or anticipation of pain, cannot or will not relax, and which has not been, so far as I am aware, described in textbooks or taught in medical schools. The patient is asked to press his head hard back into the pillow. This simple action contracts the erector spinae, and in 19 cases out of 20 the abdominal muscles, which are antagonistic, promptly relax. Moreover, this draws the attention of the patient away from the part to be examined, and a gentle "patter" of conversation on the part of the doctor keeps it away. The principle of contracting a group of muscles in order to relax an antagonistic group is probably also the basis of Dr. Price's method.—I am, etc.,

London, S.E.5.

BERNARD J. FREEDMAN.

"Unjustified" Use of *d*-Tubocurarine Chloride

SIR,—Dr. T. Cecil Gray (Nov. 8, p. 745) has drawn attention to what he describes as the "unjustified" use of *d*-tubocurarine chloride during anaesthesia for operations upon the head and neck. While agreeing with Dr. Gray in this respect I wonder whether he has not fallen into a similar fault in advocating the use of *d*-tubocurarine chloride in caesarean section—a procedure which he describes so ably in your issue of April 5 (p. 444).

To my mind the only possible reason for administering curare preparations to caesarean sections must be for its effect in relaxing the tone of the abdominal musculature, but surely this is quite unnecessary "since the muscles have been well stretched during pregnancy" (H. E. G. Boyle and C. L. Hewer, *J. Obstet. Gynaec. Brit. Emp.*, 1924, 31, 264). This relaxation can be observed quite easily when the obstetrician sews up the peritoneum, which latter can be lifted some inches above the level of the wound.

The increase in uterine tone observed in Dr. Gray's cases is almost certainly due to his use of thiopentone, "kemithal," or *light* cyclopropane, either alone or in combination, as can readily be demonstrated by omitting the administration of curare. Thiopentone and *light* levels of cyclopropane anaesthesia increase the contractility of the uterus, and since 1943, when we finally recognized this effect at King's College Hospital, the routine use of "pituirrin" has been abandoned after the employment of these anaesthetics. The first caesarean section ever to be performed under kemithal anaesthesia was at the same hospital, and the surgeon was Mr. John H. Peel; the date was Nov. 23, 1944, and in that and succeeding cases we rapidly came to recognize that this drug too had a similar tonic action on uterine muscle.

Apropos of the above, I well remember the first time I administered a *light* cyclopropane anaesthetic for a caesarean section performed by the present P.R.C.O.G. Up to that time it had been his routine to inject pituitrin into the wall of the uterus just before making the uterine incision. On this occasion he persisted with the usual routine, but as his scalpel pierced the uterine wall the surgeon was hit smartly in the face by a geyser of liquor amnii and momentarily incommode. Such an exhibition had never occurred while using gas-oxygen-ether and was the first of many instances (such as those attributed by Dr. Gray to the employment of *d*-tubocurarine chloride) which made us conclude that these three anaesthetics were uterine stimulants. Incidentally this property makes them useless for intrauterine manipulations or external version, although *deep* cyclopropane anaesthesia (which would never be used during caesarean section) does relax the uterus.—I am, etc.,

King's College Hospital.

A. H. GALLEY.

Waiting for Operation

SIR,—A. B. is referred by his medical attendant to a particular consultant at hospital. A diagnosis of early carcinoma of the stomach is made and confirmed. The patient is advised to have an operation, to which he agrees, and he is put on the waiting-list for admission. Presumably the consultant has entered into a contract with the patient and his doctor to carry out the treatment. The patient is not admitted for six or even twelve months, and the growth becomes inoperable.

Is this the responsibility of the consultant or the committee of management of the hospital? Should the law decree that the onus is on the committee of management, is it not incumbent upon the committee to review the number of patients on

their waiting-list and to advertise or otherwise make known to all concerned what prospects they envisage of fulfilling the contracts to which they are party? Your decision on these questions is a matter of national importance.—I am, etc.,

London, W.1.

HAMILTON BAILEY.

** Our Legal Correspondent writes: Any cause of action must be founded either on contract (agreement between the parties) or tort (civil wrong; in this case failure to use proper care). In each case the burden of proof is upon the patient. To succeed in an action for breach of contract he must show that an agreement, express or implied, existed to admit him to hospital or to operate on him, or both, while the growth was still operable. If he contracted for operation with the consultant, or for admission with the hospital, on this understanding and could prove it, he might have a chance of success. It is, however, hardly conceivable that either a consultant or a hospital would undertake such an obligation in these days of shortage of beds and would fail to tell the patient that he must wait his turn. Neither the consultant nor the hospital is required to do the impossible. If the patient seeks to found his action in tort, he must prove that the consultant or the hospital, or both, failed to use reasonable care. He might succeed if he could show that it would have been reasonable to warn him of probable delay and that he had not been warned, or that he had been wrongly deprived of his turn in the list, or if there was some other circumstance indicating negligence. Otherwise he would have no chance of success at law; and it may be said generally that in order to succeed he would have to prove a very exceptional state of facts. If he did succeed against the hospital, the committee would certainly be wise to make sure in future that they could not be taken to promise anything they could not perform regarding the interval of time between the acceptance of a patient and his admittance.—ED., *B.M.J.*

Morphine in a Patent Medicine

SIR,—In a medico-legal note (Sept. 27, p. 511) you referred to a case of death in a small child after drinking a quantity of a patent medicine sold for the purpose of relieving infantile disorders. You gave the quantity of morphine in the bottle but stated that it was not disclosed how this figure was ascertained. Actually, the Manchester City Analyst gave the quantity as a result of his analysis, and gave his evidence on oath at the inquest.—I am, etc.,

Salford, 7.

STANLEY HODGSON,
Deputy Coroner, Manchester.

SIR,—Dr. Paul B. Woolley (Nov. 8, p. 747), in quoting *The Chemist and Druggist Year Book* as his authority on dangerous drugs legislation, appears to have misinterpreted the paragraph he cites. Paragraph *e* (p. 339) (so far as it affects morphine) states that any solution or dilution of morphine in an inert substance is subject to the Dangerous Drugs Regulations; other preparations of morphine—i.e., preparations which are not solutions or dilutions in an inert substance—are subject to the Regulations if they contain not less than 0.2% of morphine.—I am, etc.,

London, W.C.2.

O. F. C. BROMFIELD.

Vaginal Temperature

SIR,—Dr. John Hankinson (Oct. 11, p. 574) has drawn attention to the dangers which may accompany the taking of vaginal temperatures. A further similar case has within the last few days come under my care in which a woman had accidentally introduced a clinical thermometer into the bladder. She had been practising this procedure for some twelve months, not for the purpose of birth control, but in an endeavour to become pregnant. No trouble had previously been experienced until one morning she failed to find the thermometer and concluded it had been mislaid in the bedclothes. About midday, however, she experienced a sharp pain in the lower abdomen and some dysuria. It then became apparent where the thermometer was, and she sought medical advice.

An x-ray examination confirmed the presence of an intact thermometer in the pelvis, and the passage of a sound revealed the foreign body in the bladder. After preliminary dilatation of

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 Lenz 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.