Correspondence

State Medical Service in New Zealand

SIR,—The letter from the pen of Sir Ernest Graham-Little (May 3, p. 611) invites comment. Your heading of "State Medical Service in New Zealand" is unfortunate and quite inaccurate. We have had a State salaried service in this country for many years looking after the mental hospitals, all of which, except one, are under State control. The scheme to which your correspondent refers, however, is simply a compulsory universal prepayed system whereby there is a more equitable distribution of that costly article, medical care. The only part the State plays is to collect the premiums and pay the doctor 7s. 6d. for each service rendered. It also pays the chemist for any drug ordered by the doctor providing it is one listed in the *B.P.* and *Addenda* or *B.P.C.*, and will even pay a portion of the cost of a proprietary equal to the sum payable for the official equivalent if such exists. It also pays all public hospital bills and similar sums to private hospitals, and all x-ray and laboratory facilities. Finally, it pays for immunization of school-children and provides the material free, so that now it is almost impossible to find a child who has not been immunized.

Nowadays people can get medical care for all conditions instead of having to self-diagnose and self-prescribe a patent medicine. Nowadays the doctors can and do order all sorts of laboratory procedures without wondering whether the patient can pay. And at last the profession, for the first time, have learned to think and prescribe in terms of official nomenclature and not in terms of a trade jargon covering a bewildering jumble of proprietary medicines, about the exact composition of which so many were profoundly ignorant. Yet, in spite of these and other great advances, we are told that the standards have dropped. Other people think differently. We are also told that patients cannot get attention at night and during the week-ends. I am sure that hundreds of G.P.s in this country will join with me in saying that this is grossly inaccurate and quite unjust. Certainly it is not true of the South. Finally, a dearth of specialists, if such really exists, could be readily explained by the increased amount of medical work consequent on discovering illness in people who previously could not afford medical attention. At any rate, as the general practitioner scheme has only been in operation for six years, it cannot have played any part in the alleged shortage. Furthermore, the difficulties of taking a postgraduate course in Great Britain at the present time are too real to need any stressing.

It is becoming rather tiresome to see stalwarts of organized medicine in America and Great Britain labelling this country as the Ugly Duckling in reports which are essentially superficial, misleading, and biased. If they must survey the New Zealand scene, then it is only fair that they do it thoroughly and conscientiously. It will then be found that, while the present scheme is neither wholly good nor wholly bad, yet on points it is much in advance of the old system, and that the establishment of the sociological principle that medical care shall be free and universal is here to stay.—I am, etc.,

Wanaka, New Zealand.

ALBERT D. G. BLANC.

SIR,—The following extract from a letter which has just reached me from a university professor (non-medical) in New Zealand may be found interesting and suggestive:

"If you introduce your own State Service in England, you will probably be able to profit from our mistakes. A common objection is that a young practitioner without much ability can earn a good salary so soon that he has no incentive to specialize. . . . Moreover the system does not discriminate between men of superior and inferior qualities. The general opinion is that our best medical practitioners will tend to leave New Zealand to an even greater extent than before."

I think you will agree that the above stresses a tendency which needs to be borne in mind.—I am, etc.,

Weybridge, Surrey.

A. C. LANKESTER.

Adder Bite

SIR,—In view of the fact that we have had two cases of adder bite within the last three months, we feel their case histories may be of interest. In both cases we tried the effect of "benadryl" to counter any allergic symptoms which might have arisen; in both cases this appears to have been effective. In the second case we were able to obtain anti-viperine serum, but injection was not possible until several hours after the bite, and its full value could not be assessed. In both cases there was a marked degree of shock, vomiting, and upper abdominal pain of considerable intensity. Recovery was uncomplicated, and both patients have reported no subsequent ill effects.

CASE REPORTS

Case 1.—De B., aged 60, bitten by unidentified snake—an adder from his description—at the junction of the middle and lower third left shin, at 5 p.m. on April 11, 1947. No tourniquet applied, and patient travelled thirty miles before being seen by one of us (H.H.M.) at 7.30 p.m. By this time he was considerably shocked and vomited several times, complaining of severe upper abdominal pain. A cruciate incision was made into the site of bite until blood flowed freely. No tourniquet was applied because of the time lapse (2½ hours) since the bite. The patient was given morphine 1/6 gr. (11 mg.), and the leg was immobilized between pillows. That night the patient developed swelling of lips and face; he was given benadryl 50 mg. by mouth, and the swelling subsided by morning. The following day, April 12, his leg began to swell, became brawny, and finally turned mottled blue and black up to and including the groin. This continued for one week with adenitis of left inguinal glands. On the second night his face and lips again swelled, and he was given 50 mg. of benadryl with good effect. His general condition continued satisfactory, the pain and swelling of leg after an initial three days' increase gradually subsiding, and he was discharged upon the tenth day with slight oedema of leg. On May 9 slight oedema still persisted at end of day.

Case 2.—P. T., aged 17, on June 17 found a snake coiled up under an earth bank. He picked it up, thinking it was a grass snake, whereupon it bit him on the dorsum of his left thumb over the interphalangeal joint, at 6 p.m. His young brother tied a handkerchief tourniquet around base of thumb, but apparently not very tightly. He walked one and a half miles home, where he arrived in a collapsed condition. He was immediately taken to hospital. One of us (G.E.F.) saw him at 6.45 p.m. He was then in a very shocked condition, grey in colour, pulse very rapid and weak, vomiting repeatedly and complaining of severe upper abdominal pain. A cruciate incision was made into the site of the bite and intermittent venous occlusion of upper arm was commenced. By this time there was considerable local swelling and pain. Benadryl (100 mg. in 4 oz. (114 ml.) of saline was injected P.R. and 1/6 gr. morphine given. General condition improved, and at 1 a.m. on June 17 10 ml. of anti-viperine serum was given intramuscularly into left deltoid. After a restless night sulphadiazine (2 g. stat., 1 g. 6-hourly) was commenced and continued to a total of 20 g. Benadryl 50 mg. t.d.s. was given for two days. No allergic symptoms were reported. Brawny swelling of hand, forearm, and upper arm developed, with temperature up to 100° F. (37.8° C.) on first day. Swelling became maximum on third day, involving lateral chest wall and scapular region with axillary adenitis. Region of bite became bluish, with serous discharge. Recovery began on fourth day, and patient was discharged home with slight swelling but no pain on eighth day. June 30, reported fully recovered.

—We are, etc.,

H. H. MATHIAS,
G. E. FRENCH.

Tenby, Pembrokeshire.

Choice of Drugs in Treatment of Duodenal Ulcer

SIR,—I have read with interest the article by Dr. A. H. Douthwaite (July 12, p. 43) and in particular his remarks on the use of belladonna in the treatment of peptic ulceration. With him I agree that its effectiveness is undoubted, as indicated in my article on "Dyspepsia and its Surgical Significance" in the *Journal* of June 3, 1933 (p. 954). From my own studies of its effects its main action lies in the prevention of coeliac stimuli reaching the intestinal musculature, in particular the pyloric and other junctional sphincters. By doing so it relieves all stomach excitability. The unfortunate feature in its administration, as pointed out in my article, is the low concentration in the tissues which produces the distressing subjective symptoms of dry mouth and ocular disturbances. An adequate and long course of therapy is required if permanent cure is to be reached—I have not met the patient who will submit to it.

In the surgery of dyspepsia—and surgery is frequently required—it is essential in many cases that pre-operative treatment be often long and even trying, and it was this feature that led me in my search to discover the value of bromide combined with other aids in the treatment of dyspepsia.—I am, etc.,

Dundee.

JOHN J. ROBB.

The "Costoclavicular Syndrome"

SIR,—Might I be permitted to make an addition to Mr. M. A. Falconer's valuable letter (July 12, p. 69) on this subject? At operations where the axillary inlet is displayed in the living subject it can easily be shown that depression and retraction of the shoulder cause diminution of the space between the clavicle and the first rib; downward traction of the arm also causes the subclavian artery and lower trunk of the brachial plexus to come into more intimate contact with the uppermost rib. Both these facts can be observed when operating for other conditions on patients who do not complain of the "costoclavicular syndrome."

In fact we are all potential sufferers from compression of the neurovascular bundle in the axillary inlet. Under normal circumstances the arm is only held in the position of strain for relatively short periods; also the natural mobility of the neurovascular bundle allows it to move out of harm's way. If, owing to a number of causes such as congenital abnormalities, loss of mobility, continued postural strain, dropping of the shoulder girdle, etc., compression is long continued, the "costoclavicular syndrome" results. As already stressed, there is no one mechanical cause: symptoms are often due to a combination of causes; therefore, if the symptoms and signs are severe enough to warrant operation, exploration must be thorough.

Secondly there is considerable variation in the exact relationships of the subclavian artery and the components of the brachial plexus. I believe it is the relative vulnerabilities of the artery and nerves which determine whether vascular or nervous symptoms predominate.—I am, etc.,

Liverpool.

R. ROAF.

Spinal Pumping

SIR,—In your annotation entitled "Spinal Pumping" (July 12, p. 62) you refer to the work of A. D. Speransky, which lies "buried in the Russian tongue." We feel that attention should be drawn to the following facts. The first English translation of Speransky's work *A Basis for the Theory of Medicine* was published in New York in 1935, and was reviewed in your issue of Feb. 8, 1936, p. 263. In this volume the theoretical basis of "pumping" is elaborated, though the reader who is anxious to discover it must be prepared to follow to its conclusion a difficult and lengthy presentation.

However, all the important original papers which constitute the basis of the work appeared not only in Soviet journals but also in German publications (chiefly the *Zeitschrift für die Gesamte Experimentelle Medizin*). Since 1933 isolated papers have also appeared in the *Acta Medica Scandinavica* and other non-German journals.—We are, etc.,

University of Bristol.

JAMES B. BRIERLEY.
E. J. FIELD.

SIR,—Your annotation on spinal pumping (July 12, p. 62) was somewhat unfortunate in its choice of metaphors. We are told that Soviet medicine, untouched by contemporary medical thought, has been developing behind the only too familiar "iron curtain," likewise that the work of Speransky—one of the most illustrious of Soviet medical scientists—remains "buried in the Russian tongue." But if contemporary medical thought is somewhat absorbed in the study of antibiotics then surely Soviet scientists, by their contributions in this field, particularly with reference to gramicidin, show a similar interest.

With regard to the "iron curtain," the library of the Royal Society of Medicine appears to be well stocked with current Soviet medical publications. It is true that they are mostly untranslated, but is the *B.M.J.* sent to Moscow already printed in the Russian language? It would seem that what is needed here is not a liberal use of threadbare clichés but some diligent and purposive organization. As for Speransky remaining buried

in the Russian tongue, I would recommend your annotator to refer to the *B.M.J.* of Feb. 8, 1936 (p. 263), where the first English edition of Speransky's book *A Basis for the Theory of Medicine* is reviewed, albeit most inadequately. The book was republished in English in 1943 by International Publishers, U.S.A.

In his book Speransky gives a very detailed account of the long years of experimental work which eventually led him to formulate—however tentatively—a new attitude to disease processes. Just as it is to be hoped that the results achieved by Gillman and Gillman working along these lines will stimulate others to try the method, so it is even more important for Speransky's basic experiments to be checked on the widest possible scale so that his conclusions may either be rejected or further developed.—I am, etc.,

London, N.W.11.

J. S. HORN.

SIR,—With reference to the annotation of Speransky's method of spinal pumping (July 12, p. 62), I should like to correct an error. Your annotator states: "... the steps that led him to adopt this bizarre method of treatment remain buried in the Russian tongue." Speransky's book *A Basis for the Theory of Medicine*, which contains the information your contributor is after, has been available in English since 1935, and has been in the library of the Royal Society of Medicine for several years to my knowledge. A second edition (1943) is available through any bookseller from the International Publishers, New York.

The question again rises: "Who is responsible for the iron curtain—us or the Russians?"—I am, etc.,

London, W.2.

A. W. LIPMANN KESSEL.

SIR,—In the *Journal* of July 12 (p. 62) there is an annotation on the subject of experiences in treating rheumatism and rheumatoid arthritis by the method called spinal pumping. It sounds from the annotation that this odd treatment was carried out only once on each patient. Is this correct? Naturally if a series of lumbar punctures had to be performed on each patient the procedure would be much more hazardous and less impressive. I should be grateful if you would clear up this point for me.—I am, etc.,

Reading, Berks.

K. D. SALZMANN.

* * Gillman and Gillman pumped their patients once, twice, or three times, according to requirements. They comment in their article referred to in our annotation: "First, a single spinal pumping can be followed by lasting beneficial effects; secondly, when a relapse occurs it is usually not as severe as the original attack; and, thirdly, if spinal pumping induces salutary effects on one occasion then a second or even a third pumping is indicated in the presence of refractory joints or if a partial relapse occurs."—ED., *B.M.J.*

Stress Fractures of the Metatarsals in Childhood

SIR,—With reference to Dr. Lewis D. Rutter's article on "Stress Fracture of a Metatarsal in a Young Child" (July 12, p. 5) I should like to quote a case which attended the orthopaedic clinic here over one month ago.

The father brought his child of 3 to us complaining that she was not walking properly, and that she walked on her heel with the intent of saving the fore part of her right foot. Examination revealed some puffiness on the inner side of the foot. Tenderness was doubtful. X-ray examination showed a cuff of new bone formation round the mid-shaft of the third metatarsal, with some subperiosteal new bone formation spreading proximally and distally along the shaft. No fracture line was visible. A differential diagnosis of march fracture and Ewing's tumour was arrived at, a case of the latter having been seen previously in the metatarsals of a child of 9 years. Also with Ewing's tumour in mind, the child was asked to be seen 3 weeks later, and in the meantime weight-bearing was to be restricted. X-ray examination on June 30, 1947, showed a definite fracture line, and the diagnosis was then quite obvious. There was then consolidation at the site of the fracture. The child was walking better and tenderness was completely absent.—I am, etc.,

Scunthorpe, Lincs.

ELIZABETH C. MCCLURE.