Thyroidectomy Fatality Rate

SIR,—In his comparison of safety between thiouracil and surgery for thyrotoxicosis, Professor H. P. Himsworth states (July 10, p. 61) that "it is probable that the mortality rate (after surgery) in the best general hospitals, both in this country and abroad, is not far below 2%." I cannot help thinking that this is a most pessimistic estimate for modern thyroid surgery. For a period of 29 years I have had the honour to anaesthetize for three surgeons who specialized in thyroid work, and for the whole period the total operative mortality rate for thyroidectomy was 0.75%. This includes all patients who died in the hospital or nursing-home.

In recent years, however, owing to the advances in pre-operative treatment and in surgical and anaesthetic techniques, the mortality rate has fallen to a very low figure, there having been only two deaths in the last consecutive 1,000 cases (0.2%). There is no reason to suppose that this figure differs appreciably from that obtaining generally, and I would suggest that the insertion of a decimal point in Professor Himsworth's estimate would give a more accurate idea of the present-day mortality rate from thyroid surgery. I should, perhaps, add that the majority of the thyroidectomies referred to were performed at St. Bartholomew's Hospital either in London or at Hill End.—I am, etc.,

St. Albans, Herts.

C. LANGTON HEWER.

Prevention of Dust Diseases of the Lung

SIR,—From this correspondence (July 17, p. 172, and Aug. 7, p. 311) it would appear that so far we do not possess a face mask or respirator which in use will efficiently arrest dangerous dust particles and assure the workman of protection against pneumoconiosis. At the same time it seems agreed that face masks do not represent effective action directed to the control of the disease. From practical experience one thing is certain—namely, that no mask has yet been devised which heavy manual workers, particularly workers at the coal-face, can comfortably wear throughout a day's work.

As a temporary expedient practical scientists are seeking to design a mask which is efficient in arresting the dust and at the same time is acceptable to the workman. To those scientists I would suggest they have a further responsibility, which is to ensure that the wearing of the mask, its day-to-day storage, and disposal of pads do not bring new dangers. Workmen and employers are exceedingly careless in what to medical men are elementary matters of hygiene. It is a common observation at workplaces to see masks still fitted with soiled pads thrown into a common receptacle, from which masks are taken promiscuously when required, while soiled infected pads are discarded anywhere. The recent article by Dumbell, Lovelock, and Lowbury (*Lancet*, July 31, p. 183) on "Handkerchiefs in the Transfer of Respiratory Infection" may not be entirely irrelevant to this aspect of the problem, especially as it has frequently been argued in the literature that respiratory infection by pathogenic organisms may modify adversely the action of noxious dust in the lungs.

This is no place for a discussion of measures for the effective control of pneumoconiosis in coal-mines, but I would venture to ask your correspondents, Dr. A. Harper and Dr. J. M. Morgan (Aug. 7, p. 311), or any others, what is the *earliest harmful evidence* in coal-miners at which the workman should be advised to give up his skilled occupation and seek alternative work? Or, in the language of the compensation schemes, "What constitutes the disease to a *dangerous* degree?" This is the question which more than any other urgently demands a clear, unequivocal answer now.—I am, etc.,

Glasgow.

A. MEIKLEJOHN.

Fibrositis

SIR,—The article on fibrositis by Dr. James Cyriax (July 31, p. 251) certainly offers a simple solution to an aged and complex problem. The conclusion that he "forced on the unprejudiced observer" that "the symptoms of rheumatic fibrositis coming on for no apparent reason are the result of articular lesions," and "the underlying principle of treatment" that he wishes to teach the simple observer, that of the reduction of the intra-articular lesions by local manipulation, are simple if not factual.

It would be interesting to know if Dr. M. Woodhouse is as happy about the finality of the conclusions drawn from his necessarily limited electromyographic studies as is Dr. Cyriax.

It is an accepted fact that many people who in the past have been diagnosed as suffering from fibrositis and neuritis are really suffering from symptoms due to intra-articular lesions such as prolapsed and fragmented intervertebral disk in the cervical or lumbar regions, and that the principle of local treatment is either movement or rest. Dr. Cyriax has been among those who have impressed this fact on the medical profession. This, however, is not the problem of "fibrositis," and in consequence the solution offered in this article is no solution.

"Fibrositis" is a clinical term commonly used to describe the pain which seems to be located in the soft tissues of the limbs and for which there is no obvious cause. In practice the diagnosis is based on the exclusion of known systemic diseases or local disorders. Pain and stiffness are the cardinal symptoms, occurring particularly on movement and localized on clinical examination to the subcutaneous tissues, superficial and deep fasciae, aponeurosis, ligaments and capsules of joints, tendons and tendon sheaths, bursae, periosteum, and the sheaths of the nerve trunks.

It is true that we have no adequate evidence that fibrous tissue is affected primarily, but we do know, many of us from personal experience, that sitting in a draught may be followed by a stiff neck or lumbago; also we know that pain in the shoulder may disappear after the removal of a septic tooth. We do know that the industrial worker, the harried young housewife, and the plump, middle-aged ladies among our acquaintances frequently suffer from "fibrositis." Many of us know that the "reduction of an intra-articular lesion" has not only failed to relieve their symptoms but has made them worse.

"Fibrositis" is a problem in general medicine. At the present time "unprejudiced" and far from simple observers are studying this problem, and I would bring to the notice of Dr. Cyriax and his would-be disciples the many papers and books on this subject recently published in the English language. I would mention only those by Weddell, the anatomist; Draper, the constitutionalist; May Wilson, the clinician and geneticist; Halliday, the industrial physician and psychiatrist; and Ling, the sociologist. Hench, Stone, and other physicians whose primary interest is in rheumatism have also made valuable contributions. Finally I refer Dr. Cyriax to the papers by Drs. Bauwens, Harman, and Dykes of his own hospital.

The problem of "fibrositis" is complex. To solve it the biochemist, the geneticist, the pathologist, and the clinician will need to work together as a team, probably for quite a long time to come.—I am, etc.,

London, W.1.

FRANCIS BACH.

Treatment of Chronic Varicose Ulcers

SIR,—I read the paper by Messrs. John Borrie and E. Vernon Barling on chronic varicose ulcers treated by lumbar sympathectomy (July 24, p. 203) with great interest. When I was Mr. (now Professor) Ascroft's house-surgeon we had a patient suffering from thromboangiitis obliterans with large ulcers in the region of his malleoli which caused him much pain. To relieve this pain Mr. Ascroft divided the superficial nerves supplying the area in question, and to our surprise and gratification not only was the patient's pain relieved but the ulcers quickly became smaller and healed within a very short time. Mr. Ascroft attributed this effect to the improved local circulation, as the sensory nerves also carry some of the sympathetic fibres to the area.

Since then I often divided or crushed the great saphenous nerve just below the knee when I did a Trendelenburg operation in patients with varicose ulcers over the medial malleolus, and always had the impression that this simple manoeuvre speeded the healing of the ulcer as well as relieved the patient's pain immediately.

The nerve is easily found a couple of inches below the knee, where it lies close to the saphenous vein, which I ligate in this place as well as in the thigh in these cases. Often the nerve is not in a single trunk but divided into several strands. In the case of ulcers in the region of the lateral malleolus the sural and the cutaneous branch of the superficial peroneal nerve require division. This little operation adds only a few