Complete Prostatectomy

SIR,—The case described by Mr. H. S. Souttar (June 28, p. 917) of complete removal of the prostate confirms some observations made when removing the entire prostate, seminal vesicles, and base of the bladder in a case of carcinoma of the prostate.

CASE HISTORY

The patient, an Indian peasant of some seventy years, was thought to have an adenomatous prostate, with retention of urine. His general condition was fair, but his blood urea was 120 mg. %. A suprapubic cystostomy was performed. Five weeks later a Freyer type prostatectomy was attempted, but it was soon evident that one was dealing with a carcinoma of the prostate which was infiltrating into the bladder wall.

As one side of the prostate was already partly freed, it was decided to complete the dissection with curved scissors. The tumour was gripped with Lane's forceps and pulled upwards into the bladder, and, keeping as far as possible outside the area of induration, it was snipped away. Eventually the prostate was found to be attached only by the urethra, which could be stretched to some 3 cm. easily. It was divided about 1 cm. from the prostate. The remainder immediately retracted away. Meanwhile a blood transfusion had been commenced.

The specimen was seen to consist of the base of the bladder, both seminal vesicles, and the whole prostate, which was the seat of a carcinoma invading the surrounding tissue. The lower ends of the ureters were not identified. 1 cm. of urethra was present. An examining finger felt an alarming gap in the base of the bladder, which was oozing freely. No attempt was made to suture the edges of this gap to the urethra. A large rubber catheter was passed across the gap into the bladder, the oozing was controlled by packing, and the bladder and abdomen were closed with drainage.

After some initial shock the patient made a rapid recovery. He was discharged with no apparent abnormality six weeks after operation. He had complete control of his urine. X-ray investigations of his pelvic bones showed no secondary deposits. Nevertheless stilboestrol therapy was prescribed. Castration was refused. Unfortunately a follow-up was not possible.

This case appears to confirm the anatomical findings concerning the urethra as described by Mr. Souttar, but it would seem that suture of the urethra to the neck of the bladder and the base of the bladder to the triangular ligament are not necessary. Indeed, in the transvesical approach used in this case it would hardly have been possible.—I am, etc.,

Ajmer India.

G. P. CHARLEWOOD.

Thalamic Dysfunction and its Treatment

SIR,—Dr. B. H. Kirman (Aug. 30, p. 348) taxes me with failing to "distinguish between experimentally proven fact and theories with little experimental support," apparently refusing to credit my statement that psychotic and neurotic depression can be distinguished by their specific response to E.C.T. This statement is based on a study of several hundred cases treated over a period of more than five years largely spent as a psychiatric specialist in various military hospitals for acute psychiatric cases. If this is not "experimentally proven fact" I would be extremely interested if Dr. Kirman would explain exactly what he means by this expression.

With regard to the nature of the syndrome itself, a detailed discussion of the evidence for my hypothesis was naturally beyond the scope of a short paper devoted mainly to the subject of pharmacotherapy. The subject of emotional disturbances in relation to disorders of the thalamic-hypothalamic mechanisms is fully dealt with in a number of up-to-date neuropsychiatric papers; in particular I would refer Dr. Kirman to the excellent chapter on the subject in D. T. V. Moore's book *The Nature and Treatment of Mental Disorders*, New York, 1943. In any case I fail to see why the hypothesis put forward in my paper should seem any more far-fetched or incapable of scientific proof than the bizarre concepts upheld by many present-day psycho-analytic enthusiasts.

Now, to turn from controversy to the more practical aspects of the question. No psychiatrist, I venture to think, would disagree with two of the main points in my article: first, that the symptom of anhedonia, or morbidly increased susceptibility to unpleasant sensation and affect, is a constant and almost invariable feature of neurotic patients; and, secondly, that it is one of the worst therapeutic headaches which beset both psychiatrist and general practitioner, on the last-named of

whom ultimately devolves the care of the vast majority of these unfortunates.

The psychiatrist, unlike the surgeon or physician, labours under a great handicap—namely, the lack of specific drugs for the different conditions with which he has to deal. Modern chemotherapy, with its endless variety of potent compounds, offers by far the greatest possibilities for a rational attack on the problem of therapy in mental disorders. If adequate and co-ordinated research along these lines were forthcoming, there should be no reason for psychiatry to lag behind its sister sciences in the field of chemotherapy. What does not seem to be generally realized is that more and better specific drugs for psychiatric conditions are an even more pressing need than more clinics and specialist workers. The work on which my paper was based was carried out in the hope that thereby interest in this subject would be generally stimulated. Let us therefore have discussion and criticism by all means, but let it be intelligent and constructive and directed towards a rational and practical solution of the problem.—I am, etc.,

London, S.E.6.

G. TAYLEUR STOCKINGS.

Intravenous Infusion and Transfusion

SIR,—In his article of Aug. 30 (p. 333) Mr. Hamilton Bailey appears to continue the tradition that transfusion is a formidable procedure requiring complicated apparatus and taxing the skill of the average house-surgeon in setting one up and keeping it going. He still advocates the use of the median cubital vein, and cuts down on it as a routine.

This is an unsatisfactory vein for several reasons. (1) It is frequently tortuous and does not permit the insertion of sufficient length of needle to ensure its remaining in position. (2) It necessitates the splinting of the arm in the extremely uncomfortable position of full extension and supination. (3) If the vein is damaged by a haematoma or thrombosis it tends to block the distal veins and render them unfit for use. (4) Cutting down renders the vein useless for later transfusions and immeasurably increases the risk of sepsis, even with careful technique.

A much more satisfactory vein is the distal part of the cephalic vein, about two inches above the wrist on the radial border of the forearm. It is long and straight, and is anchored by being formed like an inverted Y by tributaries, and is nearly always as wide as the median cubital vein. Also it necessitates only light splinting of the wrist, so that the patient can move his arm into comfortable positions. Cutting down is rarely necessary unless the transfusion is required for more than 48 hours, provided the vein is well dilated before needling. This necessitates adjusting the tourniquet at least five minutes before needling, while the rest of the apparatus is being tested, and is further helped by briskly flicking the skin over the vein. Hot pads are rarely necessary.

If the needle is then inserted into the Y junction of the veins, even a beginner can hardly fail to get it in up to the hilt, and if the tubing and needle are fixed directly to the arm by strips of adhesive tape the transfusion will usually run for 24–48 hours with very little trouble. For beginners a syringe connected to the needle is useful for ensuring clear entry into the vein, but with a little practice the needle can be inserted already connected to the apparatus, entry being ascertained by free flow through the drip chamber once the tourniquet and stopcock on the tubing are opened.

This method is apparently not widely known, but was well tried as the standard method in the Army transfusions, often being set up under very difficult conditions and surviving ambulance journeys and all other vicissitudes of battle casualties far better than traditional methods.—I am, etc.,

Guildford.

CHARLES CRAWFORD.

Foetus Cries

SIR,—On Tuesday, Sept. 2, at 11.30 a.m. at the Trowbridge Hospital I endeavoured to induce labour in a 2-para woman at the 39th week of pregnancy by means of a Drew-Smythe catheter. The head was floating. The catheter passed very easily through the cervix and punctured the membranes without use of the stilette and also without passing as far round the baby's head as I had intended. Liquor flowed at once in a steady stream without bubbles. When the stream slowed a hand was placed on the abdomen and a further ounce or so of liquor came away.

While still standing behind the patient, having just removed the catheter, I was astonished to hear the baby cry. I did not at first believe my ears, though I said it sounded like the baby