unsatisfactory. There are still many avenues to explore in arriving at the perfect sclerosant and the perfect operation.

—I am, etc.,

London, W.1.

R. ROWDEN FOOTE.

SIR,—Prof. A. M. Boyd and Mr. D. J. Robertson (Sept. 20, p. 452) are to be congratulated on calling attention to the two complications associated with ill-judged surgery of varicose veins. The commonest cause of recurrence after operation is failure to tie the saphena vein flush with the femoral vein and to tie and divide all its terminal tributaries. During the last four years I have seen 123 recurrences of this type. Having collected large series of cases in which both the vertical and oblique incisions were used, I have no hesitation in recommending the latter; it heals so much better, and if rightly placed and of sufficient length it gives all the exposure that can be wished for.

My clinical experience gained in operations on nearly 3,000 cases makes me agree with Boyd and Robertson as to the site and frequency of the incompetent perforating veins. There is no difficulty in discovering the presence of such veins, but it is not always easy unless a very long incision is made to find the exact spot where the vein perforates the deep fascia. In a small percentage of cases the perforating veins are grossly incompetent, and it is essential to divide their flesh with the deep fascia. The most certain, simplest, and safest way of doing this is to remove the saphena vein with a Mayo or Babcock vein enucleator.

Like Boyd I was struck by the frequency of deep thrombophlebitis in Service personnel after the combined ligation-injection treatment of varicosities, and since 1943 I have tied the vein and postponed injections until the patient was walking about normally. This may be slow in producing thrombosis of all the varicosities, but it certainly lessens the risk of deep thrombosis and shortens the convalescence. Finally I should like to support Boyd and Robertson's plea for a careful clinical assessment before operation is advised. The mere presence of varicosities is not sufficient reason for advocating operation or injection.—I am, etc.,

Liverpool.

J. B. OLDHAM.

SIR,—In their article "Treatment of Varicose Veins" Prof. A. M. Boyd and Mr. D. J. Robertson (Sept. 20, p. 452) draw attention to the danger of retrograde injection of sclerosing fluids after ligation and state that recurrence usually occurs from inadequate ligation. With their first statement I am entirely in agreement and have long since abandoned it; further, I would point out the folly of relying on even an extensive thrombosis produced by this method to give a permanent cure. Hanschell showed many years ago that even soundly thrombosed veins, where the thrombosis is caused by sclerosing fluids, frequently recanalize in a remarkably short space of time.

With regard to the adequate ligation, I think their description is over-simple and their claims over-optimistic. My work has led me to believe the arrangement of deep communications is very much more complicated (*Lon. Hosp. Gaz.*, 1945, 48, 221). I believe that it is impossible to be sure of preventing recurrences unless all deep communications are dealt with and that this is not a feasible procedure because of the enormous variations. Many times I have seen veins not previously varicose appear after adequate ligation, and I believe this results from deep communications which were normal when the original operation was performed. I have on one or two occasions ligated such deep communications with most gratifying results.

I think ligation the only method worth using in severe varicose veins despite my previous remarks, but follow-up for years, not months, is needed to be sure the case is cured.—I am, etc.,

Hutton, Essex.

W. D. PARK.

Antihistamine Drug for Pruritus of Jaundice

SIR,—There is one action of antihistamine drugs to which we are unable to find any reference in the published literature. If it has been recorded previously it is of sufficient importance to warrant a further note. We have found that patients suffering from the pruritus of jaundice, hitherto an intractable therapeutic problem, derive marked relief from the administration of antihistamine drugs. The benefit is so great that it may well make

life intolerable for the jaundiced patient with an inoperable carcinoma.

The drug which we have used entirely is "neoantergan" ("anthisan"), prepared by May and Baker but not yet upon the market. The dosage given was 0.2 g. at four- to six-hourly intervals. Four-hourly dosage appears necessary because the effect of a single dose of antihistamine drugs only lasts for about six hours. It is perhaps for this reason that we have noted in some cases a recurrence of skin irritation in the early hours of the morning, which disappears when the next dose is administered. "Benadryl," which has a similar action and is available, will certainly produce similar benefit.—We are, etc.,

R. B. HUNTER,

D. M. DUNLOP.

Edinburgh.

New Treatment of Rheumatoid Arthritis

SIR,—At the Bath Rheumatism Congress in May, 1928, I read a paper on the endocrines in arthritis in which I pointed out that women suffering from rheumatoid arthritis who became pregnant experience a marked relief of all their symptoms, but that they relapsed again during the puerperium, and I suggested that the improvement during pregnancy was due to some endocrine change, a flooding with some special secretion or an inhibition of other active gland product. The balance of the endocrines is much more unstable in the female. Stimulation of the secretion of pituitrin by the internal secretion of the ovary is arrested by that of the corpus luteum. It is noteworthy that at about the same time Cumberbatch and Robinson obtained improvement, often lasting in character, by "cooking" the ovaries with diathermy, and they believed that certain forms of arthritis were mainly due to the inactivity of the corpora lutea.

Dr. Imre Barsi raises the whole question again (Aug. 16, p. 252). He assumes that "a hypothetical material circulates in the blood of pregnant women," and, as pregnant women suffering from arthritis materially improve, he has injected the blood of pregnant women into cases of arthritis, with definite and permanent results. Unfortunately, as Dr. M. D. Warren points out (Sept. 13, p. 433), he does not mention if there was any blood grouping having been carried out, and it is quite possible that the improvement was due to protein shock. Case 4 reported by Dr. Barsi was a male aged 66, and he claims that he was definitely cured of his arthritic symptoms. This is difficult to explain, and it certainly looks as if this improvement was more likely due to protein shock.

The whole question should not be allowed to drop, and I would make the following suggestions: (1) That only those cases of atrophic rheumatoid arthritis occurring in young women should be treated by blood transfusion from pregnant women; (2) that blood grouping be carried out; (3) that an equal number of controls be treated with normal blood—i.e., blood from non-pregnant women or males; (4) that records of temperature, sedimentation rate, and blood sugar be fully recorded.—I am, etc.,

Harrogate.

G. L. KERR PRINGLE.

SIR,—I wrote Dr. Imre Barsi requesting information as to typing the blood. He replied: "The typing is very important and must be done with the greatest care. I always use blood of the same type if I can get it; if not, I use type O, but I always make in such cases a cross-typing before transfusion."

So much for the blood grouping, but I should like to know if the haematologists at Oxford could not find out what it is in the blood of the pregnant woman that arrests rheumatoid arthritis.—I am, etc.,

Salisbury.

G. BAYNTON FORGE.

Penicillin in the Treatment of Diphtheria

SIR,—Recent articles on the use of penicillin in diphtheria prompt me to place on record two cases as follows.

(1) A boy of 8 years was admitted to Shieldhall Hospital on Nov. 4, 1946, on the fourth day of illness. A doctor had not been called earlier, as his symptoms were at first attributed to mumps. He had had immunizing injections in 1940.

(2) A boy of 7 years was admitted on Nov. 5, 1946, on the third day of illness. His doctor had regarded him at first as a case of quinsy.

On admission both patients were profoundly toxic, with profuse nasal discharge, great enlargement of cervical glands, and the fauces

covered with diphtheritic membrane. Throat swabs revealed virulent *C. diphtheriae* (atypical). Each patient was given 40,000 units of antitoxin intravenously and 60,000 units intramuscularly, and within 24 hours of admission a further 40,000 units intravenously. By Nov. 8 neither showed any improvement and a fatal issue seemed almost inevitable. 50,000 units of penicillin was then administered intramuscularly, followed by doses of 20,000 units 3-hourly, which were continued until Nov. 19 and Nov. 17 respectively. By this time each throat was clean, the swelling of glands had subsided, the nose was free of discharge, and the general condition remarkably improved. Recovery was very gradual, being interrupted by palatal and pharyngeal paralysis in both cases, and by ciliary paralysis in one of them. It was 11 weeks from the onset before the patients were considered fit to sit up, and further convalescence was uneventful.

De, Chatterjee, and Ganguli (1947) advocate giving penicillin without serum to mild and moderately severe cases of diphtheria, and report success in a series of 27, but few if any workers of experience in this country will support them in such a hazardous procedure. The need for penicillin in addition to serum in mild and moderate cases is also debatable. Some benefit may be observed where there is superadded septic infection, but for pure diphtheria we have a perfectly efficient remedy in antitoxin. It is for the gravely ill patient coming under observation after several days' illness, when no amount of antitoxin can undo the damage already suffered, that the value or otherwise of penicillin becomes vitally important. One must be clear, however, as to what a really severe case of diphtheria amounts to. Dodds' (1946) group of 13 patients treated with penicillin are nearly all styled "severe pharyngeal," and while they were given considerable intramuscular doses of antitoxin, only one was deemed ill enough to be given an intravenous dose. In four of the "severe" cases, moreover, hospital treatment lasted for only 33 to 35 days, a period quite inadequate for all but the mildest of infections. Long's (1947) three patients were, judging by his reports, all very ill, one indeed being regarded as hopeless, but again none was given an intravenous dose of serum. This writer mentions the striking value of penicillin, of which he advises giving at least a million units per day in severe cases, but states that in this country no case of diphtheria without secondary infection appears to have responded to treatment in a convincing fashion.

In the two cases reported above there was no apparent secondary infection, and a much smaller amount of penicillin was used. The membrane did not clear from the throat much more rapidly than usual, nor was the date determined when the fauces were free of organisms, but in many years' experience of diphtheria I have never seen such a striking recovery as was made by these patients. Hitherto sceptical, I am now convinced that penicillin may be a life-saving agent in this disease. I await the opportunity to find further proof of its value, but grave cases of diphtheria are now rarely observed in hospital.—I am, etc.,

Glasgow.

WILLIAM NAPIER.

REFERENCES

- De, M. N., Chatterjee, J. R., and Ganguli, L. (1947). *British Medical Journal*, 1, 376.
 Dodds, R. S. (1946). *Ibid.*, 2, 8.
 Long, D. A. (1947). *Ibid.*, 1, 884.

The Extent of Neurosis

SIR,—Dr. H. G. St. M. Rees (Sept. 20, p. 468) invites "our older brethren in general practice" to comment on the extent of neurosis to-day compared with what it used to be. I am not now engaged in general practice, but of my 45 years of professional life approximately half that time has been spent in general practice, always with a psychological bias, and the remainder has been spent as a consultant medical psychologist. Moreover, during the war years I took the opportunity of refreshing my experience of general practice by lending a hand to hard-pressed colleagues in their surgeries and visits. I may therefore be considered qualified both by age and experience to express an opinion.

When I look back to the crowded surgeries of my early days in Leeds, and before that to the time when part of my vacation even before qualifying would be spent in "taking surgeries" for my father in London, it seems to me that the greatest difference between then and now is that patients had a simple faith in their doctor and in a bottle of medicine which is lacking to-day. The patient of forty and fifty years ago did not pretend to any knowledge of physiology, still less of pathology, and was content with a simple explanation and his doctor's "say so." To-day he comes full of

morbid fears engendered by advertisements of "stomach powders," vitamins, and hormones, and fed by imperfectly digested scraps of information gained by his wife's attendance at "the welfare," or by comparing notes with an O.P. hospital patient. The patient of bygone years had but two bogies, cancer and consumption, but the modern is familiar with stomach and duodenal ulcers, pernicious anaemias, coronary thrombosis, sinus infections, and has taken up "blood pressure" where the doctors are beginning to leave it off. He has transferred his faith from the practitioner to a clinical armamentarium, from the bottle of medicine to a course of hypodermic injections. This attitude makes nonsense, of course, of the demand for free choice of doctor under the Health Act. For good or ill the old type of family physician, whose personality was his greatest asset, has gone. His place has been taken by the microscope and test-tube.

The changes that have taken place in the art and science and practice of medicine can be gauged by recalling the kind of ailments one dealt with in the old days compared with the present. The bulk of one's patients at the morning surgery would be mothers and their babies. Diets were not standardized, and not every infant flourished on food consisting of "the same as we have ourselves," though some most reprehensibly did so. Rickets and its accompanying catarrhal complications were common, and dirt and sepsis more in evidence. There would be women who came to "engage," and this entailed nothing more than entering the particulars in a book. Antenatal examinations were unknown and would have been regarded as indelicate. My father taught me to deliver under cover of the bedclothes. Among the young unmarried women patients chlorosis and gastric ulcer were common, and extensive varicose ulcers demanding large quantities of Unna's paste were frequent in the elderly. The evening surgeries would bring a larger proportion of men. A simple dyspepsia, not yet described as a "gastric stomach," brought a good many of them and was usually the result of too hearty indulgence in beer. Chronic alcoholic cirrhosis of the liver was frequent, while the secondary and tertiary manifestations of syphilis such as one only meets with nowadays in textbooks were constantly providing problems in diagnosis. Respiratory troubles in the shape of acute and chronic bronchitis were, I feel sure, more common in those days, and like the syphilis were the result of lack of early and effective treatment. Chronic tuberculous abscesses and discharging empyemas took up much time with the necessary dressings. I have a very strong impression too that stone in the kidney and bladder was more common than it is now, and certainly one saw more urethral strictures due to gonorrhoea than one does in these days, again due to ineffective treatment. The early diagnosis of phthisis without the aid of x rays and often without a sputum test kept one clinically on one's toes, and there was always the possibility that an undiagnosed typhoid was sitting on the bench waiting his turn.

Now if I compare all this with my more recent experiences I am tempted to say that the patient of former times went to his doctor because he had something the matter with him, whereas the majority of patients to-day seek aid because they *fear* that they may have something wrong. There is a change in the character and incidence of neurosis during the last half-century. My early interest in neurotic illness was stimulated by cases of frank hysteria such as one only sees now in the war hospitals. The hysteria was manifested by girls who were frustrated in their love affairs or by married women as a protest against a domineering male. I feel sure that, if there had been the widespread anxiety states which permeate medical practice to-day, I should have noted it.

As for the causes of this change, it would exceed the limits of a letter if I attempted to elucidate them here. I can only point out that frustration produces aggression, and repressed aggression shows itself as anxiety. There are many obvious causes of frustration in these days of austerity, but I believe we must look deeper than that. The whole tendency of social legislation during the last half-century has been to take more and more responsibility off the individual and to put it on the State. The State thus becomes a parent substitute, so that the individual instead of learning self-reliance is kept in a state of pupillage and becomes afraid or unable to take action on his own account. His attitude towards the State is ambivalent just as is the attitude of an adolescent towards the parents. He looks to the State for guidance and protection, but at the same time he resents the control which the State puts on him. There is an increase of masked or repressed aggression and consequently an increase of anxiety.

This reads as if I were a Conservative "die-hard," but actually I am a Socialist and shall welcome the Health Act provided it is implemented in such a way as to encourage the maintenance of mental and physical health in lieu of trying to "cure"