tant solutions, might help to reduce the incidence of the infection in cattle. Early treatment of infected cattle would obviously lessen the risk to farm workers.

Summary

The literature on cattle ringworm and its transmission to man is reviewed. The disease is still frequent in some rural areas of Britain, but its real incidence is unknown.

Most infections in this country are caused by *Trichophyton discoides*, but *Tr. mentagrophytes* is responsible for some cases.

The records of 39 human cases observed in South Wales are analysed, and an account is given of the course and clinical features of the infection in man and cattle.

Treatment is briefly discussed. The acutely inflammatory infections are self-limiting, and the patient's discomfort is increased by irritating fungicides, which do not shorten the course of the disease and may produce a contact dermatitis.

Active treatment should be reserved for the less-acute cases.

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THE DOUBTFUL SYPHILITIC BLOOD TEST IN PREGNANCY

BY

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Blood tests for syphilis are now a routine procedure in almost all antenatal clinics in this country, but they are far less often carried out on expectant mothers attended by their family doctors. As a result, nearly all cases of infantile congenital syphilis seen nowadays are in infants of women who have not attended clinics. An exception to this is described below.

Of the pregnant women tested by the regional blood transfusion centres in six provincial cities in 1952, 0.35% were found to have a positive syphilitic reaction (Ministry of Health, 1952). The majority of these latter gave repeatedly strongly positive results or a definite history of syphilis, and obviously needed treatment for their own and their child's sake. Difficulty arises, however, in the occasional case in which there is a repeatedly weakly positive blood reaction unsupported by history or signs. Naturally, for psychological and family reasons, any suggestion of syphilis in a pregnant woman is to be avoided if possible, but delay in treatment may be fatal to the child. In a patient with weak serological reactions the decision has to be made whether the patient is a true though weak syphilitic reactor or a non-treponemal reactor. Rein and Kostant (1952) rightly state that

it is not safe to assume that standard serological reactions are of the non-treponemal type unless they are checked by a Nelson's treponemal immobilization test. And it is no exaggeration when Moore and Mohr (1952) say that the use of this test permits for the first time a definite answer to the question, "Does this patient have syphilis?" But, as Price (1954) pointed out, the test is so complex and time-consuming that to advise it in this country, where it is carried out in only a few laboratories, is a counsel of perfection, and a decision to treat or not may have to be made without it. Routine blood tests are usually done at the third or fourth month of pregnancy, and probably the earlier treatment is given the less chance there will be of foetal infection.

Before penicillin was in general use for the treatment of syphilis (and no other substance should be used nowadays) the clinician was faced in doubtful cases with the problem of subjecting the woman to a long course of dangerous injections with the arsenicals and bismuth, or of taking the risk of not treating her before delivery and, if the worst happened, of treating her and her syphilitic child post-natally (Stokes and Ingraham, 1939). But now that penicillin can be used—an entirely safe and effective form of treatment—it is essential that an "insurance" course should be given to all mothers who have the slightest serological suggestion of syphilis, unless they can be proved to be non-treponemal reactors (Rein and Kostant, 1952). That the signs of infantile congenital syphilis usually respond well to penicillin treatment must be admitted, but obviously it is better to treat the foetus *in utero*. Without treatment it might suffer permanent damage, die before term, or be born so marasmic that nothing would save it.

If treatment has to be given without a definite diagnosis beforehand, the problem should be explained to the mother so far as is possible. It can be emphasized that the aim is to protect the child against a remotely possible danger. Her own case and that of her husband can be investigated at leisure.

The following case is of interest as it demonstrates the danger of not treating a mother whose serological reaction is repeatedly weakly positive in the absence of a test which would prove the reactions to the standard tests for syphilis to be non-treponemal in nature.

Case Report

An intelligent woman aged 31, German by birth, but speaking good English and married to an Englishman, attended a London antenatal clinic from the time that she was four months pregnant. She gave a history of having been married previously to a German soldier who had been killed towards the end of the war and of having two healthy children, now aged 9 and 7, by him. She gave no history of disease suggestive of syphilis, or of injections, and said that she had had a blood test before she came to England as a displaced person after the war. She thought the result of the test was negative. At the antenatal clinic there were no signs of syphilis, and her blood test at 5 months was Wassermann doubtful, Kahn positive; at 6 months, Wassermann doubtful ("possibly false positive"), Kahn negative; and at 6½ months, Wassermann and Kahn negative. No further tests were taken, and she was delivered at term of an apparently normal male child. He appeared to thrive at first, but at 4 weeks he became restless, and had an enlarged abdomen and nose-bleeds. At 7 weeks he was admitted to a children's hospital obviously very ill with a blood-stained nasal discharge, a generalized rash, and a greatly enlarged liver and spleen. He was jaundiced and had oedema of the lower limbs. The Wassermann reaction and Kahn test were strongly positive, and x-ray examination

showed periostitis and osteitis of the tibial shafts. The child was treated with penicillin and bismuth and rapidly improved.

When he was brought to this clinic at the age of 4 months he appeared to be quite normal apart from an enlarged liver. His Wassermann reaction was negative, the Kahn test was weakly positive, and x-ray films of the tibiae showed healed periostitis. A month later the liver appeared to be normal and the blood tests were negative. The serological reactions have remained negative up to the time of writing, when the child was aged 2 years, and he seemed to be remarkably healthy. When the mother was first seen at this clinic four months after delivery she had no signs of syphilis and had had no treatment. Her Wassermann reaction was negative and the Kahn test weakly positive; both the cerebrospinal fluid and chest x-ray film were normal. She told us that she had been raped in a Russian P.O.W. camp in 1945 and thought that she may have been infected then, though she had no signs and had never had any treatment. She denied extramarital intercourse since then, and said that she had never had penicillin at any time. She was given routine penicillin treatment, and three months later her blood tests were sero-negative and have remained so for 20 months. The two older children and her present husband were examined. There were no signs of syphilis and all their blood tests were negative. The husband said that he had had balanitis during the war, but afterwards had had several blood tests which were negative, and he had never had penicillin.

In such a case it must not be forgotten also that the serological reaction is only part of the puzzle which has to be fitted together to make the diagnosis of syphilis. The whole picture, including the history of the patient, the family, and the husband, and the clinical signs, must be correlated. If, after that, doubt is still present, it is safer to treat than risk permanent damage to the child.

Summary and Conclusions

The problem of the weakly positive blood test for syphilis in pregnancy is discussed.

It is suggested that, if the weakly positive blood tests cannot be shown to be non-treponemal in nature, "insurance" treatment should be given to the mother as early as possible in pregnancy.

A case is described in which a woman with no history of syphilis but whose blood tests were repeatedly weakly positive gave birth to a child with marked signs of syphilis and strongly positive blood tests. The father of the child was not infected.

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In his recently published annual report for 1953, Dr. K. A. SOUTAR, county medical officer of Surrey, states that the number of confinements taking place in hospitals has increased and the number of domiciliary confinements has decreased. Of the total births in the county, 72% took place in hospitals and 22% in the mothers' homes. A survey carried out in Surrey during the past two years showed that even though there were no medical or social reasons for hospital confinement a number of women went to hospitals to have their babies. In general, maternity units are keeping mothers in hospital for 10 days after the confinement. This is the minimum period permitted by the Central Midwives Board. Dr. Soutar thinks that there are enough maternity beds in the county for it to be well worth while to consider the advantages of extending the stay in hospital to at least 14 days.

A RATIONAL APPROACH TO PROSTATECTOMY

BY

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It seemed necessary to write this short paper, an affirmation of certain principles, in view of the trend of the literature about prostatectomy at the present time. A study of recent papers would induce the superficial reader to think that a uniform operation was all that was required. The fact that different writers advocate different operations gives the clue to the present muddle.

Obstruction at the bladder neck is due to a variety of causes, and no single operation can possibly cover all these different types.

It is necessary to choose the correct treatment for each type of obstruction—in fact, for each particular patient (Cosbie Ross, 1936). Although obstruction at the bladder neck in the elderly patient may be due to an adenomatous enlargement, it may also be caused by carcinoma, a median bar, "sclerosis" of the bladder neck, an adenoma arising in one of the glands of the prostatic urethra, Marion's disease, etc., and I suggest that it is unnecessary and unwise to submit all these patients to a suprapubic operation when some of them can be dealt with more effectively by perurethral methods. A recent paper describes all types as being treated by the Wilson Hey operation irrespective of whether the cause was adenoma or carcinoma.

At the Urological Department of the Sefton General Hospital the figures for the year 1952 (see Table) emphasize the range of treatment required for dealing with this complex condition.

Operations Carried out for Obstruction at the Bladder Neck in 1952

Retropubic prostatectomy	..	..	..	16
Wilson Hey	..	..	..	12
Cold punch	..	..	..	25
Suprapubic prostatectomy with drainage	..	..	..	9

I have always thought that Wallace's (1951) views have not, so far, received the considerations and weight they deserve. Wallace suggested that it is the amount of muscular tissue in the region of the bladder neck which is the big factor. He pointed out that dogs grow large prostates in old age but never have retention, because there is no muscular tissue at the bladder neck. He investigated, by differential staining, wedges of the bladder neck removed at operation and at post-mortem examination in a large series and distinguished the relative amounts of muscle and fibrous tissue. He found that a small adenoma with a well-developed musculature at the bladder neck was likely to cause obstruction, whereas a much larger adenoma with poorly developed musculature was compatible with a normal bladder and satisfactory micturition. He found many muscular fibres in cases of "sclerosis" of the bladder neck and in Marion's disease, and quoted the action of ephedrine in precipitating acute retention. There seems to be little doubt that Wallace's findings explain many anomalies in obstruction at the bladder neck.

It is, of course, well known that not all patients with mild prostatic symptoms require operation. Chapman (1949), in a most interesting paper, showed that if a number of