later, that it had a colour, athletic or political. Looking back on that year my recollection is of a generously multi-hued enthusiasm.—I am, etc.,

London, N.W.6.

IVAN R. CLOUT.

Sudden Death after Intravenous Injection of Mercurial Diuretic

SIR,—A. G. Oettlé's case of sudden death after intravenous "neptal" (Oct. 4, p. 530) prompts me to a few remarks. Such disasters cannot always be avoided—e.g., if they happen after the first injection to a patient, where there is no reason to expect untoward reactions. Such cases, fortunately, are extremely rare. More often, faulty choice of the case and an overdose are the cause of toxic reactions.

The following rules should help to restrict fatal or toxic reactions. Mercury administration must never be given in excess of the excretory power of the kidneys. Low concentrating power and poor response to a previous injection are warning signals. The minimal injection-free interval should be three days, except in acute emergencies. Digitalis, strophanthin, urea, and ammonium chloride help to make this possible. The dose of ammonium chloride must be adapted to the needs of the case; 15 gr. (1 g.) t.i.d.—the usual dose with many practitioners—is insufficient for most cases. 15 gr. four to six times daily two days before the injection, plus an additional dose of 30 gr. (2 g.) on the day of injection, is needed in most cases. Ambulatory patients should be asked about unpleasant reactions to the previous injection. Warning signals are quite common and most important. Fever is one of them. Patients should rest for half to one hour after the injection before leaving.

Nobody has yet found out why some people tolerate intramuscular mercurials invariably well, while others don't, in spite of local analgesics. Research should be directed towards finding a uniformly well-tolerated mercurial diuretic.—I am, etc.,

Trutnov, Czechoslovakia.

M. WINTERNITZ.

"Unjustified" Use of d-Tubocurarine Chloride

SIR,—Dr. A. H. Galley's letter (Nov. 22, p. 840) does call for comment, and perhaps the more so because of its title "Unjustified Use of d-Tubocurarine Chloride." Technical details apart, the account of how even one of the great may be incommoded by the annoyances that beset lesser men is quite gratifying. In most operations the choice and management of the anaesthesia is left entirely to one's anaesthetic colleague: in a caesarean section the technical procedures of the obstetrician have to be closely adapted to the type of anaesthesia being used, and this is my excuse for intruding upon an anaesthetist's argument. Surely Dr. Galley has missed the main point stressed by those who advocate the use of d-tubocurarine chloride for this operation. Its value is that the section can be done with the minimal amount of general anaesthesia and yet with complete control of the patient. If properly administered the patient should regain consciousness as soon as the last stitch is tied. Thereby the special menace of general anaesthesia for this operation is averted. If of course the drug is not used with this object then its use might certainly be termed "unjustified."

The point about the dynamic effects of curare as opposed to thiopentone may be left for further inquiry; myself, I have no doubt in the matter, but Dr. Galley's remarks about relaxation of the abdominal muscles should not go uncontested. To say that anaesthetic muscular relaxation is unnecessary in a caesarean section because the muscles have been well stretched by the pregnancy is surely wrong. Some relaxation must be obtained for a lower-segment operation, and particularly when any general anaesthetic is being given as well; sometimes indeed when the bleeding occurs from torn sinuses on the surface of the lower flap a quiet abdomen becomes an urgent need. The whole discussion certainly is profitable if it serves to emphasize my earlier point, that d-tubocurarine chloride as an adjunct to general anaesthesia in caesarean section can only give its admirable results if both the anaesthetist and the obstetrician know what they want from its use.—I am, etc.,

Liverpool.

PERCY MALPAS.

Dicoumarol

SIR,—Dr. M. J. Pivawer (Dec. 6, p. 928) complains of anomalous results from prothrombin estimations by Quick's method and states he had to substitute (for prothrombin estimation) clotting time by the method of Lee and White. Prothrombin estimations are the safest guide; and the method of Quick has passed through many hands (and heads) with great benefit. The method we use is only partly modified here, but is very reliable. Important points are (i) use fresh plasma, (ii) conduct the operation at 40° C., (iii) vary the concentration of calcium chloride, (iv) use perfectly fresh viper venom of (if possible) guaranteed potency, (v) perform at least six estimations on every sample of plasma, varying the calcium chloride, and report the test giving the shortest time. It may be necessary to do twelve tests on one specimen of plasma, but usually six tests are enough. It is necessary to have a very bright light concentrated on the vessel in which the estimation is being performed, so that the earliest indications of the reaction can be observed. The normal time is 11 to 12 seconds; it is unsafe to allow the time to exceed 30 to 35 seconds.

It is necessary to remember that dicoumarol takes at least 48 hours to act; many failures have been reported because the process of embolism or thrombosis continued unabated after dicoumarol had been given. For immediate effect heparin is unrivalled. Heparin 100 mg. intravenously every four hours for two days is a good introduction for dicoumarol given simultaneously with the first dose. After 36–48 hours the heparin is stopped and the dicoumarol continues the anticoagulant effect. The effect of heparin, though powerful, is transient.—I am, etc.,

Epping, Essex.

FRANK MARSH.

Case of Camphor Poisoning

SIR,—At 1.25 a.m. on a Wednesday in March, 1945, I was called to see a child 2½ years old who was delirious. On crossing the threshold I noticed the whole house smelt of camphor, and the bedroom where slept parents and child smelt strongest.

CASE REPORT

The child was sitting up in bed frightened; it obviously saw things which it referred to as "quack-quacks." It was flushed, with a scarlet rash all over the body, limbs, and face, least red on the extremities. The pupils were widely dilated but contracted to the light of a torch. Temperature, 100.2° F. (37.9° C.); pulse and respirations normal; chest clear. Its chest and night clothes were well soaked in camphorated oil. Its bowels had recently opened and it had passed urine.

I was told that the child started with a cold on Saturday evening, and to protect its chest the parents had soaked it in camphorated oil ever since—i.e., for about 80 hours. Diagnosis: Camphor poisoning.

Treatment: There being no better diaphoretic available I ordered hot water with sugar to taste and a very hot bath, which was easily obtainable. While Pater was going to see to this, Mater was to collect the child's night clothes, day clothes, some of its bedclothes, its towel, and everything that smelt of camphor and remove them to the furthest corner of the scullery; open windows and doors, and clear the house of the smell of camphor; then warm up bedroom and provide clean warm bed and night clothes. This treatment was completely successful.

I understand that in 1945 camphorated oil consisted of 1 part camphor and 4 parts arachis oil by weight. Hence 1 oz. (30 g.) of camphorated oil would contain 96 gr. (6.4 g.) of camphor, which, if completely absorbed, would be more than three times the fatal dose for such a child. More than 1 oz. of oil had been used.—I am, etc.,

Lincoln.

G. D. SUMMERS.

Battle Neurosis Treated with Leucotomy

SIR,—Is reluctance to advocate leucotomy in neurotic conditions really due to "misinformed opinion or theoretical prejudice," as Drs. William Sargant and C. M. Stewart (Nov. 29, p. 866) suggest? In the huge neurosis centres which had been set up in Germany in 1918 when discipline had begun to crack "active treatment" was organized on a large scale with the aim to cure neurotics, if possible, in one session, discharge them home, and employ them in factories serving the war industries.

I worked in one of these centres. On the day of admission patients were given an interview; on the following day under mild ethyl chloride anaesthesia an injection of methylene blue, and, if cured, discharged the day after. 97% of the cases responded to the treatment given. 3% were thought to be incurable. But the study of the psychological make-up of these "incurables" showed that their case was by no means hopeless.

There was a man who had been in bed for over three years suffering from spastic paralysis of both legs, the muscles of which were atrophied to such an extent that it appeared extremely doubtful whether, even after a successful treatment, the patient could possibly stand on them. He had been through all sorts of treatment without any improvement, and the methylene blue had been of no avail either. I decided to give him methylene blue again, but after a different and more thorough psychological preparation. When this man came round from the anaesthetic, and was told to climb down from the table, he did so and walked through the room practically without help. This case became the subject of much controversy; it was argued that the man was a malingerer, as no genuine neurotic with a record of such severity could have been cured by what in the opinion of the critics amounted to a simple appeal to the patient to give up hostility, hate, and distrust and place himself willingly, confidently, and happily into my hands. Of course, the dynamic possibilities of what Freud later described as "positive transference" were not yet understood in those days. The patient was no more a malingerer than the one cured by leucotomy was a compensation neurosis. The methylene-blue treatment was no farce, as was argued, but the bridge of silver over which the patient could walk to health. It legalized, as it were, his surrender before the tribunal of his conscience, or, in psycho-analytical terms, it appeased his superego.

In my experience some sort of magic has always to be employed in cases where a powerful and obstinate superego defeats all ordinary measures of treatment, unless one is prepared to embark on a long course of psycho-analysis. The magic of the methylene blue was not very impressive even in 1918. I could have chosen a better one; and it had failed before. But I wished this case to be a test case for the thesis, that our cures were really not due to suggestion, as was generally believed, but to the solving of conflicts. Therefore the suggestion value of the treatment had to be diminished. I could do it because I was dealing with an infantile personality. His superego was open to bribery.

I do not say that leucotomy is no genuine cure for neuroses. I do not know really how it works; so the cure which it brought about may not be due to magic. But I do say that leucotomy to-day is a better magic than methylene blue even was in 1918. It could have been an efficient and suitable appeaser for the patient's more sophisticated superego, though I doubt whether in the later stages of the atom age an enlightened ego would dare to suggest it to his "super" as suitable appeasement. Incidentally, if empirical evidence of *post hoc* cures should be relied upon in preference to theories, it would be more in favour of nasal than of neurosurgery. Therefore practitioners who are called upon to recommend leucotomy against neuroses will have to depend on "theoretical prejudice" after all.—I am, etc.,

London, N.W.11.

B. SAALER.

Tetralogy of Fallot

SIR.—While not wishing to underestimate the real value of Mr. Gordon Murray's contribution (Dec. 6, p. 905) to the surgical treatment of Fallot's tetralogy I feel that there are some points, (a) clinical and (b) historical, which can be challenged. Of the clinical points, I suggest: (1) The "blue maladie" is a term which is not necessarily synonymous with the "tetralogy of Fallot"; it refers to any member of the cyanotic group of congenital cardiovascular malformations in which there is persistent cyanosis. (2) Mr. Murray might well have been more correct if he were to have said that, in a patient over the age of, say, 6 years who is suffering from chronic persistent cyanosis as the result of a congenital cardiovascular defect, the "probabilities are about 75% that the diagnosis is the tetralogy of Fallot."

The points of historical interest are largely dealt with by E. Gintrac in a monograph entitled *Observations et Recherches sur la Cyanose ou Maladie Bleue*, published in Paris in 1824. In his book Gintrac mentions some matters of relative interest as follows: (1) His own publication: "Recherches Analytiques sur Diverses Affections dans Lesquelles la Peau Présente une Coloration Bleue, et, en particulier, sur Celles que l'on a Désignées les Noms de Cyanose ou Maladie Bleue" (Collection des Thèses de la Faculté de Paris, 1814, No. 95). (2) The term "morbis cœruleus" which had long been in use by several authors. (3) The term "ictère bleue" as used by many other medical writers was probably a translation of that used by Paracelsus—viz., "icteritia cœlestina seu cyanæa"—in his *De Ictericis*, p. 487. Apparently, according to Gintrac, this term, as used by Paracelsus, was not employed with sufficient discrimination to be of any value for "modern diagnosis" purposes. However, there seems to be little doubt that Peacock, whose book *On Malformations of the Human Heart* was first published in 1858, was not the first person to speak of the "blue maladie."—I am, etc.,

London, N.4.

I. H. MILNER.

Penile Carcinoma

SIR.—Dr. D. Preiskel (Dec. 6, p. 928) can hardly expect ritual circumcision to be instituted as a routine measure, in spite of its proven therapeutic value, while prophylaxis against such killing diseases as smallpox and diphtheria is not on a compulsory basis. Surely the "psychological objection to imitating the Jews is a far-fetched and unwarranted hypothesis. After all, the Christian ritual and religion are of Jewish origin and the insinuation of possible racial prejudice cannot be taken seriously, since we are told—in Luke—that the Founder of Christianity underwent the Abrahamic ritual.—I am, etc.,

Pencoed, Glam.

BEN SAMUEL.

SIR.—The unsupported statement (Nov. 22, p. 841) of even so distinguished a member of the profession as Mr. W. Sampson Handley cannot be taken as proof that the "mixed bacterial flora that flourish beneath the prepuce" can cause or even have caused carcinoma. In the absence of scientific proof to this effect it is, I submit, wholly illogical to attribute a relative immunity to cervical carcinoma possessed by Jewesses to the mutilated condition of their spouses' sexual organs. One might almost as well suggest that the greater Jewish liability to diabetes is to be attributed to ritual circumcision.—I am, etc.,

Launceston, Cornwall.

DONALD M. O'CONNOR.

SIR.—Jewish thought on the relation of man to his Maker dominates the Christian world. In hygienic matters it is equally worthy of attention. The relative freedom of Jewish women from carcinoma of the cervix is almost certainly due to the circumcision of Jewish males. This immunity is not a racial peculiarity, for, as I have shown, it is manifest in the circumcised Fijians, who share Fiji with a separate community of uncircumcised Indians. It is a strange reflection that in this matter the hygienic code of Moses in the dawn of history is still ahead of present standards and that in consequence thousands of women are annually sacrificed to this form of cancer.

Dr. D. Preiskel's letter (Dec. 6, p. 928) suggests that circumcision is an operation of Jewish origin. That is not the case. It is found in independent communities separated by the breadth of the world, but always inhabiting hot climates, where its hygienic advantages became most manifest. It was practised by the Egyptians before the Jews went to Egypt. The oldest known mummy, that of Ra Nefer, destroyed in the bombing of the Royal College of Surgeons in 1940, had been subjected to the operation. It was practised in Arabia, and Abraham learnt its advantages from his Arabian wife Zipporah, who circumcised their son. His broad-minded adoption of the operation for himself and his descendants is an example of freedom from racial prejudice worthy of imitation.

But except for the phimotic with a long prepuce it can be replaced either by meticulous cleanliness, or more certainly by