of the profession are muddled by the ever increasing amount of scientific knowledge, and in their endeavour to keep up with and to apply that knowledge they are apt to get lost in a maze of often meaningless figures. The older clinicians in their endeavour to follow suit get lost even more easily. The language at the average residency table (to an outsider at least) would puzzle even an Egyptologist trying to unravel the mysterious message on some ancient papyrus. The nonsense being banded about on many lips in many spheres of life is becoming intolerable.

In school the new entrant is often measured by pseudo-scientific psychological tests. My own child was refused admission to school here because she did not reach up to the standard demanded by these tests. In fact, she was refused admission because she was "dull and backward." By other means I pressed her admission into this school—to find that the same "dull and backward" child shines now at or near the top of her class (no doubt a class of "backward" children). And so the nonsense goes round and round, using the words of the famous song. It is time some of us took a more sensible line, and Dr. Roberts is to be congratulated in reminding us this time of our failings.—I am, etc.,

Edinburgh.

K. I. E. MACLEOD.

The Treatment of Hyperidrosis

SIR,—Mr. H. A. Haxton (April 3, p. 636) in his opening paragraph states that essential hyperidrosis is seen in those parts of the body which are affected by mental or emotional sweating. He later goes on to say that the cause in most cases is unknown, and appears to discredit the theory of abnormal psychic disturbances, substantiating this by reference to a case in which the onset was before the age of ten years. As the genesis of most emotional disturbances occurs in infancy this would not appear to be a valid argument against the theory. It is to be noted also that in Case 5 the symptoms prevented the patient from dancing and in Case 9 occurred when the patient was warm or embarrassed—both of these would suggest an abnormal emotional background.

I have recently observed a patient, 34 years of age, in whom hyperidrosis of the hands commenced suddenly after a febrile illness, and in the early stages occurred only when the patient was playing cards, but later at frequent and apparently unconnected times. Varied local treatments were tried without success. About the same time the patient complained of praecordial pain and dyspeptic symptoms; these progressed to a frank anxiety state. Psycho-analysis revealed a deep emotional conflict of which the patient had been completely unaware. As the analysis proceeded the frequency of the hyperidrosis became less and less, and the patient was able to connect its occurrence with his conflict.

I would suggest that the majority of cases of hyperidrosis should be classified as psychosomatic, and in all cases where an organic cause is not found adequate psychological investigation should be carried out before submitting the patient to an operation, which although it may relieve his immediate symptoms will leave the basic cause unresolved.—I am, etc.,

London, W.2.

JOHN H. L. CONWAY-HUGHES.

Pulmonary Embolism

SIR,—I am grateful to Mr. Norman C. Lake (March 20, p. 569) for giving some details of the necropsy findings in two of his cases; but I doubt whether he is right in blaming Nature for being preposterous, as it seems probable that the necropsy examinations were not full enough to justify his conclusions. In his first case Mr. Lake states that clot was projecting into the superior vena cava from the azygos vein. This, I would submit, may refute rather than support his suggestion that the fatal embolus originated from this source. In the second case the fact that the clot was found projecting into the iliac veins (I take it that this refers to the internal iliac veins) is again no proof that this was the source of the embolus.

Lest Mr. Lake should consider me unduly disputatious, may I add a few further remarks?

1. It must not be presumed that any veins containing ante-mortem thrombus at necropsy were the site of origin of a fatal embolus unless (a) the veins of the legs have been carefully dissected, and (b) the loose clots in the heart and lungs can be shown to "fit" the veins from which they have allegedly

originated. Where these steps are taken there are very few cases in which an embolus can be proved to have arisen from those unusual sites which (in the absence of adequate necropsy examination) were formerly accepted as the source of some emboli.

2. In the ordinary necropsy, where examination rarely extends below the groins, it is frequently the empty rather than the clotted veins in which we should be most interested, and unless the leg veins are explored it is unjustifiable to incriminate the only veins that happen to have been examined.

3. Ante-mortem thrombosis is frequently extensive, and I have commonly found thrombosis at other sites when the veins of the lower limb were unquestionably the source of a fatal embolus. In the absence of full necropsy the wrong veins would have been incriminated.

I never doubted that Mr. Lake was fully aware of the importance of early movements nor did I think that he should have devoted much more space to the question of pulmonary embolus. I do, however, consider that his conclusions about these cases are unjustified and that it is singularly unfortunate that the little he did say should concern these two cases.

The purpose of my last letter was to challenge a too prevalent defeatist attitude to this subject of embolus. I fully appreciate that active movements alone will not prevent thrombosis, and it is for this reason that I would advocate daily examination of the legs and the "abortive" treatment of any thrombosis with heparin. If it be believed that thrombosis usually arises from the abdominal wall or from haemorrhoids then there is little possibility of early diagnosis, and still less opportunity of selecting suitable subjects for anticoagulant therapy. This erroneous belief is disproved by the results of thorough necropsy examination.—I am, etc.,

Radiett, Herts.

REGINALD S. MURLEY.

Prostatectomy for Retention of Urine

SIR,—In the article by Mr. G. A. Bagot Walters on immediate prostatectomy for retention (April 3, p. 638) I read that as recently as 1945 an excellent authority favourably compares the patient with acute retention operated on from the street and the bedded patient who has undergone "sulpha, catheter, anticipatory" treatment.

Now I think the comparison may be misleading. An acute retention with benign prostatic enlargement may frequently not demand prostatectomy, whereas a patient catheterized for a few days or weeks may not need any debilitating "sulpha" treatment and certainly no confinement to bed with attendant loss of appetite and anxiety. In this rural area I remember twenty years ago how difficult it was to catheterize for more than a few days without having the depressing increasingly dirty condition of the urine brought to one's notice. From the time I commenced giving "metramine," one capsule daily, to mildly disinfect and make blue the urine I have not failed to keep it free from unpleasant odour or cloudiness, even after catheterizing for some weeks in cottage conditions.

When one's experience is limited, it is unfortunate that in hospital the only case of acute retention I saw decompressed with a lumbar puncture needle suprapubically, died. In practice, where catheterization has been imperative and possible I have always spent an hour in emptying the distended bladder—with very frequent interruptions in the flow—while engaging the patient in conversation and deprecating all efforts to assist in expulsion.

Of my few elderly prostatic patients I give, as illustrations of what may happen, (1) a case refusing a second-stage operation, satisfied to live and get about with a permanent and leaking suprapubic drainage emptying into a milk bottle suspended by tape from the neck of the patient; (2) two cases, both over 70 years, who after catheterization for some weeks resumed normal micturition for several years; (3) one case who had weeks of catheter life, with "metramine" administration, without recovery of natural function, and who submitted to immediate and uneventful prostatectomy by a general surgeon; (4) one patient who died from a heart attack a few days after suprapubic drainage had been established by an eminent genito-urinary surgeon; (5) one sturdy patient admitted to hospital without catheterization but with considerable residual urine, as shown by percussion, who died four days later from urinary suppression after suprapubic drainage; (6) one patient, aged 80 years, who in 1947 had acute retention through unavoidable

delay in micturition. This case gave a history of nocturnal frequency over many years. Owing to having an ailing wife he refused operation; catheterized daily for three weeks, and with metramine, he resumed natural micturition, getting up once nightly, and to-day is living a very active life.

I write these particulars for the rural practitioner who may be interested in the common things of life.—I am, etc.,

Haydon Bridge, Northumberland.

RICHARD BELL.

Malignant Syphilis

SIR,—The report headed "A Fatal Case of 'Malignant' Syphilis" by Drs. Robert Lees and William Fowler (March 6, p. 451) is of considerable interest. Although the occurrence of rupial lesions and mucous patches together with penile sores and a positive Wassermann reaction makes the diagnosis of syphilis extremely likely, it seems nevertheless a pity that apparently no attempt was made to demonstrate *Spirochaeta pallida* in genital or other lesions.

It would be interesting too to learn whether any Herxheimer reaction was noted on commencing treatment. No doubt the small initial dosage of penicillin was designed to prevent therapeutic shock. Yet recent American work would suggest that the risk of therapeutic shock is no greater with large initial doses of penicillin than it is with small ones.¹ Moreover, in the apparent absence of involvement of vital structures surely it would have been more logical to have begun treatment with large doses of penicillin plus a potent arsenical, plus a soluble bismuth or mercurial salt, in order to combat an apparently fulminating infection. A fulminating meningococcal septicaemia, for example, is regarded as requiring heavier dosage with sulphonamides than would a case of average severity.

Isolation of the spirochaete would also have made possible an attempt to determine by means of rabbit inoculation whether the infection was caused by a drug-fast strain such as that reported on by Beerman and Severac,² whilst microhistological investigation might have determined the condition of the smaller and medium vasculature, as vascular causes have been held responsible for destructive changes both in early and late syphilis.³

Lastly, occasional batches of penicillin are found to be therapeutically ineffective. Was the particular batch used tested and proved to be therapeutically active on another patient, or otherwise assayed for penicillin content?—I am, etc.,

Liverpool.

C. D. ALERGANT.

REFERENCES

- 1 Olansky, S., *J. vener. Dis. Inform.*, 1947, 23, 26.
- 2 Stokes, J. H., Beerman, H., and Ingraham, N. R., *Modern Clinical Syphilology*, 1944, p. 148. W. B. Saunders, Philadelphia.
- 3 *Ibid.*, p. 22.

Thiouracil in Thyrotoxic Heart Disease

SIR,—I feel that Dr. W. E. Clarke (March 27, p. 597) has been unlucky in his experience of treating thyrotoxic cardiovascular disease with thiouracil, since in many hospitals satisfactory results are being obtained. I have before me the notes of twelve consecutive cases of thyrotoxicosis that I have treated during the past year. Six had cardiac failure, and three of these auricular fibrillation. The degree of failure seemed more severe than in Dr. Clarke's cases, and the initial pulse rate was never below 120. In all six cases the cardiac symptoms were entirely relieved by thiouracil, the fibrillation reverting to normal rhythm, which has persisted. The condition of the patients, on a small maintenance dose, is excellent. Surgery was offered but was refused in every case, though in fairness it must be said that patients referred to a physician using thiouracil are in some sense selected. One woman, for example, had refused to go to hospital for years, until she was told that a non-operative treatment was available.

As regards the frequency of heart disease in thyrotoxicosis I would question the statement that few cases now develop cardiac complications. It would be safer to say that the thyrotoxic element in heart disease is often overlooked. No assessment of the incidence of thyrotoxic heart disease is valuable unless the age of the patients is taken into account. Of my twelve cases, those whose hearts failed were all over 44, while the others were all under 41 save one. I would suggest that in

the older patient cardiac failure may occur quite early in the illness.

Dr. Clarke does not give details of dosage, and it is possible that the drug fever and granulopenia which caused him to resort to surgery were associated with a higher dose than is used to-day. I have not used more than 200 mg. of the methyl derivative three times a day in the cases of which I have spoken. A mild granulopenia should not cause treatment to be given up. Of his other failures, neurosis seems an odd reason for surgical intervention, and malignant exophthalmos is seen after thyroidectomy. Of my own cases there are two in whom I should like to see the goitre removed for cosmetic reasons, but the patients will not hear of it.

Either thyroidectomy or thiouracil can control the symptoms of thyrotoxicosis with minimal risks if properly used. Operation will always be favoured by those who regard the goitre as the *fons et origo mali*, but it is surely more correct to look upon it as a link in a disordered metabolic process. From the practical point of view patients to whom the alternatives are fairly presented will decide for themselves. It behoves us, by a careful follow-up, to see that we are in a position to present the facts.—I am, etc.,

Cheam, Surrey.

C. P. PETCH.

The Danger of Intubation under Trichlorethylene

SIR,—Dr. W. M. Maidlow (March 13, p. 523) rightly emphasizes the dangers of too early intubation. Intubation under trichlorethylene is often unsatisfactory, as the laryngeal and tracheal reflexes in the uncocainized patient are still active, and indeed under these conditions may be dangerous. This danger exists under *all* anaesthetics. Other fatalities have been reported, occurring immediately after intubation, when agents other than trichlorethylene have been employed. Early intubation can be necessary and is sometimes vital, but I feel there is a strong tendency to intubate in lighter and lighter planes of anaesthesia, more because of impatience or to satisfy a personal vanity than any other reason. Intubation should be reserved for those occasions which require it, and then only after adequate preparation of the patient.

Reflex spasm of all muscles of respiration occurs after early intubation, but I would hesitate to use curare in this condition, which always responds excellently to an increase in the anaesthetic concentration.—I am, etc.,

London, W.1.

G. E. HALE ENDERBY.

"Myanesin" as a Relaxant in Children

SIR,—With reference to the article by Dr. W. H. Armstrong Davison (March 20, p. 544) I think the use of "myanesin" combined with general anaesthesia for Ramstedt's operation is a retrograde step. The operation can be carried out quite satisfactorily using local anaesthesia with procaine, and I feel that the use of a drug about which there is still a diversity of opinion is unjustifiable in these cases.

Dr. Armstrong Davison states that the objections to local anaesthesia are that the technique is time-consuming and relaxation is unsatisfactory. The time factor should not influence an anaesthetist where the safety of his patient is at stake. The degree of relaxation obtained with local anaesthesia is quite adequate for the operation, which can usually be performed using 10 ml. of 0.5% procaine, which is well within the safety limits of the drug.—I am, etc.,

London, W.C.1.

J. N. T. HUTTON.

Naming Drugs

SIR,—In reviews and abstracts of articles appearing in foreign periodicals it frequently happens that a familiar drug escapes recognition by being referred to under a name not in use in this country. A case in point was the reference to mandelamine (methenamine mandelate) in your leading article "Streptomycin Bactericidal" (Feb. 28, p. 399). Mandelamine is, of course, an American proprietary preparation, but it will not be readily apparent to everyone that methenamine is the name used in the United States Pharmacopoeia to describe the substance known in this country as hexamine ("urotropine"). Other examples, perhaps better known because more frequently encountered, but which still cause some confusion, are epinephrine (adrena-