one case five—and are in a worse condition than they were before their operations. Moreover, operation is not without its danger to life and limb, and many fatal results have been reported. In seventeen years that I have been doing injections I have had no fatality nor lost a limb. Injection therapy is so simple and safe that scarifying the intima, as described by Mr. Riddock, seems to be unnecessary and even barbarous, though it may give excellent results when performed by his skilled hands. Nor is it necessary to pass a long catheter down a vein to enable a sclerosing fluid to reach its furthest point. If the injection is made into the highest part of the vein, simple massage will drive a wave of fluid down the main trunk, its branches, and also into the communicating veins. In this way the complete internal saphenous system can be soundly and lastingly sclerosed from the groin to the ankle.

But I will admit that in a small minority of cases injections seem to have little or no effect. These unfortunate people must submit to operation or wear stockings for the rest of their lives.—I am, etc.,

London, S.W.7.

R. SIMPSON HARVEY.

Balantidiasis

SIR,—I have read with considerable interest Dr. M. Shun-Shin's article on "Balantidial Dysentery in Rodriguez and its Treatment with Mercury Biniode" (Sept. 13, p. 417). I should like to associate myself with the suggestion of Dr. Shun-Shin, and the following case report would not be out of place.

A Hindu male aged 40 consulted me on Oct. 9, 1947, for an attack of intractable diarrhoea of three months' duration, the number of motions being 20–30 per day. Stool examination revealed *Balantidium coli* and giardia cysts. He was put on emetine injections 1 gr. (65 mg.) daily, methylene blue 2 gr. (0.13 g.) in capsules twice a day, and mepacrine tablets, one tablet thrice daily for five days. With this treatment, though the giardia cysts disappeared, the balantidia continued to be present in highly motile forms. Then on the suggestion of Dr. Shun-Shin I gave an intramuscular injection of 1/6 gr. (11 mg.) of biniode of mercury, and stool examination four days later revealed complete absence of the ciliates. In spite of negative stool findings another injection was repeated, and two subsequent stool examinations on different dates failed to show the balantidia. The patient at the time of reporting had been passing 2–3 normal motions per day and was feeling very well.

The application of hydrarg. biniode in the treatment of balantidiasis has opened up new prospects of cure and eradication of an otherwise very intractable and persistent infection, and further reports in support from members of the profession would be welcome.—I am, etc.,

Santipur, West Bengal.

S. PRAMANIK.

Anticoagulants in Coronary Thrombosis

SIR,—The annotation on dicoumarol (Oct. 25, p. 662) and Dr. John T. MacLachlan's letter on heparin for coronary thrombosis (Nov. 1, p. 709) will, I fear, raise hopes which are doomed to bitter disillusionment. I have nothing but praise for the action of dicoumarol in peripheral phlebotrombosis and thrombophlebitis. Not one of my cases has developed an embolism, and I have a strong impression that the local manifestations subside more rapidly. Although there has been an alarming drop in the prothrombin index in one or two cases, there have been no untoward results.

With this experience of dicoumarol it was with high hopes that I commenced to use it in cases of coronary thrombosis a few months ago. The first two cases in which I used it had each had more than one lung infarct before treatment was started, and each had phlebotrombosis in one leg. Despite a satisfactory drop in the prothrombin index both patients developed further lung infarcts. One occurred when the index was 54%, the second while the index was rising over a period of three days from 43% to 74%. In each case the illness ran a particularly stormy course, and occasioned greater anxiety than the average patient with coronary thrombosis and lung infarction. In addition to these two cases two patients with hypertensive heart failure and lung infarct were given dicoumarol. One of them had two further infarcts during the treatment, the first on the day when his prothrombin index stood at 76%, the other with a prothrombin index of 43%. The second patient had an extension of thrombophlebitis during an intermission in her treatment, and had another lung infarct after the treatment was resumed.

The fifth patient to receive this drug completed my discomfiture and disillusionment. A woman aged 57 who suffered from hypertension with angina of effort was admitted to the ward for thiocyanate treatment. On the fourth day, when her blood pressure had fallen

from 220/110 to 180/94, she developed a severe attack of coronary thrombosis. Within half an hour of the onset of her pain she had profuse haemoptysis, attributed at the time to pulmonary infarction, though necropsy subsequently showed that it was due to pulmonary congestion. Thiocyanate was immediately discontinued and dicoumarol was started two days later. On the eighth day after her attack (sixth day of dicoumarol treatment) she seemed to be progressing satisfactorily, and her prothrombin index stood at 38%, when she suddenly had another attack of coronary thrombosis and died after a few hours. Necropsy showed the original thrombus in a coronary artery with widespread recent extension, which, according to the pathologist, had taken place a few hours before death.

This last case makes it clear that the blood coagulability is not the only factor which influences extension of a coronary thrombosis, perhaps not even the most important factor. Figures which I hope to publish in due course, from a series of 242 cases, indicate that the mortality from all causes within the first three months is closely related to the degree of shock accompanying the attack itself. In 154 cases there was no shock, though pain in many was severe; the mortality in the first month was nil and in the first three months was only 2.4%. In 88 cases with shock the mortality was 27% in the first month (29% at ages below 50, 19% at age 50 to 59, and 48% at ages over 60).

It would seem, therefore, that the most hopeful line of attack lies in the early and effective treatment of the initial shock. I am experimenting along these lines, making use of a slow intravenous glucose-saline drip to which an ampoule of "cardophyllin" (0.48 g.) is added by injection into the rubber tubing. Treatment has so far been confined to seriously shocked patients, and they have been given morphine when required for pain. While it is too early as yet to make any claims, the results so far are highly encouraging. There have been two dramatic recoveries in patients whom I regarded as moribund, and a third striking recovery in one whom I thought seriously ill though not hopeless. One of these three patients later developed an embolism at bifurcation of abdominal aorta.—I am, etc.,

Glasgow.

ALBERT A. FITZGERALD PEEL.

Knee-jerk Examination

SIR,—I have been using a simple method of eliciting the knee-jerk during the last few years. Recently other colleagues to whom I have demonstrated it have shown interest. Their interest has prompted me to describe it. In this method no percussion hammer is required.

The middle finger of the left hand is placed carefully over the patella tendon, and then the middle finger of the opposite hand is brought sharply down on to the dorsum of the left middle finger as in percussion elsewhere. A positive response is felt by a tightening of the tendon under the examining finger.—I am, etc.,

London, W.5.

J. J. SHIPMAN.

Yeast Extracts and Fat Absorption in Sprue

SIR,—I was interested to see the conclusions of Drs. D. A. K. Black and L. P. R. Fourman (Oct. 25, p. 645) regarding the effect of yeast extracts on fat absorption in sprue. Cases such as they referred to were in the Sprue Research Unit at Poona, where their fat balances and treatment were carried out under my direction. The biochemical estimations were performed by Drs. Black and Fourman as described by them. In a group of cases treated by yeast extract, examined statistically by Mr. Dilwater, the period of treatment was shown to coincide with improvement in fat absorption. These cases had been previously treated by parenteral liver extract in large doses, parenteral nicotinic acid, and riboflavin shortly before yeast extract was used. In my view this finding showed that the whole pattern of therapy may have decreased fat excretion, not the yeast extract alone, as has been concluded. For example, the possible necessity for previous or coincidental liver therapy for the reduction of fat excretion on yeast extract is not considered by them in their article.

The issue could be easily settled by the use of yeast extract alone. I would like to ask if Drs. Black and Fourman have investigated cases other than those on the Sprue Research Unit, as yeast extract alone was never used on these cases. I think it

relevant to point out that yeast extract was not used on patients in the relapse phase of the disease, and that careful clinical observation revealed no beneficial effects from it during remission.—I am, etc.,

Staines, Middlesex.

K. D. KEELE.

Hospital Treatment of School-children in Shropshire

SIR,—I wish to bring to the notice of the profession at large a situation which has recently developed in Shropshire, which this Branch regards as one of the utmost gravity in its bearing on the everyday work of the general practitioners of the area, and the implications of which are widespread and ominous. The Education Act, 1944, imposes on local education authorities "the duty to make such arrangements for securing the provision of free medical treatment for pupils in attendance at any school or county college maintained by them as are necessary for securing that comprehensive facilities for free medical treatment are available to them."

The Education Committee of the Shropshire County Council, in drawing up its scheme, has decided that all hospitals with which it proposes to enter into arrangements for the treatment of school-children shall comply with the following conditions:

"(1) There shall be on the staff of the hospital a resident medical or surgical officer, or both, according to the type of case to be dealt with.

"(2) Treatment for eye, ear, nose, and throat conditions shall only be carried out by, or under the supervision of, a specialist in the appropriate condition, who shall be of consultant status.

"(3) Surgical cases of all categories, whether requiring operative treatment or not, shall only be treated by, or under the supervision of, a Fellow of the Royal College of Surgeons of consultant status, who will himself be expected to carry out any operative treatment required unless it is of a very minor nature.

"(4) Medical cases shall only be treated by, or under the supervision of, a physician of consultant status."

It will be plain to all that the application of these conditions results in the complete elimination of the general practitioner from any part in the treatment of such children, which now may only be carried out in such hospitals as have an active staff of consultant status. In Shropshire this has resulted in a remarkable state of affairs. The county is a large one, covering an area of 1,346 square miles, and having a population of 262,000. Within its borders there is only one hospital available for general medical and surgical cases which fulfils the conditions laid down. It contains 280 beds, is already hard pressed for accommodation, and has long lists of patients awaiting admission—nearly 500 in fact.

On the other hand Shropshire is fortunate in having no less than eleven smaller hospitals of the "cottage hospital" type, widely distributed over the county, with a total of about 250 beds, staffed by the general practitioners residing in their vicinity, and in a high state of efficiency, with consultants available when expert assistance is required. In these hospitals much excellent work of an unspectacular nature has been and is being carried out to the satisfaction of the public, the convenience of patients and their relatives, and, not least, to the relief of the major hospital.

As a result of what I can only describe as the deplorable decision of the local education authority, taken without any approach having been made even to the authorities of the main hospital, these 250 beds will no longer be available to children of school age, since the edict has gone forth that none may treat them who is not of consultant status.

I ask you, Sir, is not this an outstanding example of planning gone mad? And I believe that when the matter is raised at the Representative Meeting it will be dealt with in such a way as to convince those concerned and any others—if such there be—of a like mind that the profession will not submit to such treatment.—I am, etc.,

H. W. BAMBRIDGE,

Wellington, Salop.

President, Shropshire and Mid-Wales Branch.

Fowl Paralysis and Poliomyelitis

SIR,—I was most interested to read Dr. J. A. Goodfellow's account of his experiments on fowl paralysis (Oct. 11, p. 586). In 1937 I saw a child with poliomyelitis on an isolated farm in Herefordshire and was surprised to find a hen lying paralysed in the farmyard at the same time. There were no other cases of

infantile paralysis notified in the district and no more chicken paralysis on the farm. I removed the brain and spinal cord from the hen and sent these to the National Hospital for Diseases of the Nervous System, Queen Square, for histological examination. It was reported that no abnormality could be found.

No doubt the simultaneous occurrence of the two diseases was a pure coincidence, especially as fowl paralysis is not an uncommon disease, but it would be interesting to hear from county doctors whether such a phenomenon is often observed.—I am, etc.,

London, S.W.1.

F. L. KING-LEWIS.

Homosexuality and "Sexual Trauma"

SIR,—Those who are concerned with the social and clinical problems of homosexuality will welcome Mr. D. Stanley-Jones's able refutation (Oct. 25, p. 671) of the theory that seduction in childhood or early adolescence is an important aetiological factor in these cases. In addition to his cogent reminder of the frequent occurrence of homosexual experiences amounting to "seduction" in the early life-history of many well-adjusted heterosexual adults it is possible to adduce further evidence in support of the view that the "traumatic" significance of sexual seduction or assault in childhood has been greatly over-emphasized. The usual tendency has been to argue *a priori* on the basis of certain subjective ethical and moral concepts that, because such assaults are deemed to be morally "wrong," therefore they cannot fail to produce disastrous effects on their victims.

(1) As A. J. Rosanoff¹ has stated, "such evidence as is available would seem to indicate that such seduction can only be of lasting effect if its direction corresponds with the inherent sexual tendencies of the subject"—i.e., psychiatric investigations tend to show that any "lasting effect" is produced, not by the seduction, but by (a) constitutional and endocrine factors, (b) psychosexual immaturity resulting from disturbances in the child-parent relationship in early childhood, or (c) more probably (in the light of contemporary research into psychosomatic interrelationship) a combination of both factors.² In all true adult homosexuals who have been thoroughly investigated there has been some indication that one or both of these factors have long been present *prior* to any seduction or assault. Furthermore, psychiatric experience shows that many true homosexuals have never been subjected to seduction in childhood and, indeed, have never had any physical relationship whatsoever.

(2) Psychiatric investigations have established beyond doubt that, in very many cases of childhood "seduction," it is the so-called "victim" who is in fact the seducer, and that the sexual act with the adult may be actively sought by the child as an expression of the latter's unconscious impulses and fantasies⁴—i.e., that a predisposition in the child may not infrequently be the cause of the alleged seduction. K. Friedlander⁵ states that "it is very rare for boys who do not already display homosexual tendencies to be exploited in this way. . . . More often than not, young boys will offer themselves, if not in words then by gestures, to older men."

(3) There is considerable evidence that the large majority of children and young adolescents who have been seduced or assaulted, either by adults or by other children, and whether the act be homosexual or heterosexual, show in adult life no sign whatsoever of sexual or psychological maladjustment or abnormality. Doshay⁶ found that, among 108 unselected cases who between the ages of 7 and 16 had been involved in sexual delinquencies, there was "not a single instance of a known sex violation in adult life"; and of 148 additional cases, all of whom at the same age had been involved in both sexual and other offences, only 8 committed known sexual offences (of a minor type) in adult life, whereas no less than 25% committed further non-sexual delinquencies. Doshay states that the most frequent sexual offence (in over 40% of his cases) involved sodomy with adult men, older and younger boys, or with girls, and observes that "these practices . . . ought not, when occurring among juveniles, to be regarded in too morbid a light, nor should the boys be considered 'perverts' or 'homosexuals,' as noted in some of the texts. The vast majority of offenders engage once or a few times in these unwholesome affairs and turn from them spontaneously with disgust, shame, or fear of