industry, energy and dexterity, and perhaps ambition, the student must be entitled to decide for himself in what direction his work might be expected to bring its own reward. In coming to a decision personal trends must be given due weight :

1. There are those whose chief thrill comes from research, in following out a line of thought by experiment and logical reasoning, hoping in the end to reach a worthwhile result. For them medicine provides an ever-widening horizon, each fresh discovery a stepping-stone to the next.

2. Others are thrilled by imparting instruction on established facts and possible theories to individuals or groups. We speak of the "born teachers," whose gifts both bring and bestow enjoyment.

3. Others still are attracted by the thrill of being the bearers of hope and confidence to the sick as they are found in the wards and out-patient departments of our hospitals. Valuable equipment for these is what, for want of a better term, we call clinical instinct, and for them there is again a wide choice among the many departments of clinical work, each with its own peculiar attraction.

It is my experience that all these qualities and ideals are seldom combined in a single individual, and at a time when money prizes are unlikely in the future to compare with those of the past, but where for every medical graduate a livelihood is assured, a young man or woman should be encouraged to follow that course in which the work itself would be a continuous joy, and from which he or she might be expected in the end to obtain the maximum of individual satisfaction. If I might be permitted to end on a personal note it would be one of thanks to an old teacher, the late Professor James Lindsay, who at a critical moment gave me advice which I pass on to those faced to-day with the entrancing and decisive problems of youth.—I am, etc.,

Belfast.

S. T. IRWIN.

Prevention of Venereal Disease

SIR,—The numerous correspondents in the *Journal* of July 31 (p. 268 *et seq.*) appear to have missed the essential points of Lord Horder's letter (July 17, p. 171), and the simplest way to reply to the various issues raised in their letters is to restate the main heads of the campaign. The campaign of the N.S.P.V.D. is directed towards the enlightenment of the public on the following matters.

1. Over a long period of years the abundantly proved fact that V.D. is easily preventable has been prevented from reaching the public, and in spite of lavish public expenditure on other methods V.D. has increased.

2. The Report of the Government-appointed Trevethin Committee settled once for all the scientific fact that V.D. is easily preventable. Abundant scientific evidence was laid before that committee, and this was confirmed by overwhelming evidence from myself and others as the result of wide experience in reducing V.D. in the Services. Dramatic reduction in V.D. has always followed the introduction of reasonably effective self-disinfection.

On the subject of practicability for the average person the Report says : "We see no reason to doubt that an intelligent man, if furnished with reasonable instructions, could in favourable conditions effectively disinfect himself." A study of the actual instructions will convince anyone that no high degree of intelligence is required. The process is so simple that "official skilled supervision" of the disinfection is obviously superfluous. Practical experience, moreover, has shown conclusively that civilians will not seek such assistance, and that in the case of the Services the introduction of supervision and the unnecessary elaboration of the procedure have been the chief causes of the apparent lack of success on account of evasion. Officially supervised disinfection never has been, and never will be, successful on account of the psychological factors involved.

3. The Trevethin Committee Report replies effectively to the allegation that knowledge about preventives would lead to increased promiscuity. On this subject the Report says : "It is urged by some that any system of disinfection would tend to increase the number of exposures and to raise the disease rate. We have received no evidence of facts in support of this view, and we are inclined to think that those who hold it attach too much weight to the deterrent effect of the fear of the disease."

Conclusive evidence was supplied by myself and others that a campaign of prevention of self-disinfection in any area was often followed by a decrease in promiscuity, because the instructions given furnished the plainest proof of the danger of infection.

4. Not only is the spread of this important knowledge prevented but if it does leak out the law prevents any practical application. Incredible as it may seem, it is actually illegal for a chemist to sell to any customer the necessary materials for prevention accompanied by instructions for use. This continues in spite of the fact that the Trevethin Report in 1923 recommended that the law should be altered. Not content with compulsory ignorance the obstructionists prevent any useful application of any leakage of information. Could fanaticism go further ?—I am, etc.,

London, W.1.

R. A. LYSTER,
Chairman, National Society for the
Prevention of Venereal Disease.

SIR,—Statistics can be used to prove most things, and there are statistics to prove that prophylaxis is useless in the prevention of venereal disease. One instance will serve. In a certain distinguished battalion in Delhi 18 men contracted hard chancres in one month. Inquiry proved that all these men had used the unit prophylactic ablution centre, and had stated so in the prescribed form which men who contracted V.D. had to complete. This would seem to prove that prophylaxis was useless. Investigation of the forms, however, showed that the men had all exposed themselves to infection at 10 p.m. on various evenings during the month, had each used the P.A. room 15–20 minutes later, and that each had reported at the medical inspection room at 8 a.m. on the morning following exposure with a hard chancre.

I took a close interest in the prevention of venereal disease during the eighteen and half years I spent in India, most of it as a hygiene officer, and I wish to say that I have seldom found a British soldier in hospital with V.D. who had not used the P.A.C., but also that I have never, after inquiry, found a soldier in hospital with V.D. who had used the prophylactic ablution centre at the proper time. The centre had been used after the disease showed itself. On my visits I always used to ask the P.A. room orderlies the same question, "How many men have you known getting V.D. who had used the P.A. room at the proper time ?"—i.e., within an hour or so after exposure—and the answer was invariably the same, "None, sir." Early washing with soap and water would probably prevent 99 cases out of a 100. The use of mercurial cream after washing would make it as near a certainty as makes no difference.

Owing to the circumstances prevailing in a British division in India during the war it was decided not to establish unit P.A. rooms. Instead, the likelihood of infection if they exposed themselves was impressed on all ranks, and also the value of thorough washing on return to their quarters, using their own soap and towel, and then applying mercurial cream. Steps were taken at the same time to see that prophylactic packets were available for all, easily and unobtrusively. The results fully justified these measures.—I am, etc.,

Public Health Branch,
Control Commission for Germany.

W. STRELLEY MARTIN.

Whooping-cough and Measles

SIR,—In the spring of 1938 an epidemic of measles (morbili) coincided here with an epidemic of whooping-cough. Of 57 consecutive cases of measles seen by me, 55 were children and 2 were adults. Among the 55 children there were 46 cases of measles alone, 7 of measles developing during whooping-cough, and 2 of whooping-cough developing during measles.

Of the seven who had whooping-cough first and measles during its course all took a normal course without complications, and in two cases there was a suggestion that the whooping-cough was improved by the measles. Of the two with measles first and whooping-cough during its course one progressed to bronchopneumonia and the other was normal. Of the 46 cases of measles alone ten developed some complication or ran an abnormal course. Two had asthma at the height of the rash, never having had it before, one developed a persistent nasal catarrh, two developed erythema nodosum in the second and third weeks respectively with fever, one had joint and abdominal pains for four days before the rash came out and was unable to pass water during the third and fourth days of the rash, two had coughs persisting for more than 14 days from the commence-

ment of the rash, one had double otitis media, and one had a purpuric rash.

From this small number of cases it would appear that measles developing during the course of whooping-cough does not necessarily add to the severity of either disease, but the same cannot be said of the converse. Dr. B. L. Hodge (Aug. 7, p. 312) drew attention to a similar double epidemic, and his observations would appear to confirm this view.—I am, etc.,

Redhill, Surrey.

L. J. BARFORD.

Fibrositis

SIR,—I should like to take up cudgels with Dr. James Cyriax over his article on fibrositis (July 31, p. 251), as I feel he is showing indecent haste in interring this condition. The essence of his case is that symptoms commonly attributed to primary fibrositis are really caused by derangements of the spine, and to prove this he compares the symptoms with those of such conditions as lumbago and brachial neuritis due to disk lesions. From certain similarities he draws the conclusion that fibrositis represents the lesser degree of these and related conditions. In stressing the similarities he glosses over the differences.

Observations made on oneself may have an element of bias in them, but as an occasional sufferer from both lumbago and fibrositis I have had opportunity to study both conditions at leisure. With regard to lumbago I am in entire agreement with Dr. Cyriax. The onset, after what one might term postural indiscretions such as an afternoon's gardening, lifting heavy weights off the ground, etc., followed by diffuse aching pain in the lumbar region combined with inability to fully extend the back—the whole lasting several days or weeks—bears the hall-mark of a spinal derangement.

Primary fibrositis, on the other hand, has a curious tendency to occur with changes of climate, but bears no relationship to exercise or posture. Subjectively its pain does not feel to be of the same quality as lumbago. It is a disease of tender spots, each of an area so small that it can be accurately localized with the finger tip. It is not only confined to the shoulder girdle or the lumbo-sacral region, but, when extensive, tender spots are found over the insertions of the muscles and their bellies throughout the trunk limb, over the scalp, and over the backs of the metacarpals and phalanges—in places, indeed, where there is no muscle interposed between skin and bone. The condition is bilaterally symmetrical to an extreme degree, and tender spots may be found in the territory of so many spinal nerve segments as to make one shudder for the integrity of one's vertebral column—should Dr. Cyriax's theory prove right.

The response to treatment does not suggest a spinal lesion, as marked and permanent relief may be obtained from massage and heat applied to the tender spots, and the condition will improve more gradually though nothing is done. The spine need not be touched to effect a cure, and one wonders if time may not be the chief therapeutic agent when spinal manipulation or traction is used.

Finally, as regards aetiology, this may be under discussion, but my own feeling is that the lesions lie in the fascial sheaths covering both muscular and bony structures, and that the muscle spasm which is such a feature of the condition is merely protective to avoid stretching a tender fascia.—I am, etc.,

London, N.4.

R. G. BENIANS.

SIR,—When Dr. James Cyriax (July 31, p. 251) calls primary fibrositis an imaginary disease he is in good company, but that fibrositis coming on for no apparent reason is always due to an articular lesion, as he states, seems open to doubt. I should like to quote the following case.

On Nov. 2, 1946, a district midwife, aged 24 years, recently married, no children, called at my house for advice regarding a neck stiffness which had developed two or three hours previously. On examination she had spasm of the upper margin of the left trapezius muscle, which was easily palpable and tender to touch. Obviously this was a true fibrositis, if the disease exists. Having some doubts about this, I made further inquiries. She admitted to having had a few colicky pains during the day, and on examination was found to be tender in the left fornix. A diagnosis of ruptured ectopic pregnancy was received by the patient with such incredulity as reflected

doubts on my sanity. However, the following day she had a laparotomy and was found by Mr. Theobald, who had seen her in consultation with me, to have a ruptured ovarian pregnancy, with free blood in the peritoneum. In this case the last menstrual period had started about 17 days before the illness, and any faith in fibrositis on the doctor's part would have caused the diagnosis to be missed. But this was *not* an articular lesion, nor was there an apparent reason for the fibrositis.—I am, etc.,

Shipley.

H. S. RUSSELL.

SIR,—In his article on fibrositis (July 31, p. 251) Dr. J. Cyriax has fallen upon a concept which has been promulgated in osteopathy for the last 70 years. The article, though condemning one aspect of the osteopathic theory, is essentially the theme of osteopaths for all these years—namely, that the spinal lesion is the cause of most local spinal and referred somatic pains.

The main difference now is that Dr. Cyriax stresses the intervertebral disk as being the faulty structure, whereas osteopathy stresses the apophyseal joint as being the site where significant changes have occurred. The probable truth is that both are to blame, sometimes one, sometimes the other, and frequently both together. It is, however, not possible to tell which part of the spinal joint is the offending structure except by inference, because, as Kellgren has shown, all deep pain is segmental in its manifestations.

With the advent of disk surgery and visible proof that prolapsed disks cause lumbago, sciatic pain, and brachial pain, the disk is now blamed for everything which happens to a spinal joint. But consider the pathology and the possible effect of manipulation. How can one manipulation, as suggested, normalize a torn cartilage? It might dislodge the offending piece from a sensitive structure, just as it is possible to manipulate a displaced cartilage in the knee and obtain relief straight away, but healing requires weeks. If one manipulation is effective, then the more rational explanation is that old adhesions in the capsule of the apophyseal joints have been snapped. The analogy of adhesions in a stiff knee is complete. One manipulation frequently cures, especially if the adhesions are old and brittle.

The osteopathic type of manipulation, while making use of specific forced movements for the purpose of breaking adhesions, does at the same time use gentle articulation of all the joints in the area of the lesion with the object of increasing local circulation and restoring normality there. The osteopath advocates a series of gentle manipulations without anaesthesia, and rhythmical traction is an important part of treatment. This probably assists in the healing of the intervertebral disk if and when it is damaged, and explains much of the success of their method.—I am, etc.,

London, W.1.

ALAN STODDARD.

SIR,—Dr. James Cyriax's statement (July 31, p. 251) that primary fibrositis is *imaginary* is rather startling. Does he think the following cases are due to intervertebral lesions and not primary fibrositis?

A male, 72, has physical lesions due to fibrositis in both feet, calves, thighs, at brim of pelvis, around the spines of the vertebrae, in the thoracic walls, and also panniculitis (fibrosis of fat) at lower regions of thorax and around and between the breasts; also physical lesions in the neck and temporal regions, no sepsis found; also no rheumatoid arthritis nor osteoarthritis present. His posture and carriage are excellent. Fibrositis commenced at the age of 16.

A woman, 56, had pain in lower back for 20 years, and recently pain in the left lower abdomen. She had seen two physical medicine specialists, an orthopaedic surgeon, a consulting physician, and received every imaginable treatment. She was found to have fibrosis of fat around the pelvis and hips and a mass of fibrosed fat in left lower abdomen. She received 19 treatments of deep massage and has remained free from pain for 2½ years. No sepsis, osteoarthritis or rheumatoid arthritis, nor the usual physical signs of fibrositis found.

Good-fitting dentures suddenly become painful and are eased, and when this process has been repeated several times the dentures are ruined. In many cases it is due to fibrositis of the upper and lower jaws and can simply be remedied by deep massage a few times.

Does Dr. Cyriax manipulate as a rule with or without a general anaesthetic? Surely it is very difficult to believe that any of these cases can be *due entirely* to intervertebral lesions. It should be mentioned that in the first case the fibrosed mass, already palpable, becomes bigger and more obvious when