Bornholm Disease in the South Pacific

SIR,—DRS. W. M. Jamieson and D. M. Prinsley (July 12, p. 47) state that they are aware of only one previous report of an outbreak of Bornholm disease in the Tropics (McDaniel, 1944). Two epidemics of Bornholm disease occurred in South Pacific Islands, one in Tonga and the second the following year in the Cook Islands. Tongatabu, the main island of the Tongan Kingdom, lies in about 20 degrees south latitude. It is a low coral island and, although within the Tropics, the climate is not excessively hot nor is the rainfall great. The hottest months of the year are January to March.

In February, 1946, the first case of Bornholm disease was brought to the hospital. This was a Tongan boy, aged 10 years, who collapsed on the road. The Tongan medical practitioner who first saw him suspected an acute abdominal emergency because of pain, tenderness, and rigidity of the right side of the abdomen. Examination showed that the signs were more marked in the upper right quadrant and that they lessened on passing down to the right iliac fossa. The temperature was 101° F. (38.3° C.) and there were no physical signs above the diaphragm. A tentative diagnosis of Bornholm disease was made, and the subsequent progress confirmed the diagnosis. This proved to be the starting-point of an epidemic which affected from 20% to 40% of a population of 16,000 people, mostly Tongans. The European population in Tonga is small, but they suffered equally with the native population.

The clinical picture did not differ from the classical description—sudden onset with diaphragmatic pain and fever. In a fair proportion of cases shoulder pain was noted, and in some there were also abdominal pain and chest pains. The temperature range varied, but readings of 104° F. (40° C.) were not uncommon. The acute stage generally lasted two to three days and recovery was rapid and complete. There were no deaths, no complications, and no sequelae. The epidemic lasted about four weeks in Tongatabu. It spread to other islands of the Tongan group. Reports from several of the out-stations mentioned numerous cases of "influenza with pleurisy." These were obviously cases of Bornholm disease.

So far as could be ascertained, none of the Tongan medical practitioners had ever seen or heard of similar cases, so that within recent times Bornholm disease, at least in epidemic form, has not occurred in Tonga. Tonga has free communication with the outside world by a regular monthly steamer from New Zealand. There is also a plane service from New Zealand, via Fiji, and occasional cargo boats from the Pacific coast of North America.

The second epidemic occurred in Rarotonga, the main island of the Cook group. Rarotonga lies about 600 miles due east of Tongatabu and in the same latitude. The rainfall is higher than in Tonga and the climate is warmer, although for a tropical island it is not excessive. The first case of Bornholm disease to be seen occurred early in January, 1947, but it was not until late in February, 1947, that the disease became epidemic. By the end of March the epidemic had burnt itself out. Clinically the cases seen were similar to those seen in Tonga the previous year, and the course of the epidemic resembled that of the Tongan epidemic. Rarotonga is served by a steamer from New Zealand and also by a weekly plane from New Zealand, which calls at Fiji, Tonga, and W. Samoa on the way. One of the native medical practitioners remembers a few cases of "pleurodynia" some years ago, but there is no record that the disease was ever epidemic.

Puka Puka is the most isolated of all the Cook Islands. It is situated in latitude 11 degrees south and is visited only once or twice a year. Puka Puka, or Danger Island, is a low coral atoll. At the end of March, 1947, the Resident Agent reported by radio an epidemic, described as "gastric influenza," which swept through the three villages on the island and finally died out in three weeks. There is no trained person on this island and it was difficult to get an accurate description of this sickness. The prominent symptoms appear to have been sudden onset, pain in the epigastric region, and fever. Mostly young people were affected, and recovery was complete in three days. The point of interest is that no ship had visited this island since October, 1946. This sickness may or may not have been Bornholm disease, but whatever the nature of the epidemic it is

hard to understand how it could have originated after six months of complete isolation from the rest of the world. Could the infective agent remain dormant for so long a period or could it arise spontaneously?—I am, etc.,

Rarotonga, Cook Islands.

FARQUHAR MATHESON.

Anaesthesia for Head and Neck Surgery

SIR,—DR. J. G. Bourne (Oct. 25, p. 654) has drawn attention to the use of *d*-tubocurarine chloride as an aid to endotracheal intubation. That *d*-tubocurarine chloride removes many of the difficulties associated with oral intubation cannot be doubted and has long been recognized, but I would question his method of administration. I agree with him that "it is difficult to predict the approximate dose of curare that is required for any individual." But emphatically the solution to this difficulty is not to give 20 mg. "quickly in one injection immediately after the thiopentone." Individual variation in the reaction to a given dose is characteristic of this drug, and more than one case of apparent idiosyncrasy has occurred. The single injection of 20 mg. into an anaesthetized patient seems therefore an unjustifiable procedure.

To render the administration as safe as possible Dr. John Halton and I have for long advised the following procedure. (1) The intravenous injection of a test dose of "tubarine," usually one-third of the estimated initial dose, followed by a pause of at least two minutes. The normal reaction of a healthy adult to this small dose (usually 5 mg.) is a sensation of heaviness of the eyelids, very occasionally diplopia, and little else. Anything in the nature of ptosis which *cannot be voluntarily controlled* is an excessive reaction indicating the need for caution in the further administration. (2) In the presence of a normal reaction the injection of the *d*-tubocurarine chloride is completed and followed immediately by (3) the dose of thiopentone. The induction of anaesthesia by this method has been carried out on many hundreds of patients, none of whom have complained of any unpleasant sensation before going to sleep.

The initial test dose has always given valuable information of the range of dosage likely to be required, and the administration of the *d*-tubocurarine chloride before the thiopentone produces a synchronization of the maximal effects of both drugs. This probably accounts for the fact that I have never had the slightest difficulty in intubating after 15 mg. of tubarine and 0.5 g. of thiopentone, a dose of each considerably less than appears to be required by Dr. Bourne.

I am glad that Dr. Bourne emphasized the need for full oxygenation of the patient after the induction prior to intubation. This gives added relaxation and, as he stresses, a little more time for introducing and fixing the tube. One wonders, however, whether the use of *d*-tubocurarine chloride is really required for operations of this type. In the average patient endotracheal intubation under vision can be performed rapidly and very satisfactorily under thiopentone and a local spray alone, and it appears to me that the upset of the respiratory function caused by *d*-tubocurarine chloride is unjustified for these comparatively superficial procedures.—I am, etc.,

Liverpool.

T. CECIL GRAY.

Duodenal Ulcer and Priority Foods

SIR,—On more than one occasion attention has been called to anomalies in the schedule of diseases governing the issue of priority certificates. With one notable exception the schedule seems just and reasonable, but I am more and more appalled by the colossal amount of milk and eggs that is squandered upon patients with duodenal ulcer by granting them 2 pints (1.1 l.) of milk a day and priority eggs. In the course of a year the milk so cast upon the waters would probably float a battleship (albeit one of a pocket variety). In the schedule, I. D. includes gastric, duodenal, and anastomotic ulcers. Few would grudge priority to those with gastric and anastomotic ulcers, as their symptoms are more frequent and severe, and moreover in point of numbers they are relatively far fewer. The incidence of duodenal ulcers is very high. It has, indeed, become a somewhat popular malady—and no wonder!

Now, if there is one thing more constant than another in the practice of medicine it is the long intervals of complete freedom

from all symptoms enjoyed by patients with chronic duodenal ulcers. Surely there would be a large measure of agreement that there is no need for a patient, even during an acute phase of his duodenal, and far less during a chronic phase, to live exclusively, or even largely, upon milk and eggs. As a rule they can and do have a varied and extensive diet, and many of them are well covered and might reasonably be described as "comfortable" in appearance. If an exclusively milk-and-egg diet continued for, say, a year would cure their ulcers, it might justify such lavish awards, but we know perfectly well that it would do nothing of the sort. Furthermore, the schedule says "duodenal ulcer," not "acute duodenal ulcer," and we know that in the long intervals of freedom from symptoms the ulcer has rarely, if ever, permanently healed except where surgical measures have been adopted, and so all those who have at one time or another had an established ulcer may reasonably claim to come into the category. Indeed, as most of us know to our cost, once the patient's course has been set upon the "milky way" it is almost impossible to set a limit upon it. No infant was ever so difficult to wean as the men (they usually are men) who appear so regularly at three-monthly intervals for their certificates.

At this time of stringency to continue to grant 2 pints of milk a day and priority eggs to the duodenal ulcers, apparently in perpetuity, seems out of all proportion in the national economy and devoid of common sense. I believe that if duodenal ulcer was removed altogether from category I.D. it could be dealt with justly and adequately under II.C., and priority in eggs could be allowed during the relatively short acute stage. In this way I am confident that the scanty allowance for the general public could be appreciably improved.—I am, etc.,

London N.W.7.

A. H. MORLEY.

The Extent of Neurosis

SIR,—Patients with functional rather than organic illness, it is commonly estimated, constitute from one-third to two-thirds of the claimants for general practitioners' attention. Considerable help towards the solution of their problems could be given by general practitioners regularly devoting two afternoons a week to four or five patients for whose illnesses no materialistic interpretations suffice. It would quickly be evident that therapeutic listening alone produces effects, and further discoveries would follow in due course. Some more experienced colleague might before long be consulted, as psychotherapy has its effects on doctors as well as on patients. Observing the emergence of his patients' problems, the practitioner might find himself confronted by previously unrecognized problems of his own. But from the start any practitioner sufficiently concerned with the welfare of sufferers from functional illness would be satisfied that his time was well spent.

In support of this proposition, brief notes of six patients with whom in all fifty-six hours were spent are submitted.

CASE REPORTS

Case 1.—Mrs. A, in her thirties, three months pregnant, complained of attacks of terror at night, with palpitation, following the birth of her fourth child. "I shot out of bed, rampaged round the house, not knowing what to do with myself, then got back to bed shaking and feeling that I was passing right out," she said. In the course of eight one-hour consultations the terror turned to nightmares, and the nightmares to memories and sweet dreams. A man's exposure of himself to her when aged 6, and her father's early death, her uncle's occasional drunkenness, and the general tenor of her miseducation had persuaded her that men such as her worthy husband did terrible things to women. But she is now radiantly enjoying the fifth terrible result of what men do to women. And her four children are finding life easier.

Case 2.—Mrs. B, in her twenties, with one infant, complained of heart attacks and fainting, for which she had earlier been invalided out of the Land Army. After eleven interviews her husband was wondering what had been done to transform his wife from a shrinking girl into a vigorous young woman. Mainly we had discussed her dreams and her ideals. She had been much attached to her churchwarden father.

Case 3.—Mr. C, in his thirties, had been rejected from the Army owing to essential hypertension. He could not stop worrying about his high blood pressure, which was 190/110 at his first interview. At the start of his seventh interview his B.P. was 138/95. He had been left alone in an air raid at the age of three, and had other sources of anxiety.

Case 4.—Mr. D. had been in the Army from 18 to 24 and had a lot to tell of his experiences. He was suffering from headaches, poor sleep, inability to hold down jobs, and marital troubles. He told his tale, and felt a great deal better after ten discussions. The shooting of prisoners by his N.C.O. had not helped him.

Case 5.—Miss E, aged 20-odd, was suffering from tantrums, headaches, backache, and bedwetting. Her mother had died three years earlier and her father had remarried. Her place in the home as the spoilt eldest child was gone for good. After eight interviews she accepted this. Then she dreamt of a fortified breast-shaped island sinking into the sea, and her complaints forthwith ceased, and she became a little less attached to her elderly boy friend.

Case 6.—Mr. F, in his forties, complained of recurrent eczema of the face. This particularly irritated him whenever he was wronged. He was also troubled by a very strict sense of right and wrong, the childish origins of which we investigated. He began to see that black and white were not the only colours in the world, and he ceased, after twelve consultations, to suffer from irritation of his flushed face.

These six cases are culled from some fifty to whom, in the course of an initial year of psychotherapeutic endeavour combined with general practice, over 1,000 hours were devoted. A further six patients conspicuously failed to derive apparent benefit from prolonged attention. Encouraging responses have come from the majority of the remainder, but this is sufficient exposure of the bare bones of some benefits to be derived from psychotherapy.

It has been long known that much may be done by compassionate inquiry into the lives of sufferers from functional illness and by dispassionate discussion of their problems, but still general practitioners' surgeries remain crowded by men and women in need of understanding who get medicines and pills. This is no new problem, but it bears repetition as long as its existence is at all ignored or denied. Sufficient recognition of its existence will, as is the case with patients' problems, do much towards reducing its deleterious effects.

Grateful acknowledgments are made to Dr. E. Graham Howe for his help and encouragement.—I am, etc.,

Ruislip, Middlesex.

WILLOUGHBY CLARK.

SIR,—It is to be hoped that Dr. H. Crichton-Miller (Oct. 25, p. 669) will not be prevented by "limits imposed by a letter" in elaborating his ideas on the prevention of neurosis. His theme should be emphasized on all possible occasions until it may sink into the mentality of politicians and statesmen. It was under the stimulus of "fear" (in the psychologist's sense of the word) that the human race has evolved, and fear in one form or another has been responsible for most of the advances which human hands and brains have achieved. When the stimulus of fear is removed and milk-sop sociological ideas are substituted, the poor moron is removed from his true place on the fringe of the herd and becomes the spoilt boy of his group—and, alas, too often the pet of his doctor.

Under the more robust ideas of the pre-Socialist age this human riff-raff was taken at its true worth to the herd. To-day it too often becomes the group standard above which none may aim (500 bricks a day). "Freedom from fear," with its fellow slogan "Safety first," may well become the mottos of our social decadence.—I am, etc.,

Alverstoke, Hants.

W. H. EDGAR.

SIR,—Why does Dr. H. Crichton-Miller (Oct. 25, p. 669) suggest that Socialism eliminates fear? In a *laissez-faire* economy fear was certainly present as he suggests, but in my experience it is far from absent in such services as may be described as socialized. In local government, in municipal hospitals, in the fighting Services one sees quite a lot of fear—fear of getting a bad mark, of not being in favour with superiors, and fear of responsibility, fear of employers and unions. If things come to such a pass that those who have lost the favour of the "machine" have lost their chance of employment, which is not impossible, then fear will be augmented. The simple-minded may be inclined to put their trust in the State. But do we find the State as honourable in its dealings as we would like to be ourselves? I think not. And if we cannot trust the State we experience fear.

There seems much to be said for maintaining a society in which those out of favour are not unduly penalized. But some trade unions think differently, and so do the rulers of Russia.