Treatment of Genu Valgum

SIR,—Mr. H. A. Brittain's article (Aug. 21, p. 385) interested me greatly. It has been my lot to see hundreds of cases of genu valgum in orthopaedic inspection clinics each year for many years. My conclusions in regard to treatment agree completely with Mr. Brittain's. For some years I used the splint employed in these cases for walking. It might have been of some use if it had ever been properly applied by the child's parents, but this hardly ever happened.

I am not satisfied that the cause of genu valgum is yet understood. Rickets seems to cause only a small percentage, and in these there is always a varus curve in both femur and tibia, so that the genu valgum is masked by the other curves. Under correct diet these curves disappear first, and then the genu valgum becomes manifest. At least that has been my experience. By the time I see the patient, laxity of the internal lateral ligament is not often present. Of course it may have been present previously, but I am not satisfied that it will explain most of the cases of genu valgum. I have found it quite often in children with straight knees, so it does not always cause genu valgum.

There is another ligament which is very often lax in young children, but far oftener in those with genu valgum than in those with straight knees; this is the anterior cruciate ligament. I find that it is possible to hyperextend the knees of many young children, and that in these cases lateral movement is seldom present. I have not seen this phenomenon mentioned in the literature, and it may be confined to this district, but here it is very common. I do not pretend to explain why a loose anterior cruciate ligament should so often occur in genu valgum. Has the laxity of ligaments been general at first, but lateral movement is no longer possible after the internal lateral ligament has stretched to the limit? This would fit in with Mr. Brittain's view of aetiology. In this area genu valgum tends to "run in families."—I am, etc.,

Hull.

J. F. GILL.

The Sphenoid Sinus

SIR,—To hear Dr. A. W. Proetz is always stimulating, but his Cambridge address (July 31, p. 243) leaves the reader confused. His thesis is, "These newer conceptions require changing of the rules of sinus treatment and sinus surgery. . . . Newer methods are based on the better understanding of the cilia and their importance" (my italics).

But what is old and what is new? Dr. Proetz quotes Skillern. In the 1916 edition of Skillern's book¹ the technique of enlarging the ostium is described. A small part of the anterior face of the sinus is removed, working downwards from the ostium. "This will usually suffice to bring about a cure." (Reference might also be made to the teaching of P. Watson-Williams.²) The importance of the cilia and the method by which they roll mucus along in a ball, with bacteria if present, was shown by Yates³ in 1924, and had already been emphasized by Skillern (loc. cit., p. 27), P. Watson-Williams,⁴ and Tilley.⁵ The following instances are taken from St. Clair Thomson's *Diseases of the Nose and Throat* (1926, 3rd edition, p. 57): "The importance of not injuring the ciliated epithelium . . . all nose lotions should be alkaline and isotonic with the blood plasma. . . . Chemicals applied to the mucous surfaces cannot effect sterilization without destroying . . . the important cilia." Now Dr. Proetz announces as a new conception, "Antiseptics are of small value, partly because they impede ciliary activity . . . any solution employed in the nose should be relatively isotonic."

He states also that "the two mortal enemies of ciliary activity are cocaine and epinephrine," and their daily application in strong solution through the ostium is undesirable. Such a procedure is a startlingly new proposal to me. The greatest concentration of adrenaline that I ever allow in the nose is 1/10,000—I prefer 1/20,000. Cocaine is harmless in isotonic solution (4.8%), and since 1924 I have never used a stronger solution. It is the hypertonic solution that impairs ciliary activity; the effect of cocaine as such is quite transient.

Dr. Proetz states, "It is necessary to distinguish between an abscess and a pus-filled sinus, a distinction not usually made in years past." For "pus-filled" substitute "diseased" and you have verbatim (old students will recognize my insistence) my opening gambit on sinus disease for at least 25 years. Dr. Proetz

writes of *drainage* of the sinus; all my teaching life I have made a special point that *ventilation* is the need—to let air in, not to let pus out. The usual complaint is not that discharge cannot escape but rather that it never ceases to escape. With few exceptions the patient whose sinuses contain air will get well without operation. (How often do we see a "fluid level" in the sphenoid?) Only those need operation whose sinuses are completely filled with swollen mucosa, mucus, and/or pus. "Displacement," a variant of Sondermann's "suction," is not applicable in these cases.

Dr. Proetz suggests, when operation is necessary, "a narrow longitudinal (?) opening . . . as close to the septum or the intersinus wall as possible. This narrow opening permits access for observation, ventilation . . ." How many sphenoids can one "observe," except after the surgical crime of conchotomy? How wide is the anterior face of the sphenoid, and how narrow is the opening that permits observation? And how does one know where the intersinus septum lies? Anyone familiar with the surgery of this part will recognize that this "new" procedure is exactly what has been standard here for 30 or 35 years.—I am, etc.,

Bristol, 8.

E. WATSON-WILLIAMS.

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- ³ *Medical Annual*, 1908, p. 379.
- ⁴ *J. Laryng.*, 1924, **39**, 554.
- ⁵ *Rhinology*, 1910, p. 94. Longmans, London.
- ⁶ *Bristol med.-chir. J.*, 1908, **26**, 20.
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Tubercles of the Choroid

SIR,—With reference to the paper by Professor Ronald S. Illingworth and Dr. Trevor Wright (Aug. 21, p. 366), I would like to mention a case which I was able to observe over a period of four months in Bombay during 1947. The patient was an Indian officer, aged 30, with miliary tuberculosis of his lungs. When I first saw him there were several small, fresh, choroidal tubercles in each eye. Shortly after that streptomycin therapy was instituted and the choroidal lesions became older in type, proceeding to small atrophic areas with some pigment around their edges. Unfortunately, supplies of streptomycin were insufficient, so that treatment was several times interrupted, and it was observed that fresh choroidal lesions appeared during the intervals. No further lesions were noted while treatment was being given. In all, about ten patches were found in the right eye and six or seven in the left. When I last saw him he was still undergoing treatment and his general condition had not much improved.—I am, etc.,

Downe, Kent.

R. A. D. CRAWFORD.

Peritoneoscopy

SIR,—In regard to his excellent article (Aug. 14, p. 348) on peritoneoscopy Mr. John Hosford may be interested to know that Professor Kalk, of the Hohngatow Hospital, Spandau, Berlin, has made very liberal use of this diagnostic aid for many years and has demonstrated his method to many allied officers since 1945. From what I can remember I believe he makes his distension of the abdominal cavity with sterile air through the cannula on removal of the trocar and then inserts the peritoneoscope through the same cannula; probably there is a valve to prevent exit of air during the procedure. He also, I believe, has seen, on one occasion, the rupture of a Graafian follicle and was hoping to devise a method of taking photographic records of such.—I am, etc.,

London, S.W.2.

JAMES MELVIN.

Death in Hypoglycaemia

SIR,—I think the following case of irreversible hypoglycaemia may be worth recording. A man who had been a diabetic for a number of years was found one morning sitting on the floor of his bedroom in a dazed condition. He had not given himself his usual injection of 30 units of zinc protamine insulin. His doctor was called and, diagnosing "diabetic coma," gave him 30 units of zinc protamine insulin. The patient came round and, feeling unwell in the afternoon, gave himself a further 15 units Z.P.I. He felt and seemed quite well when he

went to bed, but his wife was awakened by his stertorous breathing in the night and found that she could not rouse the patient. The doctor was again called and, thinking that he had relapsed into coma, gave him a further 40 units Z.P.I. This time he did not come round and was sent into hospital.

On admission the patient was restless, with a peculiar to-and-fro conjugate roving of the eyes, each excursion taking about five seconds. The breath was free from acetone and the urine contained neither sugar nor acetone. The blood sugar estimated about 12 hours after the last injection of insulin was 28 mg.%. Glucose (6%) was given rapidly by intravenous drip, amounting to 2.8 litres, but the patient did not recover consciousness. Necropsy showed that the cause of the initial collapse was coronary occlusion.

It is possible that the diagnostic blunder made here weighed the balances against the patient recovering from his heart attack by so depleting the blood of sugar for a number of hours that irreversible changes were produced in the central nervous system.—I am, etc.,

Edinburgh.

D. STEWART MCLAREN

"Mushroom" Poisoning due to *Amanita Phalloides*

SIR,—The following quotation is from Dr. Paul White's book (1945) on diseases of the heart: "The mushroom *Amanita phalloides* has been reported to have been the probable cause of temporary right bundle branch block (Hyman 1928)." Dr. David Lewes (Aug. 21, p. 383) also refers to Hyman's report in his article on poisoning due to this fungus.

I do not think that Hyman's patients were suffering from poisoning by *Amanita phalloides*. The course of their illness as he described it was as follows: Three hours after ingestion the four people fell ill with violent abdominal pains, nausea, and vomiting, and two of them had diarrhoea. In one there was an agonizing frontal headache, vertigo, and blinding flashes of green light. After eight hours the abdominal signs in this case had completely disappeared, but he then became stuporose and could be roused only with difficulty. Ten hours after taking the fungus the cardiac irregularity was noticed. Hyman says that a specimen of the mushroom gave the typical silver-spoon reaction. After intravenous administration of glucose for thirty hours the patients were fit for transfer and after a few days they were quite well.

The short incubation period, the benign course, the rapid return to normal health (and, I suspect, the "typical silver-spoon reaction"), all speak against *Amanita phalloides* as having been responsible for the symptoms and the heart block. Indeed, there is nothing to suggest that this fungus had been taken. It is a pity that Hyman's statement is beginning to be taken seriously and apparently without any critical appreciation of the clear report he gives of the clinical condition of his patients.

This is the way that myths arise, and I trust that this one will be scotched before it is copied by even more authors. The only mistake made by Hyman was in identifying as *Amanita phalloides* the fungus which made his patients ill. It would be interesting if Dr. J. Ramsbottom would give his opinion on this matter.—I am, etc.,

Bristol.

J. A. R. BICKFORD.

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Gangrene after Scorpion Sting

SIR,—In his report of a case of gangrene after scorpion sting Dr. M. Y. Ansari (Aug. 21, p. 388) infers that it is a very rare condition. Actually it is not uncommon. A scorpion often stings the same victim several times. I have several times seen a young adult with three or four circular marks on the back, due to putting on a shirt with a scorpion concealed in the inner folds of the garment. The circular marks are often 7–8 cm. in diameter: the first a black disk of dead skin and subcutaneous inflammation; the second a much inflamed plaque with a central necrotic area about 5 mm. in diameter; the third a reddened and swollen circular disk of skin, with no necrosis; the fourth may be just an erythematous area with a circular margin a good deal smaller than any of the earlier lesions. Before the second world war we used anti-scorpion serum made by a German firm, but I think such a serum is now manu-

factured in this country. The remedy must be used soon after the patient has been stung. Dr. A. H. Mohammed (*Lancet*, 1942, 2, 364) describes the preparation of anti-scorpion serum. He advises the simultaneous administration of atropine and ergotamine. Young children can be killed by a scorpion sting; for them the anti-scorpion serum is essential.—I am, etc.,

Epping, Essex.

FRANK MARSH.

Repair of Indirect Inguinal Hernia

SIR,—It is refreshing to read a letter like that of Mr. Frank Forty (July 31, p. 268) which gets away from anatomical and physiological theories and faces the fact that in the hands of experienced surgeons the bulk of "recurrences" are not recurrences at all but new and direct herniae at the inner end of the inguinal canal.

Mr. Forty meets this challenge in one way, I in another, but at least we both appreciate two essential points: (1) the importance of exposing the pubic spine and the passage of the crucial first stitch through the dense fibrous structures attached to it, and (2) the importance of relaxing the conjoined tendon so that it is not sutured to the inguinal ligament under tension. If these points are attended to it will be found that the actual percentage of "recurrent" herniae is diminished to a very low figure. Similar results should be recorded by those who claim that a new hypothesis is of fundamental significance.—I am, etc.,

Liverpool.

JOHN T. MORRISON.

Use and Abuse of Tonsillectomy

SIR,—I endorse Mr. T. B. Layton's statement (Aug. 7, p. 310) that the profession as a whole should reconsider its approach to tonsillectomy. But it would be disastrous to leave the decision to the parents. Anybody with experience in school tonsil clinics knows that parents who bring their children very often say, "I want my child's tonsils removed," and are more than displeased when told that tonsillectomy is not advised. The point, however, I should like to emphasize is that far too many tonsils are being removed where all that is required is simple adenoidectomy. This is where a clear differential diagnosis must and can be made. Although complete removal of adenoids without damage to the eustachian tube and the pharyngeal mucosa is a much more difficult and skilful operation to perform, it is of course a smaller surgical intervention from the patient's point of view and less liable to complications. Unless there is definite pus in the tonsils and there is tonsillar adenitis present all the benefit from the operation called "Ts and Ads" is derived from the removal of adenoids. I see on an average 800 to 900 patients a year in my capacity of aurist to the Ealing Borough Council, and over a number of years I have practised adenoidectomy only where the tonsils were not obviously infected; with very rare exceptions I have not been obliged to do a subsequent tonsillectomy. I appeal for careful and complete adenoidectomy without removal of tonsils in every case.—I am, etc.,

London, W.1.

ARTHUR MILLER.

Prevention of Venereal Diseases

SIR,—I have read with great interest the replies to Lord Horder's letter (July 17, p. 171) on the prevention of venereal disease. One fact seems to stand out clearly, and it is this—that the crux of the whole matter is the efficacy of prophylactic measures and the extent of their efficacy. This is clearly admitted in the letter of Dr. E. W. Assinder (July 31, p. 269). If it can be shown that such measures are in a large degree effective there can be no doubt that it is the plain duty of the State and medical profession to disseminate the knowledge of these and provide facilities for their adoption.

I ask myself, and I should like to ask the writers of some of their letters, this question: If prophylaxis could be shown to be 100% effective would they still be against it? I cannot help thinking that the moral side would outweigh the social and humanitarian aspects. I would agree with Dr. G. L. Russell (p. 268) that V.D. is not only a medical and social problem but also a human one, but I do not think it is to any great extent a moral one. It is because it is a human problem that all the teaching of the churches has failed to bring about St. Paul's ideal that a man should be "the husband of one wife blameless"—*Naturam expellas furca, tamen usque recurret*.