything but decides nothing, containing not one single constructive contribution to the problem under discussion. I should, of course, welcome any constructive suggestions or comments on the new concept of affective disorders put forward in my paper and the pharmacotherapy of these conditions. But it is a pity that Dr. Kirman did not take the trouble to read the paper through properly before erupting so impulsively into print.—I am, etc.,

London, S.E.6.

G. TAYLEUR STOCKINGS.

Bornholm Disease in the Tropics

SIR,—Only a few weeks before the outbreak of Bornholm disease at Aden described by Drs. W. M. Jamieson and D. M. Prinsley (July 12, p. 47) there was an outbreak of an unusual nature in a Naval barracks at Singapore (June, 1946). The distinctive features were as follows: (1) It was larger than any recorded to my knowledge (over 100 cases). (2) It was explosive—more than seventy of the cases occurring in the first twenty-four hours. (3) It was sharply limited to European ratings in the Naval establishment concerned, the majority of cases occurring among men who fed at one end of a mess hall, but who worked and slept in different places over a wide area. (4) The primary lesion appeared to us to be in the parietal pleura, and in several cases a well-marked pleural rub ensued. Features 2 and 3 do not seem consistent with a contact infection, and contamination of food was suspected, possibly by flies. Otherwise signs, symptoms, course, and complications were as normally described.

There had been an outbreak of poliomyelitis at Singapore earlier in the year, during which a few civilians admitted to the fever hospital were regarded as probably suffering from Bornholm disease, but previously this does not appear to have been recognized in Malaya. A Dutch colleague, however, stated that he was familiar with the symptoms in sporadic cases in the Netherlands East Indies.

I was recalled to U.K. before our outbreak had entirely subsided, but a colleague remained to follow up the cases and we intended to produce a joint report for publication on his return. Unforeseen circumstances have so far prevented this partnership from delivering the goods.—I am, etc.,

Milsted, Kent.

J. VINCENT SMITH.

The "Costoclavicular Syndrome"

SIR,—The greatest number of cases complaining of this condition are women, and the production of minor degrees of this condition may be by the shoulder strap of the brassiere. I have had three such cases in recent months, in which symptoms have been functionally relieved by doing away with the shoulder strap. The present passion for "uplift," no doubt encouraged by film stars, is not without its physical disadvantages.—I am, etc.,

Sunderland.

W. GRANT WAUGH.

What is Folic Acid?

SIR,—In the article by Prof. L. S. P. Davidson and Dr. R. H. Girdwood entitled "Folic Acid as a Therapeutic Agent" (May 3, p. 587) it is stated that free folic acid is pteroylglutamic acid, and in its conjugated form is pteroylheptaglutamic acid. Your leading article (p. 604) stated, "Folic acid does not occur

free in foods but as a conjugate with hexaglutamic acid, known as pteroylhexaglutamylglutamic acid. . . ." Wilkinson *et al.* in their article in the *Lancet*, 1946, quoting from Angier *et al.* (1946), hold that synthetic folic acid is a compound of 2-amino-4-hydroxy-6-methyl pteridine and *p*-aminobenzoylglutamic acid.

There seems, therefore, to be a difference of opinion as to what folic acid really is, both in its free and conjugated form.—I am, etc.,

Dublin.

ALFRED R. PARSONS.

REFERENCES

- Angier, R. B., *et al.* (1945). *Science*, **102**, 227.
— (1946). *Ibid.*, **103**, 667.
Wilkinson, J. F., *et al.* (1946). *Lancet*, **2**, 156.

Hypertrichosis of the Lanugo Hair in Malnutrition

SIR,—With reference to Lieut.-Col. S. K. Roy's very interesting letter on achromotrichia in tropical malnutrition (March 22, p. 392), I should like to be permitted to call attention to a little-known condition also found in some cases of malnutrition, especially in children—viz., hypertrichosis of the lanugo hair.

This condition generally affects the lanugo hair of the legs, especially the extensor surfaces. The hair becomes much thicker, longer, and at times darker. It is often seen in times of war in children who, used to an abundant, well-balanced diet, have been placed suddenly, for reasons of necessity, on an insufficient diet particularly poor in animal proteins and fat. On giving the child again a proper diet the condition rapidly ameliorates and finally disappears.

It is interesting to note that the condition is well known to women of the working classes in the South of Europe. A woman who, for reasons of work or some other reason, has put her children in charge of neighbours or relations, will often complain on her return home that the children have not been well looked after and have been starved, "as shown by the thick hair on the children's shins."

The subject of lanugo hypertrichosis in general, as well as lanugo alopecias, is an interesting one, but is beyond the scope of this letter. I might mention, however, a peculiar form of lanugo hypertrichosis of the arms and legs which occurs in certain individuals every summer (summer lanugo hypertrichosis), in others (very few) every winter (winter lanugo hypertrichosis). The subject has been dealt with briefly in my little book *Diseases of Africa* recently published (Apollon and Co., Rome).—I am, etc.,

Lisbon.

ALDO CASTELLANI.

Treatment of Hydrocele by Injection

SIR,—For many years several sclerosing substances have been used in the treatment of hydroceles with varying results. In a recent follow-up of patients suffering from hydroceles treated at this hospital in 1944, 1945, and 1946, 46 patients have been treated by injection of quinine urethane. Six patients have not been traced. Of the 40 patients traced all (with the exception of one still under treatment) have been successfully treated. Some of those treated have had hydroceles of long standing, some had previously been treated by repeated aspirations, and nearly all attended hospital seeking operative treatment. The average age of patients is 55 years, the youngest being 38, the oldest 68.

TECHNIQUE

The technique used is of the simplest kind and could be carried out in a doctor's surgery using ordinary aseptic precautions. The patient lies on the operating table, the scrotum is exposed, and the portion of the skin to be punctured is sterilized with either spirit or iodine. With a 20-ml. syringe and a size 24-in. (6.3-cm.) 18 B.W.G. bored needle the hydrocele fluid is aspirated, the utmost care being taken that the point of the needle does not injure the testicle. When all the hydrocele fluid has been withdrawn the syringe is removed leaving the needle *in situ*, the greatest care being taken that the point of the needle remains within the hydrocele sac. 1-2 ml. quinine urethane (already loaded in a 2-ml. syringe) is then introduced and the needle withdrawn. In the majority of patients little or no pain is experienced. In sensitive patients a small wheel of local anaesthesia is used where the needle is to be introduced.

The patient is again seen in a week or a fortnight's time. The local reaction varies in different patients. In some it has been necessary to aspirate when the reaction has been severe. In six patients it has been necessary to repeat the injections, in four patients the injection has been repeated twice. Patients are seen at intervals as required until the treatment has been completed. When the treat-