Letters to the Journal

Letters are welcomed and will be published as space permits. Like other material submitted for publication, they should be typewritten, double-spaced, should be of reasonable length, and will be subject to the usual editing.

Views expressed in Letters to the Journal are those of the writers concerned and are NOT to be interpreted as the opinions of The Canadian Medical Association or of the editors.

THALIDOMIDE AND CONGENITAL MALFORMATIONS

To the Editor:

In response to the editorial entitled "Thalidomide and Congenital Malformations" in the March 10 issue (*Canad. Med. Ass. J.*, 86: 462, 1962)in which it was stated that "to the best of our knowledge there have been no reports of congenital malformations of this type encountered in this country", I would like to report one such case which was admitted to the Toronto Hospital for Sick Children in February 1962. We shall be reporting this case more fully in the next few weeks.

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WHAT MAKES THE PATIENT BETTER?

To the Editor:

I was interested to read your editorial comment (*Canad. Med. Ass. J.*, 86: 379, 1962) on my suggestion that atavistic regression may be the common therapeutic mechanism in such diverse healing procedures as psychotherapy, psychoanalysis, ataractic drugs, Zen practices, yoga meditation or a good vacation. But I fail to follow you when you state, "The therapeutic wonders of spell-breaking should not be ignored, but their explanation does not seem to lie with the concept of atavistic regression."

Surely prestige is one of the main factors in spell-breaking. The prestige of the spell-breaker makes the spell-bound victim regress. This mechanism is easily demonstrated in authoritative hypnosis, when the prestige of the hypnotist makes the subject regress to a biologically more primitive mode of functioning in which logical critical thinking is lost or at least reduced.

Instead of regarding spell-breaking as inconsistent with the atavistic hypothesis, I would regard it as still another example of the way in which atavistic regression is present in all those medical and non-medical procedures which work to make the patient better.

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AGGRESSIVE BEHAVIOUR IN ANIMALS

To the Editor:

The editorial on aggressive behaviour in animals (*Canad. Med. Ass. J.*, 86: 334, 1962) said: "The oryx antelope has rapier-shaped horns, but never uses them in intraspecies fights. One biologist has observed a hornless bull carry out the full ritual of combat as if he still had horns. He struck at his opponents' horns and missed by the precise distance at which his non-existent horns would have made contact. Equally remarkable, his opponents acted as though the assailant's horns were in place and responded to his imaginary blows."

This phenomenon is not confined to the oryx antelope. Frequently, at ward rounds, one might see (in hospitals other than those at which I have appointments) an uninformed Chief-of-Service carry out the full ritual of argument as if he knew what he was talking about. He strikes at his opponents' statements, and misses by the precise distance at which proper information would have made contact. Equally remarkable, his opponents act as though the assailant's facts were in place, and respond to his imaginary blows.

The final paragraph also applies: "The secondary importance of learning suggested by such findings obliges one to recognize the limitations of education as a force for eradication of aggressive impulses, and to look elsewhere for other means more likely to be successful."

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TRICHOMONAL VAGINITIS RESISTANT TO METRANIDAZOLE

To the Editor:

Recently, I saw a patient with trichomonal vaginitis which did not respond to two courses of therapy with metranidazole (Flagyl). Intensive investigation of the husband was negative, but despite this, he was also treated. *In vitro* testing showed this strain of *T. vaginalis* to survive dilutions of metranidazole weaker than 1 in 10,000. As far as I know, this is the first time a resistant strain has been reported. As a rule, dilutions of metranidazole as weak as 1 in 100,000 or even 1 in 500,000 are rapidly lethal for this organism. Both Jones and Watt have reported using a 10-day course of therapy with double the usual dose to effect cure in cases not responding the first time. *In vitro* testing in their cases did not, however, show resistance.

At the present time, it seems that patients with trichomonal vaginitis who are not cured by the ordinary dosage of metranidazole, and whose sexual partners have been proved not to be a source of reinfection, should be treated by doubling the dose. Fortunately, this drug is so effective that this should rarely be necessary.

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