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Pointers

Injury to Nervous System: Dr. W. Ritchie Russell reviews the responses of the peripheral nerves, spinal cord, and brain to trauma. Based on a Ruscoe Clarke memorial lecture (p. 403).

Daily Haemodialysis: Dr. H. Silva and colleagues at the Royal Free Hospital discuss treatment by daily haemodialysis of eight patients with acute "hypercatabolic" renal failure, seven of whom survived (p. 407). Dr. S. Shaldon and colleagues describe their technique for making this procedure more economical and easier to carry out (p. 411).

Breast Abscess: Dr. V. D. Plueckhahn and Joan Banks report a reduction in the incidence of puerperal breast abscess from 2.5% to 0.16% at Geelong and District Hospital, Australia, and discuss causal factors (p. 414).

Immunization in Infancy: Dr. N. R. Butler and colleagues advocate concurrent immunization with polio and triple vaccines. This would halve clinic attendances (p. 418).

Mitral Valvotomy: Mr. K. Fraser and colleagues in Glasgow report the follow-up of 68 patients whose valvotomy was considered technically inadequate (p. 421).

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B.M.A.'s Business: "Is to guide Government and people in matters of health . . . without fear or favour," writes Dr. A. L. Bussey in a critical letter (p. 442).

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B

Circumcision and Cervical Cancer

Many clinicians may well think that by now the epidemiologists and experimentalists should be able to give clear advice about circumcision. But the questions "Does circumcision of men influence the incidence of cervical carcinoma in the women with whom they have sexual intercourse?" and "Is smegma carcinogenic?" still cannot be answered with certainty. The difficulties in establishing the facts are of two main types.[1-5] First, accurate data are hard to get.[6] Sexual experience and habits are by nature private matters. Even if, as has been suggested, memory of sexual experiences is more accurate than of other events,[3] there are many reasons for giving false answers on interrogation. It has been shown, too, that many women are ignorant of the true state of circumcision of their husbands.[7] A further complication is that circumcision is not an all-or-none process. E. L. Wynder and S. D. Licklider[8] defined four grades of circumcision, from complete absence of the foreskin with exposure of the sulcus to the uncircumcised state where the glans penis is completely covered.

The second set of difficulties arises because circumcision is only one of a large number of variables, many of them interrelated, which cannot be considered separately in epidemiological studies of the aetiology of cancer of the cervix. Factors shown to be associated with a high risk of developing cervical cancer include: low socio-economic status, early marriage, multiple marriages, extramarital relations, coitus at an early age, frequent coitus, non-use of contraceptives,[9 10] syphilis, and multiparity.[11] The evidence for the association of cervical cancer with the last three has been questioned.[1-5] Indeed, the only associations which are not really in dispute are a history of early or frequent coitus or both and low socio-economic status. Against this background F. Gagnon,[12] in a 20-year survey, found no cases of cervical cancer among 13,000 nuns exposed to none of the factors listed above; and, as is well known, the disease is rare among Jewish women. The latter differ from other women not only in being Jewish and in being married to fully circumcised men, but also in being supposed to follow the Niddah ritual, which precludes coitus during and for a period of seven days after menstruation. The incidence of cancer of the body of the uterus is not particularly low in either nuns or Jewish women. A. Hochman and others[13] pointed out that the low incidence of cervical cancer in Jewish women is unlikely to be a racial factor, because it occurred in both Ashkenasi and Mizrahi women, who are different ethnically. They also suggested that the Niddah ritual was probably not an important factor, as had been suggested by the late Sir Ernest Kennaway,[14] since the Mizrahi women followed this much less strictly than the Ashkenasi women. A recent survey of cancer of the cervix in relation to circumcision and general hygiene among Moslem and non-Moslem women in the Macedonia region of Yugoslavia pointed in the same general directions.[15-17] Malignant and premalignant lesions of the cervix were found to be more common in non-Moslems than

Moslems, and both inflammatory and malignant or premalignant conditions more frequent in emancipated Moslems than in strict Moslems, who wash after intercourse, shave the genital regions, and follow certain other ritual sexual practices.[17] Unfortunately, it was not possible to ascertain by physical examination the circumcision status of more than a few of the husbands of the women surveyed. Moreover, the majority of lesions regarded as premalignant in the non-Moslem group were not carcinomata *in situ* but simply areas of " unquiet " or " atypical " epithelium. V. R. Khanolkar[18] found the cervix to be the site of origin of cancer more frequently in Moslem than in Parsee women with cancer, though the husbands of the former are circumcised and those of the latter are not. The Parsees, on the other hand, attach much greater importance to cleanliness.

The present position with regard to circumcision may be summarized as follows. First, circumcision together with certain hygienic measures, rather than racial differences, probably accounts for the low incidence of cancer of the cervix in Jewish women and in women of certain other communities. Secondly, different standards of hygiene probably account for socio-economic differences in the incidence of cervical cancer in other communities. Thirdly, circumcision probably improves the hygienic status of the penis in circumstances where a low standard of hygiene would otherwise prevail. Fourthly, there is as yet no evidence that circumcision reduces the relatively low incidence of cervical cancer associated with high hygienic standards. Lastly cleansing of the penis with soap and water, particularly prior to coitus, and regular removal of smegma may be the only important hygienic measures. Douching after coitus and abstinence during the menstrual flow are probably not very important factors.[2 9]

Little is known about the carcinogenicity of smegma. Kennaway[14] thought that even when smegma is present not much of it is likely to come into contact with the cervix. It is difficult to ascertain to what extent the sulcus region of the uncircumcised penis is exposed during sexual intercourse. Benign and malignant tumours in animals have been obtained by repeated application of human and horse smegma in some experiments[19 20] but not in others.[21] The heterogeneous and infected nature of the material makes full assessment and proper control of such experiments difficult or impossible. Possibly chemical analysis of smegma will one day show the presence of a specific carcinogen, perhaps derived from *Mycobacterium smegmatis*. In the meantime it seems more likely that the presence of smegma is simply a sign of poor hygiene, and that this is the factor which increases the risk of both penile and cervical cancer. High standards of hygiene should therefore be advocated, and circumcision in infancy (especially where advice on hygiene may not be followed) should not be discouraged. But there is no case for recommending circumcision rather than hygienic measures to adults as a means of preventing cervical cancer.

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Hospital Medical Staffing

The brief Parliamentary answer[1] to a question on the outcome of the regional reviews of hospital medical staffing recommended by the Platt Working Party three years ago[2] has now been amplified by a statement from the Ministry of Health (see page 438). The Minister has agreed with the profession on how new consultant posts should be allocated to hospital boards, and boards will shortly be notified of their allocation. They will be asked to proceed with reviews for the personal upgrading of senior hospital medical officers who hold special allowances and are in consultant posts ; and it has been agreed that the new intermediate grade of medical assistant should be introduced. The Ministry states that to implement the recommendations of the Platt Report some 5,000 more hospital doctors would be needed over the next five years—an increase of 28%. This, it is admitted, " is not practicable." But the foreseeable supply of new graduates, the continued service of some young doctors for longer periods, and the use of the new medical assistant grade " can go some way " towards supplying the need. The " some way " it seems is not much more than half way.

The results of the review of hospital medical staffing in Scotland published earlier in the year[3] were very similar to those for England and Wales, and in view of this and of what has been disclosed in medico-political discussions in recent months the magnitude of the staffing deficiencies in the hospital service comes as no surprise. But for those who were optimistic enough to hope that out of the Platt Working Party's deliberations would come a long overdue new deal for this crucial branch of the Health Service the disappointment will be none the less great. For example, the number of additional consultant posts to be allocated falls short by some 700 of what the reviews have shown to be required, and apparently this takes no account of the normal vacancies occurring from retirement or death. As the Platt Working Party and others before it have stressed there can be no satisfactory hospital service unless there are enough consultants. It seems that that position will not be reached for many years.

Whether there will be enough senior registrars forthcoming over the next few years to fill the new consultant posts is problematical. At least that distressing ailment of the hospital service in the past, the redundant senior registrar, is unlikely to recur in an intractable form in the future. Nor will there be any regret over the end of the senior hospital medical officer grade. The Joint Consultants Committee has done well in ensuring for it a decent burial. Many S.H.M.O.s now in consultant posts will probably be promoted to con-

1 *Brit. med. J.*, 1964, **2**, 394.
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