the urethra a pair of narrow-bladed forceps was passed into the bladder, the thermometer lightly gripped and, with the aid of a guiding finger in the vagina, easily withdrawn. A cystoscope was then introduced, and apart from some bruising of the trigone the bladder was seen to be intact. The occurrence of a second example serves further to emphasize the risks inherent in this undesirable procedure, and it seems that patients who follow this practice should be warned of its dangers.—I am, etc.,

Hove, Sussex.

W. R. FORRESTER-WOOD.

SIR,—The rectal (or vaginal) method of obtaining the basal temperature gives a more accurate record than the oral. To condemn the method because one woman has accidentally inserted the thermometer into the bladder is as unreasonable as it would be to disallow the practice of self-administration of an enema, when necessary, in case the nozzle was passed into the wrong passage. Dr. G. I. M. Swyer (Oct. 25, p. 672) would do well to read an article by Dr. Hales (*Medical Press and Circular*, May, 1946) in which he gives charts of a number of chronic diseases in which the condition would have been overlooked had reliance been placed on the oral recording. I know of an instance in which absence of the ordinary biphasic temperature record of the menstrual cycle drew attention to a tuberculous endometritis. The patient was warned for investigation, and it was observed that the temperature taken by the oral route failed to show the persistent slight rise shown by the rectal method.

The rectal route gives a more accurate degree of temperature. There are a few women whose records of the basal temperature in the pre- and post-ovulatory phase show only a slight difference in the fluctuations, the biphasic character of which could easily be missed if recorded by the less sensitive oral route.—I am, etc.,

London, W.1.

M. MOORE WHITE.

Health Visitors

SIR,—The existing shortage may be attributed to a combination of causes: (a) greater demand on a reduced supply; (b) long course in training—as a nurse, midwife, and health visitor's certificate; (c) less call for change of area from stabilization of pay; (d) multiplicity of duties; (e) interference with training during the war. Two questions arise in one's mind to meet the existing demand: (1) Should a special interim short-term policy of a shorter course, or only a health-visitor's certificate course, be carried out? (2) Should only a long-term policy of existing methods of training prevail even at the expense of acute shortage for years—it may be five to ten years before normality reigns?

At the present time there is no doubt that considerable economy could be carried out in the use of health visitors and that in this respect either (or both) an assistant nurse or a voluntary worker could be utilized in the place of some of the duties now carried out by health visitors. Locally lady members of the maternity and child-welfare committee (both councillors and co-opted members) take turns of duty on a rota at my infant-welfare clinics. No trained nurse is required at an immunization clinic, at weighing of infants and toddlers, the recording of such, and the distribution of foodstuffs. With a doctor in attendance at infant-welfare clinics it should be possible with lectures on hygiene and baby welfare to release some trained nurses for hospitals, where the claim of the sick should hold priority for their services.

There are also some new fields now being attempted for utilization of the services of health visitors. I refer to immunization and blood withdrawal for Rh factor. A hypodermic injection is one thing, but an intramuscular injection of an antigen (capable sometimes of producing shock) and the introduction of a needle into a vein (not always at first shot) are quite different and definitely surgical procedures. In the latter of these unless great care is exercised in asepsis and method there can be a cause for toxæmia. Again this Rh factor concerns midwifery and the midwife at the antenatal clinic is more concerned with the result than the health visitor, and so surely the midwife should be trained to do this at the clinic. One has recently had judgments against a hospital in connexion

with a certain case, and it behoves us to defend our authority to the best of our judgment. On these thoughts I should like to have views of others, and perhaps we may get a lead from the Ministry on some of the problems raised.—I am, etc.,

Blyth, Northumberland.

A. G. NEWELL.

Penile Carcinoma

SIR,—An experiment conducted on a national scale for two thousand years has proved that penile carcinoma is preventable by circumcision, and King Edward's question about tubercle, "If preventable, why not prevented?" is relevant to this form of cancer. As the writer of the annotation (Nov. 1, p. 699) observes, carcinoma of the penis is a rare disease. From a selfish point of view men need not trouble themselves about it unduly, but the interests of the other sex are involved. Correlated with the absolute freedom of Jewish men from this form of cancer is the relative freedom of Jewish women from carcinoma of the cervix. In New York, where three million of the eight million inhabitants are Jews, Dr. Maurice Lenx states that not 1% of the cases of cancer of the cervix occur in Jewish women. During a short visit to the Fiji Islands, where circumcised Fijians live alongside uncircumcised Indians, I obtained statistical evidence that cervical carcinoma is rare in the Fijian women but relatively common in the Indian women, no doubt from a transference to the vagina of the mixed bacterial flora that flourish beneath the prepuce.

As your annotation states, it is unlikely that the routine circumcision of male infants would commend itself to English opinion. But a simpler operation—slitting up the prepuce in the dorsal midline—would be equally effective, and in the first few days of life can be done without an anaesthetic. Only for a long phimotic prepuce is circumcision necessary.

The evidence indicates that routine preputiotomy for male infants would abolish penile cancer and ultimately reduce the incidence of carcinoma of the cervix in this country from about 4,000 cases per annum to 500 cases per annum. The principal obstacle to its adoption appears to be the erroneous belief that carcinoma of the cervix is the result of tearing of the cervix during parturition—an accident to which women of all races are equally liable.—I am, etc.,

London, W.1.

W. SAMPSON HANDLEY.

Modern Treatment of Neurosyphilis

SIR,—I was most interested to read of the experiences of Drs. F. Graham Lescher and H. R. M. Richards in their article "The Modern Treatment of Neurosyphilis" (Oct. 11, p. 565). I note that their most successful results were obtained with combined penicillin and malarial therapy. The following two cases which I treated in conjunction with Sir Sidney Sewell early last year may therefore be of interest.

Case 1.—Mrs. B., a woman of 36, was found to have a positive Wassermann reaction* when her husband developed neurosyphilis. She had no clinical symptoms or signs of disease, but the Wassermann and Kline reactions were positive +++ in both blood and cerebrospinal fluid, and the C.S.F. cell count was 40 lymphocytes. Prior to my seeing her she had had three courses of intravenous arsenic and intramuscular bismuth and one seven-day course of penicillin, 15,000 units three-hourly. Following the first course of penicillin the Wassermann reaction of her blood had been negative, but this had reverted to positive when I saw her, and the C.S.F. findings were as above.

She was put into hospital and given penicillin, 20,000 units three-hourly for ten days, and for the last seven days 5,000 units was given intrathecally twice daily. A month later the Wassermann reaction was negative in the blood but still positive in C.S.F. A further month later the blood Wassermann was positive +, and after another month positive ++.

She was then subjected to hyperthermia in the inductotherm to 105° F. (40.6° C.) for six hours, with two doses of penicillin, 50,000 units (the first at the commencement and the second three hours later) given intramuscularly. In all she was given twelve treatments at weekly intervals.

A month after cessation of treatment Wassermann reaction was negative in both blood and cerebrospinal fluid and has remained so with monthly blood and quarterly C.S.F. Wassermann tests since then—a period of eighteen months. Apart from one occasion (the fourth treatment) when she developed hyperpyrexia which responded to the usual measures, she tolerated the treatments well.

Case 2.—Mr. D., aged 42 years, was a tabetic. He originally had presented with gastric crises three years before. When I saw him for the first time he had been under continuous treatment with arsenicals, bismuth, mercury, and iodides for three years. He complained of intractable lightning pains and frequent severe gastric crises and was in danger of becoming a morphinomaniac. Wassermann reaction was positive +++ in blood and C.S.F.

He was treated by twelve inductotherm fevers combined with penicillin as in Case 1, and a month after cessation of treatment Wassermann reaction was negative in blood and C.S.F. Repeated tests for the past year have remained negative. Lightning pains disappeared after the fifth treatment and have not recurred, and there have been no further gastric crises. At the commencement of treatment both ankle jerks were absent; they are now present, though diminished as compared with a normal individual. He tolerated treatment well and was able to carry on his business in between treatments.

I have not had the opportunity of treating any further cases along these lines, but it seems to me that the inductotherm is to be preferred to malarial therapy. With skilled attendants the risks are slight and certainly no greater than those with malarial therapy. Where anaesthetic areas are present, especially over the heels or coccygeal region, burns are a very real risk, and the state of the pain fibres in these segments should be carefully tested before commencing treatment. The risk of hyperpyrexia can be minimized by skilled and experienced attendants. It is a very frightening complication, but prompt treatment should prevent fatalities. Using treatment at weekly intervals the patient's daily life is not unduly upset, and he can usually continue with his occupation, attending for treatment as an out-patient—a very important matter in these days of shortage of hospital beds.

Stratton St. Margaret, Wilts.

SIDNEY A. SEWELL.

Duodenal Ulcer and Priority Foods

SIR,—Dr. A. H. Morley's statement (Nov. 8, p. 745) that the symptoms of chronic duodenal ulcer are here to-day and gone to-morrow only to return another day, and that two pints of priority milk daily for these patients is squandermania, should not go unchallenged. The symptoms of chronic duodenal ulcer are chronic, recurring at regular intervals every day and every night throughout many years. Patients suffering from this disease have to learn and apply a strict and rigid regime of diet and conduct if they wish to avoid the symptoms of pain, vomiting, acid regurgitations, laryngeal spasms. Alkaline powders are often useless and even harmful. Small amounts of milk at frequent intervals is the best method of counteracting the hyperchlorhydria, and two pints a day is not over-generous. If any alternative to present certification were contemplated it should be to extend the period covered by the certificate to six or twelve months.—I am, etc.,

Harrold, Beds.

R. STUART.

Milk for the Sick

SIR,—I feel that the following account of a recent and, presumably, continuing struggle with the food authorities may be of interest. The relentless undermining of the doctor-patient relationship is once more demonstrated and made very clear, and it is possible that ventilation of the story may be of help to someone in a similar predicament in the future.

Miss X. is a panel patient aged 54. She has a permanent gastrostomy necessitated by inoperable carcinoma of the oesophagus. Until a fortnight ago she required and obtained a special milk ration of 3½ pints (2 l.) per day. Two weeks ago this was without warning cut to 1½ pints (850 ml.) per day, but as a result of my intervention at the food office and at the cost of a wasted morning it was restored pending the consideration by the medical advisers of a "confidential" report from me.

Yesterday the ration was again cut without warning to my patient or myself to 2 pints (1 l.) daily, an allowance on which she will quickly starve. I visited the food office at once and was shown a letter which simply states that "Our advisers recommend that the patient be granted two pints of milk daily and a priority allowance of eggs for three months renewable . . . but they cannot recommend any supplies in excess of the allowance, and the request for five pints of milk must be

refused." This last request had not of course been made. The medical advisers had made no inquiries further to my original letter, nor of course had they or anyone else seen the patient. It would appear possible that these gentlemen are somewhat out of touch with the problems of management of gastrostomies in general practice.

At this stage, in an attempt to save my patient's life, I sought the help of the Association, and a very helpful secretary put me in touch with a charming gentleman at the Ministry of Food. To him, not a medical man, I was compelled by circumstances to disclose the patient's name and address. The diagnosis he already had, so the breach of professional confidence was complete. He told me that he would make an immediate authorization as a "life-saving measure" while the matter was referred to these mysterious advisers. When I told him that they had already decided, he rescinded his decision, but when I further reminded him that the phrase "life-saving measure" was his own he changed his mind again, and the issue is now, as far as I know, again authorized pending some undefined further decision.

It does seem intolerable that when these "advisers" decide against an application on behalf of a patient that they have never seen action can be taken to implement their decision without further reference to the doctor concerned, that one should have to disclose confidential details to a completely unknown layman, and incidentally that one should have to spend a sum considerably greater than even the new capitation fee on telephone calls to obtain the bare necessities of life for a desperately ill patient. And it would appear to bode ill for anyone rash enough to suffer from this complaint after July 1, 1948.—I am, etc.,

Gt. Yarmouth.

H. DE B. MILNE.

Homosexuals

SIR,—May a schoolmaster with some knowledge of history be permitted to comment on the concluding paragraph of Mr. D. Stanley-Jones's letter (Oct. 25, p. 671)? It is difficult to recognize in his description of Innocent III as "a repressed homosexual and a fanatical persecutor" the subject of Prof. E. F. Jacob's brilliant opening essay in the sixth volume of the *Cambridge Mediaeval History*. Mr. Stanley-Jones's conviction that the Albigensians and Bogomils were engaged solely in a quarrel with the Church of Rome looks odd after reading, for instance, the views of a scholar of international repute such as Prof. Jean Guiraud, a useful summary of which may be found in the third volume of *European Civilization* (Oxford University Press, 1935).—I am, etc.,

York.

T. CHARLES-EDWARDS.

Refraction Testing

SIR,—It is a strange suggestion that a medical man should be invited to prescribe spectacles for a visual disability if he lacks adequate specialist knowledge to investigate other possible causes, or that, being recognized to possess such knowledge, he should abstain from applying it. These are the only logical interpretations to be placed upon the recommendation of a lesser sessional rate of remuneration for "clinical refraction work" than for specialist examination, and for countenancing the evasion by local education authorities of liability in respect of children attending a hospital eye department "solely for the prescription of spectacles." The estimate of error of refraction and of the possible benefit to be conferred by spectacles is but a part of ophthalmic specialist examination; the desire of the patient or of others to elicit a prescription for glasses cannot absolve a doctor of responsibility to apply special medical knowledge of eye conditions or warrant a cheap or gratuitous "semi-specialist" service.

A patient consults a doctor for his opinion and advice, and although this may be expressed in relation to pharmaceutical means the attendance is not "solely for the prescription of a bottle of medicine." The representatives of the profession cannot recognize any such suggestion of limited application of the skill of its members, bearing the implication of a "dual standard" or worse. It is legitimate to establish certain qualifications of experience and training to merit recognition in special fields; it is paradoxical to suggest that the eyes of each school