basophilic cells of the anterior lobe are increased and gonadotrophic hormone secretion is augmented. Loss of weight of organs can be caused by other endocrine glands or by changed influence of the hypothalamic, supraoptic, and paraventricular nuclei, and is not a symptom just of old age.

A certain difference of the body's reaction to castration and to growing old should be expected, because at the former fully functioning ovaries are suddenly removed from the system, but in the latter ovarian activity slowly has ceased, together with the loss of the ova. Further, a woman ovariectomized at the age of about 35 may live fifty more years, but a woman of 70 certainly not. Characteristics of old women, such as senile skin changes, loss of hair pigment, and growth of beard, do not commonly occur after ovariectomy, especially not involution of the whole of the body (osteoporosis, etc.), nor the pronounced emaciation often seen in senile women.

After the menopause gradual shrinkage of the adrenal cortex occurs, its function becomes weaker, and the 17-ketosteroids excretion decreases. As a result of castration, however, hypertrophy of the cortex, at least in some species, is observed. Especially in the male and in older female animals the hypertrophic phase may continue. Unlike what happens in old age, hypertrophy of the thymus occurs after castration in adult rats. Among eunuchs in Oriental countries there have been men of high intelligence who led long and active lives. Variations in fat metabolism and muscular weakness are due to individual differences in the influence of the hypothalamic centres. On the other hand, spermatogenesis is not unknown in old men of 80 or more, in spite of obvious signs of senility.

All experimental operations such as hypophysectomy, thyroidectomy, adrenalectomy, or gonadectomy have far-reaching consequences on the entire endocrine system, on the diencephalon, and on general metabolism. But the changes brought about are very different from the physiological process of ageing, which depends on two factors. (1) The life cycle and lifetime of cells of different tissues are different, and determined according to specific physiological needs. Relatively, the adrenal cortex begins to diminish in size in late embryonic life, but its extreme involution is significant of senescence. Involution of the thymus, of the pineal gland, of the gonads, and finally of the anterior lobe takes place during particular stages of life. The latest "natural" involution seems to be that of the vital nerve centres in the medulla oblongata. With this sequence the process of ageing is a very gradual one. (2) The whole endocrine system, which is of decisive importance in the ageing process, itself depends on the nervous and chemical function of the diencephalon. Because of this physiological relation all hormone therapy of ageing remains restricted within certain limits. As yet we do not know how to control and influence diencephalic activities either by chemical or physical means.—I am, etc.,

London, N.W.3.

HANS BAB.

Medical Photography

SIR,—Having spent much more time and money than I could afford on clinical photography, but without any regrets, I would nevertheless endorse the views of Drs. Frangon Roberts (March 13, p. 485) and James F. Brailsford (May 1, p. 855). The hospital photographic department is an absurdity based on a misunderstanding of the function of art in medicine; or would anybody propose the employment of a biographer to take case histories?

For the clinician must take his own photographs if they are to be of any value to himself or of any use to his students; and the hospital need only provide a studio, some non-mobile equipment, and the part-time services of a technician for processing. Every university, however, should have a department for medical photography in order to provide instruction and advice on technique and to facilitate research.

The reason for the present exorbitant demand for ancillary services should be clear enough. The prudent householder uses all the electricity he possibly can in case his present consumption becomes the basis of rationing—and will not our new masters echo the cry of those who put them in power, "Never had it before, Doctor"?—I am, etc.,

Manchester.

J. H. TWISTON DAVIES.

SIR,—Dr. J. F. Brailsford (May 1, p. 855) is of course entitled to his opinion that there has been no improvement in medical photography during the past forty years, but it would be strange if this branch had stood still while all others have progressed. I cannot help but suspect a *laudator temporis acti*.

To mention names would perhaps be invidious, but it would be nearer the truth to say that while there do exist many excellent illustrations in the literature, the great bulk of pictorial work is mediocre. Blaming the editorial boards will not help if the material is not good in the first place.

The scorn which Dr. Brailsford pours on the figures quoted in his last paragraph would have borne more weight had he told us whence they emanated. There are two main reasons why output has risen, apart from the demand for teaching. First, the supply of material is improving; this held down availability in preceding years. Secondly, more uses are being found; in the control of the growth of visible tumours, for example, a controlled scale print is much less liable to error than the more usual outline sketch, and in a properly organized department is not only more accurate but actually time-saving. The photograph is free from any possibility of personal error, which may well change with the observer.

An Exhibition of Medical Photography sponsored by the Medical Group of the Royal Photographic Society is to open at the Royal Society of Medicine on May 24. May I suggest to Dr. Brailsford that he permits the committee to exhibit some of his forty-year-old illustrations? Even allowing for any deterioration of the prints due to age it should be most instructive to compare them with present-day work.—I am, etc.,

Manchester, 13.

ROBERT G. W. OLLERENSHAW.

Treatment of Pruritus Ani

SIR,—Dr. Alexander Orley, in his letter on the treatment of pruritus ani (May 8, p. 904), tends to indicate that in Guernsey the aetiological factors of this troublesome condition differ greatly from those which obtain in most other parts of the world. He states, "The variety of methods of treatment and the frequent therapeutic failures in pruritus ani are probably due to a lack of recognition of the fundamental cause of the complaint." This is exceedingly true, but surprisingly enough he then proceeds to remark, "This cause, however, is always the same. It is the exposure of the perianal skin to particles of faecal matter." In his series of about 50 cases he does not seem to have encountered some of the most common causes of pruritus ani, such as asthma, eczema, yeast and tinea infections, nor any of the others not infrequently discovered, such as threadworms, amoebiasis, lichen planus, gonococcal proctitis, etc.

He remarks that it usually occurs in middle and old age, more seldom in young individuals, and practically never in the young and adolescent. Of 107 cases seen by me in 1946, 19 patients were aged between 21 and 30; 32 between 31 and 40; 13 between 41 and 50; and 21 between 51 and 60 years of age.¹

Undoubtedly x-ray therapy is, as he says, extremely useful, but it has the great disadvantage that the patient obtains so much relief from it that should a relapse occur he is apt to importune the doctor for further treatment, and only those who have seen a number of pruritus ani patients with a complicating radiodermatitis can know what this combination means.

Finally, he remarks that a combination of x-rays and anal hygiene has been uniformly successful in over 50 cases, but it is to be regretted that he does not state what period of time he has chosen as the criterion for a cure.—I am, etc.,

Edinburgh.

G. A. GRANT PETERKIN.

REFERENCE

¹ *Edinb. med. J.*, 1947, **54**, 584.

Unusual Inguinal Hernia

SIR,—In March, 1948, an African male aged about 35 years was admitted to Cape Coast Hospital. He stated that he had had a swelling in the left groin for four years. It was difficult to make out from his history whether the swelling had been self-reducing or not. Three hours before admission the swelling had increased in size, become painful, and he had vomited twice.

On examination there was a tender, tense, irreducible swelling about the size of a tangerine in the left groin, with slight protrusion through the external inguinal ring. There was no cough impulse. The condition was diagnosed as strangulated left indirect inguinal hernia.

Under hypobaric "percaïne" spinal anaesthesia the diagnosis was confirmed. The hernial sac contained a loop of very congested but viable small intestine. The strangulation at the internal ring was

relieved. All attempts to reduce the gut to within the abdominal cavity failed, though a finger could easily be passed through the internal ring. A sudden subserous haemorrhage into the gut wall, stripping up the serous coat for several inches, made resection of about ten inches of gut with end-to-end anastomosis necessary. It was easy to draw down additional gut to perform the resection wide of the injured area.

Again attempts to reduce the remainder of the loop of gut failed. Laparotomy through a low left-paramedian incision revealed the reason for this inability to reduce the intestine to within the peritoneal cavity. About three inches above and internal to the internal inguinal ring there was a narrow-mouthed pouch formed by the posterior parietal peritoneum, through which the intestine passed. This pouch expanded downwards and outwards into a wide serous-lined cavity, which narrowed as it passed through the internal inguinal ring and was prolonged into the inguinal canal as the hernial sac. The abdominal mouth of this long serous-lined cavity was narrow, and, though firmly holding the loop of small intestine, was not causing strangulation. By pulling gently from above and pushing from below the gut was easily returned inside the peritoneal cavity. The abdominal opening of the sac was ligatured and the abdominal and hernial wounds closed. The patient's condition caused some anxiety for the next twenty-four hours, but subsequently recovery was rapid.

I am indebted to the Director of Medical Services for permission to publish this case.

—I am, etc.,

Cape Coast, Gold Coast.

A. F. FOWLER.

Waiting for Tonsillectomy

SIR,—It is certain that the waiting-lists for admission into hospitals of children needing tonsillectomy and adenoidectomy have now reached such proportions that a desperate position has arisen. As many of us know from personal contact with the parents and reading their letters, their anxiety about the health of these youngsters is leading to acute distress; whilst to doctors whom they have consulted and who have advised the operation—often marking their notes, "Needs very early operation"—this state of things has become intolerable.

Both parents and medical advisers see the steady deterioration in these children, and just at a time of life when it is of the utmost importance that healthy growth should be encouraged and not hindered, with all the serious complications that may reasonably be feared.

I cannot see that this problem is insoluble, nor that its urgency is not obvious, and I sincerely hope that this letter will stimulate response and lead to action without delay.—I am, etc.,

London, W.1.

WILLIAM IBBOTSON.

Advantages of Impure Penicillin

SIR,—In relation to the annotation entitled "The Advantages of Impure Penicillin" (April 24, p. 795), in which it is stated that it has been suspected for some time that the imperfectly purified penicillin of earlier days was more effective than the refined present-day product, and that recent experiments show conclusively that in the purification of penicillin something unknown and valuable is lost, I would mention that this conclusion was arrived at by co-workers and myself in this hospital in early 1944.

In this pioneer work aseptic pyrogen-free penicillin filtrate injected intramuscularly in human beings was followed by recoveries and clinical effects in fulminating diseases such as subacute bacterial endocarditis and meningitis which could not possibly be accounted for by the penicillin content of the filtrate, thus suggesting some potent unknown factors, probably both antitoxic and antibacterial, and immeasurable by known methods. I am not, of course, advocating a return to the filtrate, but it would appear that a wide field for further research lies open in that direction.

Unfortunately our results were not published, presumably—and possibly quite rightly—on the grounds that the idea appeared in those early days too far-fetched to be put forward as a scientific theory.—I am, etc.,

Wellhouse Hospital, Barnet, Herts.

H. R. SEGAR.

SIR,—With reference to the annotation entitled "The Advantages of Impure Penicillin" (April 24, p. 795), I beg to point out that I arrived already in 1944 at the conclusion that "in the purification of penicillin something unknown and valuable

is lost." Together with W. K. S. Wallersteiner I wrote, "The effects of this suspension, in addition to the penicillin effect, are due to the presence or production of other potent bacteriostatic compounds—which are destroyed or left behind in the manufacture of penicillin" (*Nature*, 1944, 153, 380). The suspension referred to was the product "vivacillin." Preliminary animal tests with this product had been carried out by E. v. Lustig-Lendva (*Vet. Rec.*, 1944, 56, 178), whilst Dr. R. Segar, Medical Superintendent at the Wellhouse Hospital, Barnet, was the first one to submit the product to clinical tests on a large scale at his hospital.—I am, etc.,

London, N.W.4.

H. ENOCH.

Viennese Twilight

SIR,—I have received from my publisher, Heinemann and Co., London, your review (Jan. 17, p. 103) of my book, *The Art of Healing*, and I feel that this criticism should not go unanswered, as it misrepresents the whole tendency and contents of my book and misinforms the British medical profession as well as the general reader. At a time when the British medical profession is in such a predicament that a large part of the nation is disappointed enough with its accomplishments to want to make the physicians servants of the State, the medical profession should consider whether it is not itself responsible to a large extent for this shameful situation.

Those among British physicians who are not "isolationists," as the reviewer of this book, may know that in Germany and in France medical thinkers, including this author, have spoken during the last decades of a very serious "crisis in medicine," which was brought on by overemphasis of "hyperexact" detail work, over-specialization and laboratory medicine, and by neglect of the practical, erroneously called "empirical," methods of pre-Virchowian medicine, thus making the practice of medicine too fussy, complicated, and expensive. In England itself it was mainly outside of the medical profession that this harmful development was recognized. Bernard Shaw's *Doctor's Dilemma*, despite its satirical exaggerations concerning the overemphasis of the so-called "scientific," bacteriological, and surgical trend, is still valid to-day. A. Flexner, the emissary of the Rockefeller Foundation in America, has sufficiently exposed in his famous reports on "Medical Education" and "Universities" the superficiality of the present British trend.

There are in fact two principal approaches to theoretical and practical medicine. One—and this is the prevailing doctrine in England and some other countries—denies the value of the methods of our medical predecessors and looks for salvation in present and future new discoveries only, stressing at the same time the allegedly "exact" (auxiliary) natural sciences such as physics, chemistry, anatomy, experimental physiology, bacteriology, etc., while discarding all the methods (of medicine proper) of proven practical value which have been collected by earlier successful physicians from antiquity up until 100 years ago.

The second trend believes that, even more than any other science and art, medicine (which is not an exact science but collected experience) must be founded on the best of the practical therapeutic methods of the past. All the pious talk about Hippocratic ideals and Hippocratism becomes pure lip service and nonsense if we sneer at such fundamental and indispensable methods of general care as the deplethoric, antiphlogistic, antidystric, tonic, antispasmodic, and other methods, which include properly indicated purging, sweating, bleeding, venesection, cupping, leeches, vomiting, and the utterly neglected counter-irritation.

The Constitutional Doctrine is itself divided into these two principal approaches to medicine. Julius Bauer, the author of *Constitution and Disease*, whose fatalistic philosophy is praised so highly by the reviewer of my book, is a follower of the former hyper-rationalistic, dogmatic, and hyperexact trend of dialectic materialism, which has led medicine to scepticism, therapeutic nihilism, and unnecessary incompetence in many fields. According to Bauer, constitution must be identified with heredity and therefore cannot be influenced by therapy.

On the other hand Hippocrates and all his followers, including Sydenham, Hunter, Heberden, Hufeland, and in modern times Friedrich Kraus (Berlin) and F. Martius (the original founder of modern constitutional doctrine), do believe in the possibility of influencing human constitution by therapy. I myself tried to put this endeavour into practice by combining the discarded but valuable fundamental methods of the past with modern medical standards. Scientific evidence in my *Textbook of Constitutional Therapy* (Hippocrates Verlag, Stuttgart, 7th edition, 1934). As this attempt was new, at least in our time, I tried to bring it into a teachable system and called it constitutional-therapy, an accomplishment which was given credit by the noted medical historian Dr. H. E. Sigerist,