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

crying, Sister said and repeated, "It is the baby crying"—and it was. The mother also heard it. I got a foetal stethoscope and went round to the front of the mother to listen to the foetal heart and heard the crying again, louder than before. The baby cried a third time, but I had left the room hoping to find another doctor near, and only Sister and the patient heard it. No further intrauterine crying was heard.

More liquor drained during the afternoon. Contractions began about 6 p.m., and the baby was born at 12.10 a.m.—i.e., over 12 hours after the intrauterine crying. It cried at once and is quite well.

(It would have been possible for the Drew-Smythe to have been passed into the child's mouth.)—I am, etc.,

Trowbridge.

E. CURPHEY.

Examining Overseas

SIR,—The recent tragic death of one of the most able members of our profession shortly after a long round of examinations overseas calls attention to an important aspect of these tours. I can speak with personal experience of several such trips and considerable experience of long-distance flights. In this particular case I met two of the examiners in Cairo on their way home. Both were tired men, and one was completely exhausted.

Those invited to undertake this work are of necessity busy men with heavy commitments at home. It is sometimes held out as an inducement that no time will be wasted and that the tour will only occupy some surprisingly short period of weeks. The tour in such circumstances is extremely trying. Oral examinations and marking of papers are crowded into a minimum of time before the examiners fly—often at awkward hours—to their next appointment, and finally start on their homeward journey tired out, usually to pass through rapid changes of climate with only a few hours' rest at night. Return home involves instant immersion in a welter of arrears and urgent engagements, and a holiday is an impossibility.

If further tragedies are to be avoided these tours should be planned to allow reasonable leisure, and a rest in some pleasant surroundings should be arranged to take place before the trip home. Electing bodies should not only provide for such rest but insist that it should be followed in spite of possible protests by examiners.—I am, etc.,

London, W.1.

HENRY TIDY.

Housing the Infirm

SIR,—The recent B.M.A. booklet on *The Care and Treatment of the Elderly and Infirm* is so excellent that all who are interested in the welfare of old people hope that it will reach a wide public. This subject, once scarcely developed, is now being given more prominence, and it is to be desired that many more doctors should realize the interest of tackling this difficult problem, of exploring new methods and seeking for fresh solutions. There is plenty of room for creative work.

Among the list of publications consulted by the B.M.A. special committee which drew up this work my booklets are mentioned. As they are now out of print, I have given one of the few remaining copies of *Housing the Infirm* to the B.M.A. Library. I wish to point out, however, that it was written in 1937, and that if I were going to republish it to-day it would have to be amended in several important respects. There is little that I should wish to omit, but much that I might add.

Part I consists of suggestions for brightening up existing public assistance institutions, both how to improve the appearance of the rooms and how to provide a more interesting life for the inmates. Points like permission for daily visiting, the wearing of private clothing, and the provision of more occupations have now been officially recommended in the Ministry of Health Circular 49/47. The chapter on pocket money is now out of date, since Miss Irene Ward's Poor Law (Amendment) Act, 1938, allowed the authorities to give it to inmates aged 65 or more; and, after a long campaign, all of them, including the Scots, agreed to do so. Further sections could well be added in order to mention the more difficult types of patient—senile, bedridden, incontinent, and so on—as I am afraid that to readers unfamiliar with institutions the impression might be given that the author believes that the majority of inmates would be suitable for transfer to small hostels. This is not the case. Probably no more than a fifth, or at most a quarter, of the present elderly inmates in institutions could be suitably provided for in

hostels run on the freer lines of voluntary ones. All authorities should, however, be encouraged to follow the lead of those progressive counties and county boroughs which have already provided such hostels, in some cases for several years. Their experience proves what great satisfaction is given to those old people capable of enjoying a fairly active and normal way of life in the background of an ordinary large house.

Part II consists mainly of advice on how to build new institutions for the old. It is to be hoped that this will be relevant some day, as most people would like to see scrapped the worst of our old-fashioned public assistance buildings. In view of the present building crisis, however, authorities are unlikely to be able to build afresh for some years. If, therefore, I were to republish my booklet to-day I should stress the advisability of buying up or taking over ordinary fairly large houses, which do not require very much adaptation. In some ways they may even be preferable to new erections, since they were built originally as private homes and therefore do not smack of institutions.

The last chapter in the book I would now put first, since I regard it as the most important. It stresses the fact that it is the staff, far more than the building, which makes or mars the happiness of those who "go in."—I am, etc.,

London, S.W.7.

OLIVE MATTHEWS.

British Rheumatic Association

SIR,—An association to forward the interests of sufferers from rheumatism has been formed on the lines of the well-known Diabetic Association. Mr. H. G. Wells, who was largely responsible for the founding of the Diabetic Association in 1933, prophesied that it would be followed by other associations of people with a common disability.

A letter dated House of Commons, May 19, 1947, was signed by five M.P.s representing all parties: Lady Megan Lloyd George; Col. Stoddart-Scott, and Major C. York; Dr. S. W. Jeger and Mr. Stephen Taylor. This was published in the Press. The key paragraph read as follows:

"A Rheumatic Association is visualized to organize the general welfare of sufferers on a national scale both by direct action and advice and by assisting existing institutions. There would be an executive and an advisory staff, and a monthly journal to keep sufferers, and the public generally, informed of developments in the treatment of rheumatism, of research into the disease, and of matters of public health bearing on rheumatism."

The response to this letter justified the founding of the Association. It has been constituted essentially as a lay body with lay activities; its Council must always have a non-medical majority. Apart from myself, the medical men at present serving on the Council are: Dr. Francis Bach, Dr. S. W. Jeger, M.P., Dr. C. E. Lakin, Col. Stoddart-Scott, M.P., and Dr. H. D. Wyatt. The following are among those who have consented to be titular vice-presidents: the Marchioness of Reading, Lady Megan Lloyd George, the Dean of Westminster, Sir Ian Fraser, Sir Alan Herbert, Sir Ralph Richardson, Sir Harold Tempny, the Earl of Scarborough, Mr. Percy Rockliff, and the Rt. Hon. Tom Williams.

The British Rheumatic Association is not intended to rival any existing body. It has, in fact, the approval of the Empire Rheumatism Council, and is seeking registration as a charity trust. It has been formed primarily to help rheumatic sufferers to help themselves; but its membership is open to all who are interested in rheumatism, whether sufferers or not. The subscription has been fixed at 10s. per annum. Donations would be welcomed. The headquarters of the Association is at 118-120, Wardour Street, but written communications should be addressed to the Hon. Secretary, Mr. A. C. M. Bowen, B.A., at the clerical department, 111, Woodville Road, New Barnet, Herts.—I am, etc.,

New Barnet, Herts.

F. HERNAMAN-JOHNSON,
Chairman of Council, B.R.A.

The Report of the London Council of Social Services for the Year 1946-7 has recently been published. Of particular interest is the expansion of the Old People's Welfare Department that it reveals. An experimental London Federation of Homes for the Aged has been set up with the object of raising the standard of homes for the aged and for providing a consultation service. The Federation is planning a conference for matrons of old people's homes. The London Council has surveyed the home help available for old people in various boroughs. Ten local committees are now providing mobile meals services and canteens.