Ankylosing Spondylitis

SIR,—I was sorry to see the suggestion put forward by Dr. C. B. Heald (March 26, p. 546) that it is possible to arrest spondylitis deformans by x-ray treatment given early in the course of the disease. I do not believe that this is ever possible, but the patient (if he is already in his thirties when first attacked—an age when the evolution of the condition is usually slow) may have to be kept under observation for several years before the presence of symptoms and extension of the physical signs become manifest.

At St. Thomas's Hospital all patients found by me to show clinical signs of subacute sacro-iliac arthritis are treated at once by radiotherapy. This has meant that some cases have completed the course of x-ray treatment at a time when no radiological signs of any disorder were yet discernible. Nevertheless these patients would almost certainly have been attacked and the typical sclerosis had now appeared on the radiograph of the joint first affected.

It is obviously impossible to start treatment earlier than during the clinical and pre-radiological stage of sacro-iliac invasion. Failure to arrest the disease even in such favourable circumstances shows that x-ray therapy, however effective it may be in relieving pain (at times for several years), is palliative, not curative.—I am, etc.,

JAMES CYRIAX.

SIR,—Dr. C. B. Heald (March 26, p. 546) raises several most interesting points. He lays stress on the value of early x-ray examination of the sacro-iliac joints and suggests that more frequency of these joints would lead frequently to a much-needed earlier diagnosis in this condition. This is very true. But apart from radiological diagnosis it is amazing how long such patients can suffer, openly and obviously, from ankylosing spondylitis and still escape the notice of the clinician whose eye is only open to diseases of more popular systems.

The most obvious cases are missed frequently in busy out-patient departments even though the complaint that took the patient to hospital may have been directly due to spondylitis. The following history is by no means unusual.

A man, now aged 54 years, suffered his first symptoms while in the trenches in 1916 at the age of 22. He experienced great pain in the buttocks, the right more than the left, which greatly interfered with his work. At that time he felt stiff, pain in the left shoulder, and numbness in the left hand. He received little sympathy and no treatment. The condition worsened, he was finally discharged from the Army as a man of poor moral fibre. From that time on relapse and remission alternated, though the latter never lasted longer than three months at a time. Any change of weather upset him; usually the cold suited him better than the heat. His spine gradually became flexed, his chest sunken, and his abdomen protuberant. "Feeling as though bands were pulling tight round the chest" became a major symptom. At no time were peripheral joints affected. He attended hospital several times and was seen in 1947 in a general medical out-patient department of a teaching hospital, where notes read that he was complaining of tight feelings round the chest, that his chest expansion at nipple level was only 1 in. (2.5 cm.), and that he was suffering from bronchitis and emphysema. On Nov. 30, 1948, 32 years after his first symptoms, the correct diagnosis was made in a case so obvious that it could have been diagnosed across the Horse Guards Parade.

Such a history is not unusual. But no clinician who will not notice the obvious will bother to order a skigram of the sacro-iliac joints. Ankylosing spondylitis is a condition that is often just not considered in the differential diagnosis of exertional dyspnoea, transient or persistent backache, alternating sciatic pains, sternal pains and tenderness, or even pyrexia of unknown origin. In our ex-Service patients the average between onset of symptoms and correct diagnosis is 2 years 11 months; in our civilian cases it is nearer three times that figure. Yet few patients give such typical histories or show such obvious physical signs.—I am, etc.,

London, W.1.

F. DUDLEY HART.

SIR.—The enthusiasm of your correspondent, Dr. C. B. Heald (March 26, p. 546), for the early diagnosis and x-ray treatment of ankylosing spondylitis needs tempering. If he consults the literature of the disease, which comprises some hundreds of papers, he will discover that success was usually claimed in the treatment of early cases before x-ray therapy became popular.

He will also find that there is no evidence that deep x-ray therapy arrests the disease, though it does appear to relieve the pain, at least temporarily, in most cases.

That the sacro-iliac joints should be studied for early diagnosis has been advocated for at least twenty years.4 Buckley was the first worker in this country to draw attention to the early changes in the sacro-iliac joints. Dr. Heald refers to "this crippling disease which affects the most normal healthy physicists." These two ideas were popularized in Gilbert Scott's monograph,5 which in my opinion contains many other unsubstantiated statements. Only some 10 to 20% of patients seen in general hospital practice can be described as "cripples," and the disease affects people of most diverse physiques.

If we had a cure for the disease and money to spare, Dr. Heald suggested mass miniature radiography of the sacro-iliac joints of young adults might be worth while. As it is, we cannot afford to deal with the far greater matter of pulmonary tuberculosis. Dr. Heald speaks of the x-ray changes being "so diagnostically significant." Personally, in studying large films of the sacro-iliac joints of patients' relatives who have suggestive symptoms (such as the pre-spondylitic thigh pains described by Davies-Colley in 1885?), using the radiographs of some 40 normal students as controls, I often find it difficult to decide whether the appearances are significant or not.

Finally, Dr. Heald approves of a skin dose of 2,500 r. I doubt whether one is ever justified in irradiating the sacro-iliac joints of a young woman with such a dose unless harmful effects on the ovaries can be avoided with certainty.—I am, etc.,

Bristol.

H. F. WEST.

Obstetrics in Great Britain and Ireland

SIR,—The statement of Dr. Bethel Solomons (March 26, p. 545) "that from an obstetrical point of view we consider that Great Britain and Ireland are one" is so completely at variance with the facts that I cannot let it pass without the strongest protest. As an ex-assistant-master of the National Maternity Hospital, Dublin, I know that the practice of obstetrics in relation to such matters as (1) so-called therapeutic abortion, (2) caesiotomy, and (3) sterilization is the direct contrary to that obtaining in many centres in this country. Convinced as I am from the medical point of view—apart altogether from ethics—that such operations are not necessary in the best interests of patients, I feel that the practice of obstetrics in England would be greatly improved by the adoption of the Irish practice as an addition to those various matters. However, the point is that these fundamental differences in the practice of obstetrics in England and Ireland do exist, and no one knows this fact better than Dr. Solomons; therefore his statement quoted at the outset of this letter is misleading and gives a wrong impression of obstetrics as practised in Ireland.

I am, etc.,

Sheffield.

TOM BOLAND.

Fulminating Meningococcal Septicaemia

SIR,—I was interested in the article by Drs. P. Turner and R. V. Dent on fulminating meningococcal septicaemia (March 26, p. 524), more especially because I recorded findings in a series of 173 cases of meningococcal infection occurring in a recruiting depot in East Africa.
Fibrosis

Sir,—Surely Dr. J. H. Young (March 19, p. 499) is right. No one need doubt that Stockman and Steinberg demonstrated small areas of polymorphonuclear infiltration in incised fibrous tissue; also no one doubts that Copeman and Ackerman, when dissecting the lumbar muscles of subjects selected at random, really found fatty lobules there. The question is not, Are these findings factual? but, Are they relevant?

It is futile to examine the myofascial tissues for evidence of the cause of the disorder unless previous clinical examination has shown that the fault lies in those tissues. Since clinical examination on accepted lines shows that patients with condition similar to “fibrositis” are in fact suffering from articular disorders, examination of the myofascial tissues is pointless. However many little patches of inflammation or fatty lobules may be found, these must not be thought to represent significant deviations from the normal. Still less can they be regarded as in any way causative of the patient’s symptoms. Careful clinical examination must point to the structure at fault, which structure should then be examined for the nature of the lesion.—I am, etc.,

M. C. WOODHOUSE.

Whither Tuberculosis?

Sir,—There have been numerous letters in the Journal on this subject, but so far the question of its prevention and control does not appear to have been stressed. The real aim of the profession must be the control and prevention of this foul disease.

About 1930 it was definitely shown in the U.S.A. that tuberculosis of bovine origin could be prevented by the eradication of tuberculosis in cattle and the pasteurization of milk. At that time some 2,000 persons, mainly infants, were killed each year by that form of tuberculosis in this country. If the profession had then insisted on the eradication of tuberculous cattle we should not have to-day some 1,500 deaths each year from this form of tuberculosis. Since 1930 only 16% of our herds have been certified free from tuberculosis. To prevent human tuberculosis of bovine origin we must insist on the complete eradication of tuberculous cattle so that there will be no living germs of tuberculosis in the milk; and then, if it is considered necessary, pasteurize the milk to make it doubly safe.

For the control and prevention of tuberculosis we must know who has been infected and who has so far escaped infection. This is most necessary, as at 20 years of age 80-85% of our population is said to have been infected. The only way to learn the truth about infection is by the tuberculin test, which is reliable in over 95% of persons tested.

Some really effective chemotherapeutic agent must be found that will kill the tubercle bacillus in the human body, and if used as soon as infection has been discovered, and before it has developed into a case of clinical tuberculosis, we shall be nearer our aim of controlling this disease.

Those persons who are still found to be free from infection urgently need protection, and B.C.G. should be made available for these cases. These two methods would save the spending of hundreds of millions on our sanatoria.

The public should be given the following information about our sanatoria: (1) How many beds were available in 1948. (2) How many patients were treated in those beds during 1948. (3) How many of these patients were discharged in 1948 with the disease “arrested.” Has any record been kept of the fate of these “arrested” cases after their discharge, and, if so, with what result? (4) Were any patients discharged in 1948 with the disease definitely “cured”? If so, how many have been cured? (5) What was the cost of this sanatorium service in 1948?

The publication of the above facts would show the value of this sanatorium service and raise the question. Can we to-day afford it?—I am, etc.,

SYDNEY GORDON TIPPETT.

Tuberculosis in Childbirth

Sir,—I was very interested to read the report of the Medical Women’s Federation on “Pain in Childbirth” (Journal, Feb. 26, p. 333). As a woman doctor with two small children I have had the interesting experience of having had the first in England in 1946 and the second in 1948 in America, where analgesics in childbirth are more extensively used.

Having given a good deal of time and thought to the problem of muscle control and relaxation I approached my first confinement with an open mind. The labour, however, proved to be excessively painful and little relief was obtained from either pethidine or nitrous oxide, though “trilene” inhalations did give a measure of relief.

In comparison, the second confinement was a pleasure. Four hours after labour started I had a dose of barbiturates sufficient to cause me to doze almost painlessly through the second and third stages. The infant was born healthy and strong, and