

extend to 15 countries in the English-speaking Caribbean. Support in the form of finance or accommodation is provided by the World Health Organization (Pan American Health Organization), F.A.O., U.N.I.C.E.F., the Williams Waterman Program, the University of the West Indies, and the Governments of Jamaica and Trinidad and Tobago. The director is Dr. D. B. Jelliffe, a leading authority on the nutritional aspects of paediatrics. The professional staff, international in character, is relatively small, consisting of about nine members with experience in nutrition and related fields. A budget of \$419,500 for five years covers staff, consultants, field investigations, travel, equipment and supplies, and the cost of a "training course in community nutrition" held every second year for appropriate people from the area. The institute follows an interdisciplinary approach in all its activities, including research. An entire number of the *Journal of Tropical Pediatrics*<sup>1</sup> has been devoted to its programme and contributions from its staff.

Protein-calorie malnutrition, reflected in high mortality in infants and young children, was until recently widely prevalent in the Caribbean. Pioneer research on the problem has been done by J. C. Waterlow and his colleagues in Jamaica.<sup>2</sup> In many territories it is now coming under control, with the infant mortality rate down to 40+ per 1,000 live births. The rate on the slave estates probably used to be over 500, and high rates persisted after emancipation. The conquest of protein-calorie malnutrition will be hastened by the institute's programme. A relic of slavery which affects maternal and child welfare is the matriarchal structure of society, with diminished paternal responsibility.

Another major problem for the institute to study is the dependence of the Caribbean on food imports, which is increasing year by year. This, again, derives from the monoculture of sugar in earlier days.

The Caribbean Food and Nutrition Institute has much interesting and important work to do in an area where results are readily visible and easily recorded. Progress is reported in a lively bi-monthly journal called *Cajanus*, after a legume (the pigeon pea) which is a potential source of needed protein.

## Prostatic Syncope

Though rectal examination has sometimes been thought to carry a risk for patients with heart disease, D. L. Earnest and G. F. Fletcher<sup>1</sup> showed it to be safe for those with acute myocardial infarction, and their rectal findings justified the need for the examination. But since their report a number of adverse reactions to prostatic palpation have been described. R. H. Bilbro<sup>3</sup> has recorded eight episodes of either frank syncope or faintness during 2,500 prostatic examinations. In one patient the syncope was accompanied by a brief generalized seizure. The patients turned pale and had a bradycardia of 48 beats per minute or less. As these patients showed a precipitous loss of consciousness if they were not placed supine it must be assumed they were not lying down when

rectal examination was carried out. V. A. Poleshuck<sup>4</sup> describes the collapse of a 30-year-old man after examination of the prostate. After sustaining a head wound while falling, he had a mild seizure and subsequently became apnoeic and pulseless. A blow to the anterior chest produced a carotid pulse with a bradycardia of 46 beats per minute. The patient regained consciousness after three minutes and recovered uneventfully. His father and paternal uncle had suffered syncopal attacks after rectal examination. Again, it seems that this patient was not lying down during the examination.

There is the occasional patient who is so dyspnoeic on lying down that rectal examination is more practical if he stands and leans forwards. For the vast majority, however, maximal information can be attained with the patient placed in the left lateral position with the buttocks at the edge of the bed and the knees well drawn up, though some doctors may prefer to have the patient in the dorsal position. The patient should be instructed to breathe freely through the mouth, as this will relax the abdominal muscles for bimanual palpation and avoid a Valsalva manoeuvre. The finger should be well lubricated and introduced slowly. Both transrectal needle biopsy of the prostate and prostatic massage to obtain prostatic secretions are perfectly feasible in this position. After either of these procedures, or if the rectal examination causes more discomfort than usual, the patient should be allowed to remain horizontal for a few minutes and then get up slowly. In this way syncope will be avoided and rectal examination will continue to enjoy its safe and valuable reputation.

## Protean Symptomatology of Myxoedema

One of the many fascinations of clinical endocrinology is the variety of ways in which its clinical syndromes present. Despite all the achievements of diagnostic science there is still the need for some astute clinician to suspect the disease before the appropriate battery of confirmatory tests can be fired off. In future the choice of them may be eased by computer analysis of symptoms and signs, but at present a high index of diagnostic suspicion is more economical and more exact. These considerations apply with special force to the recognition of disorders of parathyroid and thyroid function and in particular to the early diagnosis of hypothyroidism.

Delays in the diagnosis of thyroid failure most often occur when the onset is gradual and protracted or when one organ or system of the body reacts out of proportion to the others. This illustrates the old principle that each patient is an individual with his own peculiar diathesis and not a predictable machine. Moreover, in this age of increasing specialization patients with undiagnosed hypothyroidism may reach the wrong specialist owing to their having presented with the symptoms appropriate to that particular specialty. They bypass the general physician or endocrinologist, who might have been able to recognize more promptly the underlying disorder.

The E.N.T. surgeon, when faced with a patient with a croaky voice, may diagnose hypothyroidism only after a laryngeal biopsy has disclosed myxoedematous tissue; or the

<sup>1</sup> Earnest, D. L., and Fletcher, G. F., *New England Journal of Medicine*, 1969, **281**, 238.

<sup>2</sup> *British Medical Journal*, 1969, **4**, 319.

<sup>3</sup> Bilbro, R. H., *New England Journal of Medicine*, 1970, **282**, 167.

<sup>4</sup> Poleshuck, V. A., *New England Journal of Medicine*, 1970, **282**, 632.

<sup>1</sup> Golding, D. N., *Annals of the Rheumatic Diseases*, 1970, **29**, 10.

<sup>2</sup> Fessel, W. J., *Annals of the Rheumatic Diseases*, 1968, **27**, 590.

<sup>3</sup> Fincham, R. W., and Cape, C. A., *Archives of Neurology*, 1968, **19**, 464.

patient may have presented to him with unexplained deafness. Or the neurologist confronted with a case of cerebellar ataxia may reach the diagnosis by remembering the delayed return of the ankle jerks to resting phase or the unexplained rise in cerebrospinal-fluid protein, or the patient may have been referred to him with a carpal tunnel syndrome or a peculiar peripheral neuropathy. The chest physician may be asked about an unusual pleural effusion, or the surgeon about unaccountable ascites which, after repeated paracentesis, responds to thyroxine. Even ileus and intestinal obstruction, though usually late symptoms of hypothyroidism, may be the initial cause of referral to hospital, for patients with myxoedema are notoriously uncomplaining. Patients may be sent to the cardiologist because of intractable angina, pericardial effusion, or congestive failure or to the nephrologist because of puffy eyelids and unexplained oedema. The gynaecologist meets them with menorrhagia, the haematologist with anaemia, and the dermatologist with dry skin, falling hair, and, at least on this side of the Atlantic, with erythema ab igne. Many patients in the past have been retrieved from psychiatric wards after eventual recognition of their "myxoedema madness." Finally, when stupor and hypothermic coma have supervened, the diagnosis should be obvious, but unfortunately this is not always so, especially in elderly patients. Far from impugning the diagnostic acumen of specialists in this context we owe much to their carefully collected and reported series of patients for our knowledge of the rarer presentations of hypothyroidism.

Another aspect of the disorder, described by D. N. Golding,<sup>1</sup> is of particular interest to rheumatologists and specialists in physical medicine. Golding has seen nine patients who presented with various musculoskeletal symptoms found to be secondary to thyroid failure. Most of them showed few of the obvious features of myxoedema; yet in seven the biochemical evidence of hypothyroidism was convincing; in two it was equivocal. All of them responded well to treatment with thyroxine. Most of these patients complained of a generalized aching and stiffness of muscles, but in some it was localized to the arms and wrists or to the back. Their muscle pains resembled the sensation which follows unaccustomed physical activity. Paraesthesiae of the hands were common, and in three such patients the carpal tunnel syndrome was confirmed electrically by finding delayed conduction in the median nerve. This complication of myxoedema is now thought to be due to pressure of pseudomucinous tissue on the median nerve at the wrist, though rarely there is also a myxoedematous neuropathy,<sup>2</sup> and true muscle weakness simulating myopathy has been reported.<sup>3</sup>

## Meeting at Harrogate

In the 21 years that have passed since the B.M.A. held its previous Annual Meeting at Harrogate in 1949 the therapeutic revolution has been an astonishing feature of the medical scene. The antibiotic era has opened up, and as well as bringing enormous benefits these remedies are now seen to have contributed to what we today call "pollution" of the environment. A multitude of antihistamines, diuretics, and tranquillizers have come upon us and rung their molecular changes to the bewilderment of clinicians; milliequivalents have become a commonplace, and milliosmoles are now

treading on their heels. Much of this was the natural background to the discussions in the scientific symposia held at the Annual Meeting last week. Reports of the proceedings appear in the middle pages of this issue of the *B.M.J.* and will continue in the next. The many doctors who attended these meetings owe a debt of gratitude to the experts who found the time to come and expound their ideas and techniques.

As well as renal dialysis, the hazards of pesticides, and choosing a diuretic, to name some of the notably contemporary subjects discussed, the meeting opened with two plenary sessions on another characteristic question of our day that has come much into prominence during the past 21 years. That is "communication." The President, Sir John Richardson, gave the opening address on this topic and expressed the concern which many people with a scientific training feel at the contrast between the clarity usually attained in communication on technical matters and the imprecision that too often mars political debate. Subsequent speakers took up some of the relationships between language (and non-linguistic signs) and psychological development, while others discussed if not afresh—which is hardly possible—at least again the communication lines between doctors and their patients, the general public, and the Press.

Sir John thought that communication between doctor and doctor on clinical and scientific matters was reasonably satisfactory, especially in British medical education. Certainly students who have had the privilege of learning clinical medicine from Sir John himself would acknowledge him a master of the educative arts. But there is an aspect of this question that deserves further thought. In many parts of the world where English is a foreign language, both in technically advanced and in developing countries, it is nevertheless the language of medicine—medical training, medical practice, medical research. Students and doctors whose own language is remote in thought and construction from our own, and who may not even have learnt the language from a person born and bred to it in one of the English-speaking countries, must struggle with our textbooks and journals. Authors and editors have a responsibility to bear these readers in mind, for the audience is large and growing.

To the retiring president, Sir James Howie, who is director of the Public Health Laboratory Service, the B.M.A. is immeasurably grateful for the time and thought he devoted to Association affairs during the past year in addition to his many other duties.

The welcome that the Harrogate Division gave was enjoyed by every visitor to the meeting, ranging as it did from many acts of individual kindness and hospitality to a sumptuous reception in which they were joined as host by the Leeds Regional Hospital Board. The town itself and through the person of its Mayor, Alderman Edwin Pickard, was as generous as its aspect is handsome.

To the local organizing committee the meeting was especially indebted for its success. Its chairman, Dr. T. G. Reah, the general secretaries, Drs. E. C. Fear and G. N. Tyler, and the scene secretary, Dr. M. R. Jeffrey, all won the gratitude of their guests for the months of planning they devoted to this enjoyable and instructive occasion. The ladies likewise found that the committee to look after their entertainment had excelled itself, the president of it being Lady Richardson, with Mrs. H. R. W. Hawson as chairman and Dr. Alison Suffern as secretary. They were able to provide for some memorable visits to historic houses in the vicinity.