Seasonal Trend in Onset of Lung Cancer

SIR,—The recent observation of seasonal variations in the onset of reticulo-endothelial tumours[1-5] prompted a survey of a series of 479 cases of lung cancer. In all cases the diagnosis was proved by histological examination of tumour tissue. Cases were divided into two groups, those with cough as one of the main symptoms and those in whom other symptoms, chest pain, dyspnoea, or haemoptysis were the presenting features. In the group in which cough was prominent a lower frequency of onset of symptoms was seen in the summer months. Ninety-five of these patients first began to suffer from cough in the first four months of the year, 84 in the last four months, and only 59 in the four months May to August. The group without cough had an onset of symptoms evenly spread throughout the year—64 in the first four months, 66 in the second, and 67 in the third four months; the difference between these groups is significant at the 5% level.

The symptom cough is most often due to the presence of tumour within a bronchus causing partial or complete blocking of the lumen, with subsequent infection of the lung distal to the growth. The frequency of infection in these cases is related to the general frequency of respiratory infection in the population, itself a seasonal phenomenon. The even distribution of the month of onset in the other cases is to be expected. We know little of the mode of origin of lung cancer save that it takes some time to grow sufficiently to produce clinical symptoms, and it is not surprising that in the absence of infection the clinical onset is non-seasonal in character. The precipitation of cough in a patient with lung cancer by superadded infection could provide a means of earlier diagnosis and therefore possibly of earlier treatment with a better prognosis. Unfortunately this does not prove to be the case. In the group presenting with cough, 37% were operable, and in the other group 47% were operable. The reason for failure to find a better operability rate in the coughing patients is twofold. First the cancer which obstructs a sufficiently large bronchus for significant infection to occur will often be more proximal and therefore more liable to early infiltration of the mediastinal structures. Bronchoscopic examination showed a visible lesion in 73% of the patients in whom cough was prominent, but in only 56% of the other patients. Considering only those cases in which bronchoscopy was negative a slight difference in favour of patients with cough was seen. 76% of those with cough and 67.5% without this symptom were operable.

The second reason why tumours in patients presenting with cough are so far advanced might be that there is undue delay in diagnosis because of a less dramatic symptom. In the group of operable cases 20% were diagnosed within a month of the onset of symptoms, while in the inoperable group only 6% were so diagnosed. The lesson is surely that a cough or a change in the character of cough persisting for more than a week in a man in the cancer age should be regarded as seriously as a haemoptysis. What matter if the number of negative investigations be multiplied if some improvement in the present cure rate of under 5% in lung cancer can be achieved?

I am indebted to my colleagues Dr. E. A. Danino, Dr. T. W. Davies, and Mr. C. J. Evans for use of their clinical notes.

—I am, etc.,

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Oral Contraceptives and Coronary Thrombosis

SIR,—Up until recently I have felt quite justified in prescribing oral contraceptives for my patients. However, on Boxing Day a patient of mine, a young woman aged 33, the mother of six children, died suddenly from coronary thrombosis (confirmed at necropsy). She had been taking oral contraceptives for three years and had had no ill effects whatsoever. In fact according to her it was only since taking the pill that she had had any life at all. She was happy and contented, looking after her children well and no longer waiting in fear and trepidation in case her next period did not arrive.

One cannot draw conclusions from a single case, but is there an increased risk of coronary thrombosis in those taking the pill, and if so are we justified in subjecting our patients to this risk?—I am, etc.,

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Oral Contraceptives and Liver Damage

SIR,—After having used the bromsulphalein test (B.S.P.) for several years I feel I must comment on some of Dr. G. Linthorst's conclusions (10 October, p. 920).

It has been shown that some steroids with an alkylated group at C 17 may produce a B.S.P. retention and the occurrence of jaundice.[1 2] To this rule there is at least one exception—methenolonacetate contains no alkylated group at C 17—and Weller[3] has shown that this steroid in spite of that has a B.S.P.-retaining effect. Throughout all these investigations, that by Dr. A. Eisalo and his colleagues (15 August, p. 426) included, the usual laboratory liver tests are mostly negative. In some cases there are, however, elevations in enzyme levels and almost without exception positive B.S.P. tests. Dr. Linthorst gave rather small doses of steroids, and above all he performed all the liver-function tests except the B.S.P. test. In all probability if this test had been performed the results would have been otherwise.

I have mostly examined patients with rheumatoid arthritis and the following parallel exists. Both liver-biopsy studies and laboratory tests have failed to show liver damage in rheumatoid arthritis. In some cases there are, however, slight enzyme elevations and increases in thymol turbidity. Our results with the 20-mg. B.S.P. test, however, demonstrate a striking correlation between the activity of the rheumatoid arthritis and the B.S.P. retention. The capacity of several patients to excrete B.S.P. was equally as low as in those patients suffering from severe liver cirrhosis.[4]

No definite interpretation of the decreased capacity to excrete B.S.P. can be given. The B.S.P. transport through the liver is an active process, which is affected by an oxygen deficit. The means of transport for B.S.P. is not specific, and the passage of the dye can be blocked by competing compounds as, for example, the steroids mentioned above, bilirubin, and bile acids.

A considerable number of facts indicate a connexion between the metabolism of oestrogen and bilirubin—for example, they are mostly conjugated with glucuronic acid and are excreted in a conjugated state in the bile. It is also necessary to remember that several anabolic steroids are partially transformed into oestrogens in the body.—I am, etc.,

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What is a Therapeutic Community?

SIR,—Drs. Mary Lightbody and S. Jacobson (2 January, p. 47) have given a most interesting account of the opening up of communication in the hierarchical organization of a mental hospital. However, their paper once again highlights the unhappy fact that under the catch-phrase "therapeutic community" are now grouped techniques which have nothing in common except a belief that communication is helpful to the recovery of mentally ill people.

The concept of the "therapeutic community" originated from Main[1] and fellow psycho-analysts through their application of the principles of group dynamics to a hospital social milieu. As is well known the concept has been intensively developed and adapted by M. Jones,[2] Martin,[3] and others in this country. However much these approaches have departed from the original model, they are still based on techniques derived from analytical group therapy. Drs. Lightbody and Jacobson have embodied both formal structure and "didactic" pedagogy in their groups. Whatever the merits of their approach, it clearly has little connexion with unstructured, transference-exploited groups.

If the concept of the "therapeutic community" is to retain any meaning at all I would suggest that the term be restricted to techniques derived from analytical group therapy. Certainly it is in this sense that it is practised at Claybury. It is our experience that groups cease to function when staff become anxious, and that non-directed groups are the most effective means of both uncovering and reducing staff anxiety. However, it is here that personality, training, and technique of the psychotherapist(s) are critical factors in achieving therapeutic goals.—I am, etc.,

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