Air continued to be troublesome, and I think has taken longer to remove than it should have done, because of the inefficient artificial-pneumothorax apparatus. We were fortunate that there was no recurrence, or perhaps at most only a slight recurrence, of bleeding. If this had occurred again I think transfusion and surgical treatment would have been needed."

Full re-expansion occurred during the following 10 days, and he returned to his unit for duty.

Comment

Although at the time unaware of Borrie's (1953) paper, we had already, from experience with traumatic haemothorax and penetrating chest wounds, appreciated the need for early exploration of the chest if there is evidence of continuing intrathoracic bleeding or if clotting has occurred. It is a life-saving procedure, and is essential if the lung is ever fully to expand again without later decortication.

In this respect the three cases reported make an interesting comparison. Case 1 was admitted initially to a surgical ward, where, on general surgical principles, the need for early exploration was appreciated. He was operated on within 24 hours, had full lung re-expansion from the time of operation, and was up fully convalescent within two weeks. Case 2 was admitted to a medical ward and treated expectantly on conventional lines for six days, during which he continued to bleed and to deteriorate progressively. Although after operation he never looked back, the delay lengthened the time required for full lung re-expansion and convalescence generally. Case 3 was treated by the traditional medical methods, surgery at no time being even considered. This case can be regarded as a successful result of conservative treatment, giving no cause for anxiety after the first few days. Nevertheless, full lung re-expansion took seven weeks. We feel that it was the layer of fibrin coating his pulmonary pleura rather than the defective aspirating syringe which was the real cause of difficulty in removing air from the pleural cavity.

We are in full agreement with Borrie that spontaneous haemopneumothorax is a surgical emergency demanding thoracotomy whenever bleeding is serious. We would go further and recommend emergency thoracotomy, after resuscitation, as the treatment of choice for all cases. At this stage it is a straightforward surgical procedure which, provided anaesthetic and surgical facilities are adequate, carries very little risk and permits direct access to the bleeding point, evacuation of all clot and air, and immediate lung re-expansion. Reluctance to operate has led to a high mortality, with a chest disability in survivors which at best results in slow convalescence with probably some permanent pleural thickening, while less fortunate cases will require the major procedure of pulmonary decortication to correct a crippling chest condition. In at least one case in five, spontaneous arrest of bleeding does not seem to occur, and these cases have contributed most of the fatalities in the past. In the remainder the chances of evacuating all blood and exudate before the occurrence of clotting or fibrin deposition sufficient to prevent ultimate full expansion appear to be less than even. It is important to remember that after initial resuscitation the patient, a healthy young adult, is fitter for surgery than he is likely to be for a long time if operation is delayed, and that the real risk in these cases lies not in operating but in not operating.

Summary

Three cases of spontaneous haemopneumothorax were reported, two of which were treated by emergency thoracotomy.

The condition should be regarded as an acute thoracic surgical emergency for which immediate thoracotomy is indicated.

We are indebted to Brigadier Douglas Bluett, Director of Medical Services, Far East Land Forces, for permission to report

Cases 1 and 3 and to Air Commodore G. P. O'Connell, Principal Medical Officer, Far East Air Force, for permission to report Case 2.

REFERENCES

- Borrie, J. (1953). *British Medical Journal*, 2, 16.
Hansen, J. L. (1949). *Acta med. scand.*, 132, 517.
Hartzell, H. C. (1942). *Ann. intern. Med.*, 17, 496.
McGown, F. M. (1954). *Proc. roy. Soc. Med.*, 47, 255.
Myers, R. T., Johnston, F. R., and Bradshaw, H. A. (1951). *Ann. Surg.*, 133, 413.
Ross, C. A. (1952). *J. thorac. Surg.*, 23, 582.

ULCERATIVE COLITIS TREATED BY TOTAL COLECTOMY AND ILEO-RECTAL ANASTOMOSIS

BY

STANLEY AYLETT, F.R.C.S.

Surgeon to the Westminster Hospital Teaching Group
(Gordon Hospital) and to the Metropolitan Hospital

In a preliminary communication (Aylett, 1953) I described an operation of ileo-rectal anastomosis with colectomy as a possible treatment of cases suffering from diffuse ulcerative colitis. The reasons for suggesting that it was possible to retain the rectum, thus avoiding a permanent ileostomy with its aesthetic and practical disadvantages, were detailed. In a further communication (Aylett, 1954) the types of cases in which the operation was indicated and in which ileo-rectal anastomosis could be achieved were described. Briefly, the operation can be carried out in all cases of ulcerative colitis in which surgery is indicated, with the exception of those in which the rectum has already been irretrievably damaged by gross fibrosis or by perirectal sup-puration and fistula formation. The presence of pseudo-polypi is not a contraindication for its performance.

The purpose of this short paper is to indicate certain modifications of surgical technique that experience has indicated to be desirable and to record the progress of the patients upon whom the operation has been carried out.

Modifications of Technique

Although in the first few cases the ileum was anastomosed to the rectum in its upper third the establishment of a safety-valve opening in the left iliac fossa necessitated the retention of the lowermost portion of the pelvic colon. This severely diseased portion of the large intestine may be included in the excision if the rectum is mobilized as an initial stage in the operation by division of the upper part of its lateral ligaments and of its posterior attachments. After the ileo-rectal anastomosis has been carried out the colectomy is completed by transecting the rectum through its upper part about 2 cm. above this anastomosis. It is then possible, as a result of the mobilization of the rectum, to exteriorize its open upper end through the lowermost part of the paramedian incision to act as a safety valve. The reasons for considering that such a safety valve minimizes the danger of a breakdown of the line of anastomosis, made as it is through a diseased rectal wall, have also been described previously. Moreover, this proctostomy tends to undergo spontaneous closure more readily than a colostomy in the left iliac fossa, so that the necessity for its closure by operation is required less often.

The large majority of patients are now operated upon in one stage, and in only one of the last 10 has an anastomosis and total colectomy not been effected in one operation. In this very gravely ill acute case the colon was excised and an ileostomy established as an initial stage of treatment, the upper end of the rectum being exteriorized

and restoration of continuity being delayed until the patient had been restored to good health. It is essential in the fulminating case, the case with uncontrollable haemorrhage, or the desperately ill patient to remove the colon as the first stage in operative procedure, leaving the patient with a temporary ileostomy. Subsequently the anastomosis between ileum and rectum is undertaken.

Results of Operation

The results are summarized in the accompanying table. There was no mortality in the series.

In a further two cases not included in the table the caecum seemed at operation to be so little diseased that in each it was retained and the anastomosis was effected

between it and the rectum. One of these patients has remained perfectly well over a period of 18 months, and her bowels are opened only twice in each 24 hours. The other case remained well for four months and then suffered a severe and uncontrollable haemorrhage. Operation was undertaken for this and the caecum was found to be acutely inflamed. It was resected, continuity of the bowel being re-established by an anastomosis between the terminal ileum and the rectum. On opening the caecum subsequently the whole of its mucosal lining was seen to be ulcerated and the site of multiple points of haemorrhage. The patient ultimately died. It would appear, therefore, that unless the caecum is absolutely normal no attempt should be made to retain it.

Summary of Results

Case No.	Age and Sex	Duration of Disease	Reason for Operation	Weight Before Operation		Date of Operation	Weight Dec., 1954		No. of Bowel Actions Dec., 1954		General Remarks	Result
				st. lb.	kg.		st. lb.	kg.	Day	Night		
1	30 F	12 years	Uncontrollable haemorrhage	6 5	40.4	14/3/52	7 11	49.4	6-7	1-2	Working normally as housewife. Developed intestinal obstruction, July, 1954. Post-operative recovery satisfactory. Prior to this episode bowels open 4-5 times in 24 hours	Good
2	44 M	7 "	Chronic ill-health. Diarrhoea, with blood and mucus	10 10	68	6/6/52	10 9	67.6	8-9	2-3	Majority of bowel actions occur after breakfast and supper. Patient works in heavy steel industry	Satisfactory (not classed as good on account of number of bowel actions)
3	10 F	2 "	Acute exacerbation with gross toxæmia	3 6	21.8	3/10/52	4 2	26.3	6	Slight faecal incontinence 1-2	Frail and physique poor	Fair
4	37 F	10 "	Chronic ill-health. Anaemia; diarrhoea with blood and mucus	8	50.8	10/10/52	9 11	62.1	6-7		Back to normal work as Civil Servant	Good
5	30 M	3 weeks	Fulminating type with perforation of colon	9 5	59.4	20/11/52	12	76.2	6	0	In excellent health. Previously professional footballer, is now on administrative side	"
6	29 F	1½ years	Severe toxæmia and subacute obstruction due to pericolic abscess	7 13	50.3	1/12/52	9 12	62.6	5-6	0-1	Working normally as housewife with one child	"
7	29 M	9 "	Patient treated by ileostomy in 1949 elsewhere	13	82.6	30/1/53	13	82.6	5-6	0	Working normally as electrician	"
8	40 F	11 "	Chronic ill-health. Severe diarrhoea, 14 times each 24 hours, with blood and mucus	9 3	58.5	5/12/53	11	69.9	5-6	1	Working normally as housewife with two children	"
9	31 M	5 "	Chronic ill-health. Severe diarrhoea, 16 times each 24 hours, with blood and mucus	9 7	60.3	11/1/54	11	69.9	5	3	Back to full work as motor mechanic	"
10	45 F	14 "	Chronic ill-health. Severe diarrhoea, 20 times each 24 hours, with blood and mucus	7	44.5	1/2/54	7 8	48.1	4-5	1	Patient back to work as clerk	"
11	20 F	6 months	Severe toxæmia—acute case	8 2	51.7	22/2/54	9	57.2	5-6	2	Back to normal work in city. Travels 50 miles by train each day	"
12	38 F	2 years	Chronic ill-health. Severe diarrhoea, 20 times each 24 hours, with blood and mucus	6 6	40.8	1/3/54	7 8	48.1	4-5	4	Back to work as shop assistant. Feels "wonderful"	Satisfactory (not classified as good on account of number of bowel actions)
13	30 F	10 "	Chronic ill-health. Anaemia; diarrhoea with blood and mucus	7 7	47.6	26/7/54	8 10	55.3	6-7	3	In excellent health. Bowels have not yet completely settled down	" "
14	49 M	9 "	Chronic ill-health and diarrhoea	10 2	64.4	17/9/54	10 5	65.8	5-6	0-1	Back to work as driver's mate	Good
15	43 M	2 "	Chronic ill-health. Diarrhoea, with blood and mucus	9 8	60.8	11/10/54	10 7	66.7	5	3	Now convalescing	"
16	51 M	2 "	Chronic ill-health and development of carcinoma in transverse colon	10 10	68	25/10/54	10 7	66.7	3	1	" "	"
17	26 F	3 months	Acute case progressing to fulminating state with peritonitis	5 12	37.2	19/7/54 (total colectomy, ileostomy, and proctostomy). 22/11/54 (ileo-rectal anastomosis)	7	44.5	6	4	Almost in extremis before operation. Bowels have not yet settled down after the anastomosis. Feels fit and well	"

Comment

The satisfactory progress of all but one of these severely and sometimes desperately ill patients, and their return to good health and to full work, seem to indicate that the method of treatment described is a satisfactory one. The follow-up is admittedly a short one and the series is not large. Nevertheless in no case has the disease flared up in the remaining rectum, and regular proctoscopic examination has shown that resolution of the inflammatory changes existing before the operation has taken place.

Addendum.—Since this article was compiled six other cases have been operated upon. Of these, two have returned to good health and three are convalescing. The sixth patient died during the fourth post-operative week following a burst abdomen. Of the patients reported on in the table, Nos. 11, 13, and 17 now have only one to two bowel actions at night.

REFERENCES

- Aylett, S. O. (1953). *British Medical Journal*, 2, 1348.
— (1954). *Surgery of the Caecum and Colon*. Livingstone, Edinburgh and London.

ANXIETY NEUROSIS: TREATMENT BY THE GENERAL PRACTITIONER*

BY

RONALD A. B. RORIE, M.D., D.P.M.

Foundation Member of the College of General Practitioners; Assistant Psychiatrist, Eastern Regional Hospital Board (Scotland)

Between the world wars attention was drawn to the fact that a large proportion of chronic sickness was due to the neuroses. Gillespie (1933), while on the subject of psychotherapy in general practice, mentions the fact that, of 600 cases referred to a special clinic, 436 were diagnosed as neuroses. Halliday (1935) found that psychoneuroses accounted for as much as 30% of the sickness of insured persons in Glasgow, and there is no reason to think that this proportion has since diminished. These figures are borne out by the report of the British Medical Association (1941).

The family doctor, while he has unique opportunities for studying the factors that bear on a case, through lack of training has not the knowledge, and too often not the inclination, to attempt to deal with the obviously neurotic patient. At out-patient clinics one often hears the story that "my doctor says it is just nerves, and gives me phenobarbitone."

The palpitations, choking sensations, and innumerable phobias of the anxiety neurotic are all too real to the sufferer, and can incapacitate him totally for work. The man cannot face the bus journey to work, and, once there, has to leave the crowded workshop because of intense feelings of apprehension. The woman is unable to leave home to shop unaccompanied, and cannot attend church or go to the cinema. In face of the exhortations of the family and friends to "pull themselves together," these patients rapidly lose heart; fears of insanity follow, with suicidal impulses which may have fatal consequences.

During the last decade the general practitioner has become aware that a large part of his time is taken up by patients suffering from psychoneuroses. The coming of the National Health Service Act, leading as it has to

a reduction in the time available per patient, has tended to make it difficult for the practitioner to do more than pass the case on to the specialist, with the result that only a small minority, and only the most patent cases, get treatment at all. The majority, of lesser degree, struggle along unhappily, treated by sedative. A recent analysis of prescriptions issued by practitioners under the National Health Service Act shows that the commonest by far is for sedative (Dunlop *et al.*, 1952).

Before the second world war the neurotic could expect to be treated in one of two ways. By the older school, in whom there persisted a moral disapproval of anyone suffering from a neurosis, he would be dismissed as lacking in moral fibre or as malingering. By the inter-war generations, who, while admitting the existence of an illness in such cases, could do little through lack of training, he would be given sedatives and allowed to drift.

I qualified in 1938 and do not remember ever being shown an anxiety neurosis as such during my training in mental diseases. From contact with colleagues during the war, I found that this did not simply reflect on my medical school as compared with others.

The tendency persists to diagnose neurosis in a negative manner, by exclusion of organic disorder, rather than in a positive recognition of the various neurotic syndromes. This leads to much waste of time and effort on the part of other specialists. It is as though one was afraid to admit that the complaint was functional. In practice even to-day, if a diagnosis of neurosis is made, it is necessary to explain that it implies no derogation or criticism of the patient. Even so, many patients feel insulted by such a diagnosis.

In spite of the community's increasing interest in mental illness, as shown by Press, popular fiction, theatre, and cinema, there still persists the Victorian disapproval of a subject which lays such emphasis on the emotional aspect of man's life. It is partly this disapproval which discourages general practitioners from facing and attempting to treat the vast number of minor neuroses they meet every day.

In this paper an attempt is made to describe the treatment of the commonest of the neuroses—the anxiety neurosis—from the general practitioner's point of view.

The Physician's Reaction

It is obvious that if the general practitioner refuses, consciously or otherwise, to face and treat the neurotic, and depends on the specialist, the vast majority of cases will go untreated.

When he is confronted with the anxiety neurotic, what is the physician's reaction? The complaints are indefinite but insistent; a physical examination is negative; a placebo, usually in the form of phenobarbitone, is prescribed, the only psychotherapy being a word of encouragement. If a diagnosis is requested, too often a hint of an organic condition is given—"a nervous stomach," "a tired heart," "overwork," etc. The patient is unrelieved, and on persistence is referred to one specialty after another, with negative findings. The psychiatrist is often the last consultant called in.

Two factors contribute to this maltreatment of the neurotic. The first is lack of time for proper history-taking and evaluation of the symptoms. Ross (1937), discussing the treatment of such cases, states that at least an hour should be set aside for the initial examination. It is a reflection on the conditions of service under the National Health Service Act that few general practitioners could find this easy to-day. The second factor is the blind spot

*From a thesis submitted to the University of St. Andrews for the degree of Doctor of Medicine.