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

minutes to a routine Trendelenburg operation and is, in my opinion, always worth while doing before embarking on a major operation like lumbar sympathectomy.—I am, etc.,

Coventry.

P. E. ROLAND.

Prevention of Venereal Disease

SIR,—I feel obliged to add my testimony on the subject of prevention of venereal disease to that of your correspondents in the *Journal* of July 31 (p. 268). I am sure that to rely upon methods of prophylaxis to be applied after exposure to infection is to court failure. The attention to detail necessary to make them efficient is rarely available, and the false sense of security given simply encourages risks to be taken. Dr. Earle Moore, with his vast experience, has no doubt that prophylactic treatment if properly carried out can be of value, but he says the average man will not take the necessary trouble; and when one remembers how often the patient was more or less under the influence of alcohol when the risk was taken this is not surprising. If anything is to be done on such lines of prevention, surely the use of a rubber sheath is much simpler and more likely to be carried out; this indeed is what I am in the habit of telling those patients who seem unlikely, in spite of all one can say, to abstain from future risks.

Finally I must add that I am astonished Lord Horder (July 17, p. 171) should take such a pessimistic view of the present situation. Looking back over the 25 years that I have been in charge of a fairly busy clinic I feel that, owing chiefly to the action of the Ministry of Health in making the public "V.D. conscious" and in providing free treatment, we can reasonably anticipate a continuation of the improvement which was so marked before the war and which is now showing itself again. That war conditions should cause a relapse was inevitable and to be expected. Has not this happened in every war since syphilis was first brought to Europe by soldiers in the sixteenth century?—I am, etc.,

East Croydon, Surrey.

P. W. HAMOND.

SIR,—The sexual requirements of the individual vary immensely, and each is entitled to judge for himself or herself whether extramarital relations are right or wrong. There can never be a standard sexual morality. The problem is therefore a moral one for the individual only. To regard V.D. as a moral problem, as does Dr. G. L. Russell (July 31, p. 268) is to be prejudiced. It would appear from what Miss K. B. Hardwick writes (p. 269) that the Association for Moral and Social Hygiene, having found chastity as an ideal unsuccessful, is now preaching chastity as an anti-V.D. device.

The first essential in any campaign against V.D. is to stop looking upon extramarital relations as a disease in itself. The lack of a marriage certificate does not transform sexual experience from something beautiful into something ugly and shameful, but the present official outlook of Church and State, by driving sex into back streets and sordid lodgings, does precisely that, and at the same time favours the spread of V.D. The inevitability of extramarital sex relations must be accepted, and every effort made to keep such relations, if not on a spiritual, at least on a healthy physical level.

All anti-V.D. appliances should be banned until some really efficient method is discovered, and V.D. propaganda stopped. Would not anti-T.B. propaganda be of more value in its own field? Surely the early symptoms of pulmonary tuberculosis are more insidious than those of any of the venereal diseases, and early treatment more important.

Until some super prophylactic drug which can be taken by mouth comes along, legalized and controlled prostitution, as was carried on until recently in France, is the only sure method of V.D. control. The termination of this system in France has led to an increase in V.D. The relaxation of official harshness manifested in the adoption of such a system would also do much to establish a healthier outlook on sexual matters, and a more sensible attitude to V.D. A quotation from *Sex, Life, and Faith* by Rom Landau is appropriate, "The number of divorces for sexual misdemeanour is much smaller in France than in Great Britain . . . they have suffered far less from neuroses or sexual aberrations. Evidently their more frank and natural approach to the problem of sex is to some extent responsible."—I am, etc.,

Edinburgh.

W. B. LAING.

Confidential V.D. Treatment

SIR,—By her complaint against the Minister of Health for removing the statutory requirement of secrecy about V.D. Miss Katharine B. Hardwick (Aug. 7, p. 313) fails to see the wood for the statutory trees and betrays signs of a legalistic mind out of touch with realities.

When in 1916 the V.D. service was started the Government accepted the recommendations of the Royal Commission on Venereal Diseases that attendance should be voluntary and free, but added a statutory requirement of secrecy which was not one of the Commission's recommendations. No doubt this addition was made for propaganda purposes to beguile an unprepared and possibly distrustful public into voluntary attendance at V.D. clinics. No doubt also the provision was inserted in deference to the fears of those who thought that the public would not regard public clinics as sufficiently private and that therefore V.D. would still be treated inefficiently in an underground manner by unqualified persons.

Whatever the reasons for inclusion of the provision of statutory secrecy there is no doubt that after more than thirty years of experience of the V.D. service the public is firmly convinced that the staffs of V.D. clinics do in fact maintain the greatest secrecy, and few members of the public who use the V.D. clinics are as well informed as Miss Hardwick about the legal background or as impressed by its power.

Having worked in V.D. clinics for many years I have no hesitation in emphatically stating that the high standard of secrecy and confidence obtaining in these clinics is due neither to statute (as she asserts) nor to Ministerial hopes (as she agrees), but to the sense of responsibility and loyalty of the medical and lay staffs, who have learned during more than thirty years' experience the great importance of securing the trust and confidence of their patients. Secrecy is now so strongly entrenched by custom in the minds of public and clinic staffs alike that a statute is unnecessary to buttress it. Rather than complain that a Minister of a Socialist Government revokes regulations we should congratulate him and those who advised him for removing unnecessary legal lumber.

Finally, by encouraging ventilation of the Minister's revocation of statutory secrecy Miss Hardwick is tending to obtain the very opposite of what she wants. If she says from the mountain tops that there is now no secrecy about V.D. (because it is not statutory) not only is she publishing error, not only is she casting an unwarranted slur on the devoted staffs of V.D. clinics, but she is herself likely to cause unfounded doubts to arise in the minds of the very public she wishes to protect.—I am, etc.,

London, N.W.5.

F. R. CURTIS.

Thiouracil in Treatment of Thyrotoxicosis

SIR,—We should be grateful to Professor H. P. Himsworth (July 10, p. 61) for his lucid exposition of the status of thiouracil in the treatment of thyrotoxicosis. For more than a year I have taught that white counts are not a routine necessity in thiouracil therapy, but that they should be done in the three following circumstances: (1) In the first few weeks of treatment they are valuable in order to detect the occasional case in which granulopenia reaches a dangerous level. It is helpful to know the usual white cell level of each patient, for this varies greatly in different individuals (my own white count is usually between 4,000 and 5,500 with about 50% to 60% of polymorphs), and it is correspondingly difficult to generalize regarding the level of granulopenia. (2) A white count should be done whenever the minor toxic effects of thiouracil appear. By themselves these manifestations do not call for cessation of the drug; it is the level of the white count that matters. (3) Agranulocytosis: I fully agree with Professor Himsworth that routine white cell counts are no safeguard in preventing or detecting this dangerous complication.

I believe that the quickest way of dealing with a suspected case of agranulocytosis is to make a thick film of peripheral blood, as is done in the diagnosis of malaria, and stain it with Field's stain—a few seconds' gentle agitation in solution A, then in distilled water, then in solution B, and finally in water again. Anyone can make a good thick film if they trouble to practise, and most people should be able to distinguish a polymorph in a thick smear. Given a microscope and the necessary stain (which