Correspondence

Cervical Sympathetic Paralysis

SIR,—In their interesting historical account of cervical sympathetic paralysis Dr. J. Donaldson Craig and Mr. R. C. Fuller do not refer to the observations of Jonathan Hutchinson, who in 1875 (*Illustrations of Clinical Surgery*, Plate XXXIV, p. 203, London) noted that the small pupil associated with what was then called vasomotor paralysis was not in a state of spasmodic contraction but unable to dilate when shaded. The upper figure of the plate shows the eyes in full light, the lower one when as much shaded as possible consistently with the artist's convenience. In the former the two pupils are of equal size, in the latter the right pupil is twice the size of the other. The patient had a left cervical sympathetic paralysis together with a flaccid paralysis of the whole upper limb on that side, following a fall on head and shoulder—evidence, as Hutchinson remarks, that in these cases "the nerves give way at their roots and not in any part of their trunks." This paper, which contains many interesting observations, deserves mention in any account of the subject.—I am, etc.,

London, W.1.

C. P. SYMONDS.

SIR,—In their article on this subject (June 19, p. 1182), Dr. J. D. Craig and Mr. R. C. Fuller describe the details of Horner's syndrome with meticulous care. On two minor points I should like to join issue with them. They state that what might be described as the reverse of a Horner's syndrome—viz., the stage of stimulation of one side of the cervical sympathetic system, as described by Nicati—is "rarely," if ever, seen in present clinical practice, but should be borne in mind as a possible source of confusion in diagnosis." In an investigation which I reported in *Brain* (1945, 68, 98), I did not find that this condition was the rarity they claim. Indeed I could not collect 50 normal controls to compare with a series of pupillary inequalities investigated without discovering three who had on close inspection slight inequality of the pupils. Some of these inequalities were due to transient causes, and it was impossible to say with confidence that they were not from stimulation of one side of the sympathetic system rather than transient block of the other side. They were not due to any abnormality of the parasympathetic system, nor to permanent sympathetic paralysis, for the pupils dilated equally well with cocaine and adrenaline drops. At least one case was demonstrably due to sympathetic stimulation, as the side which was affected was known.

Secondly, although the authors describe the vascular changes in Horner's syndrome as variable, because "with the passage of time compensatory mechanisms are brought into play," they describe the pupillary changes as constant. This is not the case, unless the term "constant" is taken in a comparative sense. In one of the cases illustrated by photographs in the same paper in *Brain* it is shown that in the pupils, too, compensatory mechanisms may develop. This has been recognized before, and has been attributed by Magitot and others to an increased sensitivity of the pupil to circulating adrenaline. The affected pupil, however, does *not* enlarge when cocaine and adrenaline drops are applied, and it seems more likely that the mechanism is one of central inhibition of the parasympathetic centre. The true nature of the condition is then shown only by testing with eye drops.

These small points, like the details in the authors' article, are of importance only in so far as they reflect our understanding of the mechanisms involved in pupillary inequality. With the increasing interest in surgery of the sympathetic system, and in particular in the phenomenon of recurrence of Raynaud's disease after sympathectomy, it may be that such details are of more than academic importance.

In few sites can the balance of the two opposing forces of the autonomic nervous system be as clearly observed as in the pupils, and nature has, for good measure, thrown open the curtain of the iris to the winds of man-made collyria. Sympathectomists might well turn to the pupil to see demonstrated in two dimensions the problems they are trying to solve.—I am, etc.,

Rutherglen, Lanark.

ERIC A. TURNER.

Lower-segment Caesarean Section

SIR,—I agree with Mr. Bryan C. Murless (June 26, p. 1234) in his condemnation of Willett's forceps for extracting the foetal head in lower-segment caesarean section. I have known a nasty scalp wound to be caused by this barbarous instrument, which subsequently became septic and seriously endangered the infant's life, though thanks to penicillin it recovered. Neither is extraction by the operator's hand or by the single forceps blade satisfactory, especially if the head is deep in the pelvis. Wrigley's forceps are too short and have in my opinion the great disadvantage that they have no screw which can be tightened to keep the blade applied to the head, so that it is liable to slip when traction is made.

Since first performing this operation in 1929 I have used the same method of extraction and found it invariably satisfactory. I use a Haig Ferguson forceps (though I doubt not any other forceps possessing a screw would do equally well). The right blade is applied first, on the left side of the mother's pelvis, and with the concavity downwards. The left one is then applied on the other side, the blade locked and the screw adjusted and tightened. All this is done without any hurry, and the head is slowly delivered. Of course, if the head is in the transverse diameter of the pelvis it should be rotated so that it lies antero-posteriorly, with either occiput or face presenting in the wound. The blades are then applied, as they always should be, over the ears. The essential point in this procedure is the tightening of the screw before attempting traction. The head is always easily extracted even though it lies deep in the pelvis.—I am, etc.,

London, W.1.

F. J. BROWNE.

Prevention of Tuberculosis

SIR,—In the leading article (June 19, p. 1189) on the Prophit Survey carried out by the Royal College of Physicians you underline a plea made by the President that further efforts should be made to prevent those suffering from pulmonary tuberculosis from transferring their bacilli to other members of the community. According to your leader writer this problem is an epidemiological and social one and might well form the main future task of medical officers of health, who should concentrate their attention on the prevention of this disease. Surely this advice is misdirected and misleading. Medical officers of health have for long been fully aware of this problem and have made continuous efforts to cope with it. Many medical officers of health, charged in 1930 with the provision of residential treatment also, were increasing their knowledge of the whole problem in an integrated fashion. Now there is a splitting of responsibility again and it becomes the duty of Regional Hospital Boards to make arrangements for the necessary institutional treatment of tuberculosis.

Before the 1939 war London had approximately four beds for every three deaths annually from tuberculosis (about 4,000 staffed beds in sanatoria and hospitals throughout the country for approximately 3,000 deaths). During the war the available beds declined because of bombing and shortage of staff. Pre-war the accommodation was barely sufficient, but it did enable that bugbear of tuberculosis schemes—the waiting-list—to be virtually abolished. Now the waiting-list is much swollen, and with the probable further loss of beds through those beyond the Home Counties being taken into use locally, and with the merging of the always worse waiting-lists of the counties adjacent to the capital with the London list, the control of tuberculosis in the Metropolis may become more difficult than ever. In these circumstances it seems useless to urge the medical officer of health to do more to prevent the spread of the disease. How is he to proceed in the crowded home when a positive-sputum member of the household waits for months for a vacancy in a sanatorium, and when in another family, or even in the same, a sufferer with advanced disease cannot be offered segregation in hospital? Surely the main burden of preventing the spread of infection resides primarily with the hospital authority whose duty it is to provide sufficient institutional accommodation.

Regional Hospital Boards are facing one of their gravest problems here, particularly in view of the special difficulties of staffing tuberculosis sanatoria. It is not easy to see where