thyroid adenocarcinomata in almost 50% of rats to whom they administered thiourea for more than two years.

The histological picture of the human thyroid after thiouracil therapy shows marked cellular activity, and before its general use is recommended further research should be carried out on the possibility of delayed after-effects. The experienced surgeon who resects a toxic goitre knows that 99% of his patients should survive the operation, that about 90% will lead approximately normal lives without special supervision, and that, in the event of an error in diagnosis, malignancy will be revealed and can be treated without further delay. The thiouracil drugs are most valuable in preparing a patient for operative treatment, but caution is advised before suggesting that they should replace it.—I am, etc.,

London, N.2.

HENRI ROUALLE.

REFERENCE

¹ Purves, H. D., and Griesbach, W. E., *Brit. J. exp. Path.*, 1947, **28**, 46.

Measles Prophylactic

SIR,—Following your leading article (Nov. 8, p. 737) on the use of gamma globulin as a measles prophylactic it would seem worth while to stress once again the value of a dose of adult whole blood intramuscularly if given at any time up to the sixth or seventh day of incubation. Gamma globulin is expensive to produce and uses the time of highly skilled technicians. Blood, 4 to 10 ml. according to the child's age, taken from the mother and injected immediately, is cheap and speedy therapy. The marked difference in the severity of symptoms in the unprotected case and the partially protected contact is so constant that the method can be advocated as a routine measure when the first of a family of children is found to have measles or other contacts are known.—I am, etc.,

Stanmore, Middlesex.

HARWOOD STEVENSON.

Dicoumarol

SIR,—I read with interest your annotation (Oct. 25, p. 662) on dicoumarol and subsequent letters. I feel that Dr. Frank Marsh (Nov. 8, p. 748) is on the right lines when he suggests a large dose for the first two days, then an interval, and subsequent smaller doses.

My experience with Quick's method of prothrombin estimation has been singularly unfortunate. The results I obtained were far too varied to permit of any serious consideration. We used the clotting time and attempted to double the original figure. This was done throughout by Lee and White's method. In a number of cases alarming features resulted before the clotting time had doubled. Obviously the drug has a cumulative effect, and the clotting time does not begin to rise appreciably until the patient has been on it for some time, and then it rises with marked rapidity.

I would suggest that the drug be given in maximal doses—i.e., 300 mg. the first day, 200 mg. the second day, then 150 mg. daily until the clotting time begins to rise, and at that stage withheld. When the clotting time has returned to its original value, dicoumarol should be given again. We used fresh-blood transfusion to lower the clotting time and found that it works fairly rapidly. There is at least a 48-hours latent period before intravenous vitamin K begins to show its effect.—I am, etc.,

Birmingham.

M. J. PIVAWER.

Yeast Extracts and Fat Absorption in Sprue

SIR,—For a detailed discussion of the points raised by Dr. K. D. Keele (Nov. 15, p. 794) we would refer those interested to our paper in the current issue of the *Quart. J. Med.* (1947, **16**, 99). In that paper the evidence for the effectiveness of yeast extract is given, and due acknowledgment for statistical help is made to Mr. Dilwali (not Mr. Dilwater). As Dr. Keele rightly points out, we were not in clinical charge of the patients in Poona, and so we have relied mainly on biochemical evidence for the effect of yeast extract; nor were we in a position to "settle the issue" at that time by the use of yeast extract alone. However, we have since treated patients with sprue in this country and have been able to maintain them in clinical remission by yeast extract without any liver therapy.—We are, etc.,

Manchester.

D. A. K. BLACK.
L. P. R. FOURMAN.

Status Epilepticus after E.C.T.

SIR,—Dr. A. Folkson's memorandum on a case of status epilepticus precipitated by E.C.T. (Aug. 30, p. 335) prompts me to record a similar case.

In September, 1944, an African woman of the Yao tribe (who live on the borders of Tanganyika and Portuguese East Africa) was admitted to this hospital. She was about 45 years of age. The certificate stated that she wandered aimlessly among her neighbours, that she slept in the bush, and that she thought people were going to kill her. After admission she was either indifferent and pre-occupied or nonsensically loquacious. She had corneal opacities and septic teeth. The spleen was enlarged, but there were no malarial parasites in the blood. There were no neurological signs or history of epilepsy. The blood Kahn was negative and the C.S.F. W.R. was negative, with no increase of cells or protein. Attention to her general health produced a partial improvement. On Feb. 20, 1945, she was tried with E.C.T. at 10 a.m. (105 volts, 0.4 sec., 160 milliamp.-sec.). There was a delay of 3 or 4 sec. The next day at 3 p.m. she suddenly passed into typical status epilepticus. At 3.45 p.m. she was given 1/2 oz. (14 ml.) paraldehyde in olive oil per rectum. The fits began to lessen in a few minutes and had ceased after 1/4 hour. There has been no recurrence to date.

—I am, etc.,

Dodoma, E. Africa.

E. J. FOLEY.

Routine Serological Tests for Syphilis

SIR,—At a recent conference of doctors in America surprise was expressed that in this country serological tests for syphilis were not routinely carried out by law on such occasions as marriage, at life insurance examination, or on entry into the Services as is current practice in the States. It was furthermore stated that representatives of this country had indicated that such a proposal would lead to public outcry and would never be permitted, and in any case such a course was unnecessary, because the incidence of venereal disease is so much lower in this country than in the States.

Surely in these enlightened days such a position is indefensible? If we have no serological tests, what reason have we for saying that our incidence is low? Clinical manifestations of the disease are no guide, because they may be dormant for many years and thus be undetected. Is it national prudery, smug hypocrisy, or a fear of exposition which leads us to adopt this rather dubious delicacy on such a matter? I am not a syphilologist, but doubtless there are many with greater knowledge in the matter who can give the answer to this apparent diagnostic obscurantism, and whose views I should like to hear.—I am, etc.,

Bristol.

K. G. BERGIN.

Penile Carcinoma

SIR,—The incidence of cancer of the cervix in Jewish women is relatively low, and this has frequently been ascribed to the observance of laws which combine common-sense hygiene with religion. Mr. W. Sampson Handley (Nov. 22, p. 841) brings forward evidence which suggests that it is the routine circumcision in the male which is the operative factor. If the "transference to the vagina of the mixed bacterial flora that flourish beneath the prepuce" ultimately, by means of chronic infection, leads to cancer of the cervix, then there must be many more cases in which, even without cancerous changes, it results in discomfort and chronic invalidism. Having built up a strong case and drawn the correct inference, your correspondent advises routine preputiotomy in male infants because "it is unlikely that the routine circumcision of male infants would commend itself to English opinion."

What are the objections to routine circumcision and how does preputiotomy meet them? Does the main obstacle to the former lie in the lack of knowledge of a simple operation or in the psychological objection to imitating the Jews? It seems to me that your correspondent's compromise is a bad one. It is true that circumcision, as generally taught, involves general anaesthesia, pressure forceps, scissors, and sutures, while slitting up the prepuce "in the first few days of life can be done without an anaesthetic." Although reference is made to "an experiment conducted on a national scale for two thousand years" (the estimate is a conservative one), there is no mention of the technique which has made it possible. In fact few, if any,

surgical textbooks mention it, and one can only wonder at the apathy of our surgical colleagues. Imagine the consternation that would be caused at the Final Fellowship examination by the question, "Describe the technique of circumcision as practised by the Jews."

"Ritual" circumcision takes about two seconds, and apart from a shield and scalpel does not involve the use of scissors, forceps of any kind, sutures, or general anaesthesia. Nobody can deny that the results are excellent in every way. Preputiotomy would take almost twice as long, on the average, and the introduction of scissors points (they would frequently have to be sharp ones) is not without potential danger to the meatus. The final result can only be described as aesthetically and cosmetically deplorable. Were it practised on a national scale there would soon be a revulsion of feeling on the part of public opinion and the incidence of cancer of the penis and cervix would rise to even greater heights. Your correspondent asks us to face the facts but has only produced half-hearted proposals to meet them.—I am, etc.

London, W.1.

DAVID PREISKEL.

Chemical Carcinogenesis

SIR,—As you point out in your leading article (Oct. 25, p. 659), chemical causes of cancer are so numerous that specific action is not confined to any one of them. It is perhaps worth noting that they all cause damage to a group of cells, with stagnation of circulation, which must be maintained for months. Partly devitalized cells, with local stagnation, are quite characteristic of cancer. As the artifact and the disease seem to originate from the same conditions, the origin must be intracellular, and there is little doubt that local stagnation is a dominant cause.—I am, etc.,

Montreal.

RICHARD KERRY.

Tapered Sutures for Vascular Surgery

SIR,—A successful issue after such operations as those for coarctation of the aorta, congenital pulmonary stenosis, etc., depends chiefly on the establishment of a water-tight, or rather blood-tight, anastomosis of the blood vessels concerned. Accurate apposition with no tension is essential if leakage is to be prevented, and this can generally be attained; but there is another snag—leakage from the needle holes—and I know of several disasters from this "complication." In these cases an atraumatic (eyeless) needle with non-capillary suture material was used with the obvious result that the suture did not completely dam the holes made by the needle of larger calibre. I put forward the suggestion, which may have been made before, that the suture material should not only be absorptive but that it should be tapered. Only the first few inches need be tapered, and experiment will easily prove the exact gradation of tapering necessary to adequately dam the holes made in the vessel wall by the needle. Most good fishing lines (made of silk) are tapered: there should be no difficulty in procuring tapered suture material.—I am, etc.,

Dundee.

F. R. BROWN.

Synchronous Combined Total Gastrectomy

SIR,—I have read the article by Messrs. J. Basil Hume and Guy Blackburn (Nov. 22, p. 817) with great interest and feel that they deserve congratulations on their ingenuity in approaching this problem. While it is an asset of the method that the question of operability can be decided on abdominal exploration, there are a number of points I would venture to criticize. I cannot agree that the division of the thoracic arch in the combined abdominal and thoracic incision "is undesirable for the patient's convalescence." When, in the abdomino-thoracic approach, the costal arch and diaphragm are divided, the ribs can be retracted with minimal pressure and therefore minimal trauma and shock; again, the arch can be firmly reconstituted at the close of operation by a single suture through the cartilages. The resection of a rib appears to me a more serious problem for the patient.

Are they not too generous in their time allowance? A single surgeon, using the abdomino-thoracic method, can easily do an uncomplicated case inside two and a half hours. I certainly do

not consider that "excision of the cardia and 2-3 cm. of the oesophagus is essential if ablation of a growth is to be radical." Some 80% of gastric carcinomas begin in the prepyloric region and only in the late stages involve the glands on the left of the cardia, while the glands on the right are removed in the standard partial gastrectomy for carcinoma. It is the spread to the coeliac axis and porta-hepatis glands that decides the issue as regards glandular involvement in late cases. For this reason alone total gastrectomy is unlikely to give late results better than partial gastrectomy in the case of carcinoma arising in the common site. Its best role is for linitis plastica, growths of the fundus and cardia, and as a palliative for certain late carcinomas. Finally, is the Roux or any type of entero-anastomosis really necessary in total gastrectomy? I have not found it so in a small number of total and a fairly large number of high partial gastrectomies.—I am, etc.,

Dublin.

T. O'NEILL.

Anticoagulants in Coronary Thrombosis

SIR,—Prof. A. A. Fitzgerald Peel mentions my name in his letter in the *Journal* of Nov. 15 (p. 794). He does not seem to have used heparin in the cases he cites—the drug that produced such a remarkable recovery in Prof. Lambert Rogers's case of pulmonary thrombosis. Whether heparin offers any advantage over dicoumarol I do not know. It will be observed that Prof. Peel's first two cases had each more than one lung infarct before treatment was started. Two cases with hypertensive heart failure and lung infarct were given dicoumarol and developed further lung infarcts. His fifth case with hypertension and angina of effort, after treatment with thiocyanate and the blood pressure dropping from 220/110 to 180/94, developed a severe attack of coronary thrombosis.

I respectfully submit that Prof. Peel's cases are rather complicated to dogmatize about the action of heparin or any other anticoagulant in coronary thrombosis in its initial stage. Prof. Peel has, however, established in his letter "that the blood coagulability is not the only factor which influences the extension of a coronary thrombosis." In my judgment the two essential factors in producing coronary thrombosis are degenerated arteries in the heart and low blood pressure, which will favour the formation of a thrombus.

Coronary thrombosis usually occurs when the patient is quiet and often in bed, when the circulation is quiet and perhaps slow. In my letter of Nov. 1, I pointed out that it was the underlying cause—arteriosclerosis—that required treatment. A suitable regimen would be one in which flesh foods are reduced to a minimum, with plenty of fruits, vegetables, etc. From years of observation I have found the prolonged use of iodide of potash is the only drug I know that will arrest atheroma of the arteries and largely restore them. But the drug has to be given at least three months before decided changes can be observed from the improvement of the patient. Dr. Lauder Brunton expressed a similar opinion on this action of iodide of potash in his book on the action of drugs.—I am, etc.,

Glasgow.

J. T. MACLACHLAN.

The Extent of Neurosis

SIR,—One cannot but express sympathetic agreement with Dr. Willoughby Clark's plea (Nov. 8, p. 746) that more time should be devoted to those suffering from functional illness. Nevertheless, his suggestion that two afternoons per week could be set aside for such patients—each presumably to be subjected to an hour's psychiatric probing—is for the average busy practitioner a sheer impossibility. This would entail the sacrificing of one's hard-earned half-day (often no half-day at all) and Sunday afternoon to this, albeit worthy, purpose. Admittedly the neurotic forms a certain proportion of the normal surgery "clientele," though I disagree with Dr. Clark's estimate that from one-third to two-thirds are in this category. It is considerably lower than that—I would place it at perhaps 15% to 20%. Many of these people have very mild functional derangements, which the much maligned pill and bottle of medicine go far to eradicate, combined as they are with the sympathetic advice of an experienced practitioner, who can find out quite a lot about his patients' problems in considerably less time than