

with physicians and their families. It was partly to escape this trying life that Osler went to Oxford, leaving behind a sorrowing medical profession, much disturbed, as he was, by the notoriety exploded by his kindly intended comments on the ageing physician.

So misunderstood even then, his jocose banter, attuned for a private farewell, are the only Oslerian words to find their way into *The Oxford Dictionary of Quotations*.—I am, etc.,

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Schizophrenia in General Hospitals

SIR,—While expressing our appreciation of Dr. Russell Barton's philosophical approach to the problem of schizophrenia (September 9, p. 709), we feel that it should not be allowed to pass unanswered.

There is no doubt that Pinel in the eighteenth century was well advised to put his faith in almost anything rather than the pharmaceutical remedies of his time, of which the best that could be said was that at least they did the patient no harm. This could hardly be said to apply now.

We have also given some thought to the enigma of why the schizophrenic should require psychiatric attention after having lived in the community with his illness, often for long periods. One conclusion, for which we would not claim infallibility, is that it is due primarily to an exacerbation of the illness itself. Social, financial, and other difficulties shortly result, and these can be easily misinterpreted as being cause rather than effect.

The problems involved in the community care of the schizophrenic are very considerable, sometimes insuperable, and if persisted with in the face of such difficulties may lead to the disruption of the community itself. Rather than modify the community to absorb the schizophrenic we believe the better approach is to attempt to control the illness of the schizophrenic so that he fits into a normal community.—We are, etc.,

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Electric Convulsion Therapy

SIR,—Dr. W. E. R. Mons (July 29, p. 307) has drawn attention to the fear of E.C.T. that some of his patients have experienced. This is important because no doctor wants to frighten his patients. Many psychiatrists are unwilling to give this treatment, even though it would do a lot of good to the patient, because fear arising during the treatment may cancel the therapeutic effect and because it tends to induce a negative public attitude towards a treatment of potentially great value—so much so that the editor of a national daily newspaper in Calcutta referred to it recently as a "brutal" form of treatment. There are many causes for dislike and fear of this treatment and many ways of avoiding such reactions, but there are two things I would like to say here.

First, the practice of giving a standard dose of thiopentone is responsible for some patients, possibly including the one mentioned by Dr. Mons, feeling the distressing effects of suxamethonium chloride as too little anaesthetic has been given. On the other hand this standard dose may be too much for some patients, and

lead to complications. The dose of thiopentone should always be suited to the individual patient. It is given slowly, at a steady rate of about 0.1 g. per minute, with the patient counting aloud. With a little experience in watching the reflexes it is not so difficult to assess the most suitable state of unconsciousness, and even if one is inexperienced one can take the help of a frontal E.E.G. recording, which shows copious 16–20 c/s activity as soon as the end-point is reached (if the patient has had several treatments before this fast activity is replaced by high voltage 3–5 c/s slow waves). I have treated about 800 cases using this technique. The average dose is about 0.2 g. with a variation from 0.1 g. to 0.5 g. in Indian subjects. The exact figures are under preparation and will be communicated when available.

Secondly, it is essential to reassure the patient at all stages of the treatment and ensure, by the lay-out of the clinic and the details of procedure, that nothing avoidable is done to frighten the patient.—I am, etc.,

Ranchi, India.

R. B. DAVIS.

Lolly Rash?

SIR,—I have just received my *B.M.J.* for August 19 and would like to mention that I have seen skin rashes here after the ingestion of coloured sweets and lollies. These dermatoses resemble fixed drug eruptions, and it would be interesting to know from Dr. Alun Lloyd-James (p. 525) if the lolly rashes he saw were circinate, pigmented, or bullous.

I have tried to discover what colouring matter is used in these sweets and ice creams, but so far I have failed to do so.—I am, etc.,

Bulawayo, S. Rhodesia.

H. J. KINGSLEY.

Pythagoras and the Beans

SIR,—There is much more than his teaching on beans which is puzzling about Pythagoras. This is not surprising since so little definite is known about his life and work. The surviving biographies by Diogenes Laertius, Porphyrius, and Iamblichos are often self-contradictory, and we have to rely on fragments gleaned from earlier writers to corroborate or supplement their accounts and to support any views which we may hold about his teaching. No writing of his survives—indeed, we are not sure that he wrote anything at all. The secrecy of the Pythagoreans makes it difficult to distinguish how many of the beliefs attributed to him by later writers are really his and how much of his teaching is frankly Orphic or owes much to Orphism. As a native of Samos he would have been steeped in the Ionian scientific tradition, but his forced move to Croton must have brought him into close contact with the Orphic cult there. A further difficulty arises from the splitting of the Pythagoreans into two sects, the *Akousmatikoi*, who were religious and believed in revelation, and the more scientifically minded *Mathe-matikoi*. Aristoxenus numbered some of the latter among his friends, and not unnaturally, as befits a pupil of Aristotle, he wishes to display them and their master in a favourable light. He must therefore be regarded as a biased source of information.

It would be fair, on the whole, to say that the Pythagoreans had adopted and adapted Orphic rites and practices which they rationalized and made acceptable to the more educated section of the community—that is, they made a mystery cult fashionable and "U." Be that as it may, Orphism and Pythagoreanism have many things in common,

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including a belief in the transmigration of souls, and both prohibited the eating of beans: because to do so is equivalent to eating the heads of one's parents. It would take up too much of your space to trace the origin of this belief, as it would involve us in tracing the development of the idea of the *psyche* or soul as well as the Orphic belief in the descent of the soul into the underworld or Hades. We would also have to consider the significance of the lack of nodes in the bean shoot which permits the soul to escape from the underworld and how the soul manages to get into the bean pod.

I think it is a mistake to seek a rational explanation for the taboo such as that put forward by Dr. George Discombe (August 5, p. 385) that Pythagoras was warning his followers against venereal excess. Most, if not all, of the sexual significance of beans came much later. Thus the likeness to the *feel* rather than the shape of human testicles (because the early broad bean was much rounder, even in Theophrastus' time, than it has become since). The suggestion of Aristoxenus that *κόμες* (bean) and *κόμεν* (to be pregnant) are homophones is not quite the whole story, since most authorities would agree that both words come from an earlier Indo-European word *bhouna*, meaning to be swollen or bloated. A well-known effect of eating beans is flatulence, and an obvious consequence of pregnancy is to swell up or be bloated. Incidentally, Pythagoras could hardly continue any of Empedocles' practices (*pace* Dr. Discombe), since he probably died some time before Empedocles was born.

Dr. T. H. D. Arie's attractive theory (September 9, p. 709) that Pythagoras either suffered from favism or knew its cause, supported as it can be by judicious culling from the classical literature, demands medical sophistication from the sage far in advance of his time. It is conceivable that an acute observer, brought up in the Ionian school, might have noticed that attacks followed the breathing-in of pollen from a bean field (this would, I am sure, have provoked interesting speculation on the effect of beans on the *psyche* had he in fact done so), but he would have had to be a remarkably perspicacious observer indeed to distinguish the jaundice which follows the consumption of broad beans in individuals whose red cells are deficient in glucose-6-phosphate dehydrogenase or glutathione from other forms of jaundice.

It is no longer necessary for us to think that everything Greek was rational, for, as Professor Dodds has reminded us in his delightful Sather lectures,¹ they were irrational in many of their ways, and it is to their great credit that they sought a simple explanation for the world around them and thus laid the foundations of scientific knowledge, for beneath all this there was a strong undercurrent of irrationality.

Dr. Discombe and Dr. Arie are merely following Aristoxenus in their quest for a rational explanation of some of Pythagoras's beliefs and practices when they might have learned more by reading Freud and Jung, and they might recognize too that Pythagoras and the latter have a great deal in common.—I am, etc.,

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REFERENCE

- ¹ Dodds, E. R., *The Greeks and the Irrational*, 1951. Sather Lectures, Vol. 25. Cambridge Univ. Press, London.

Abdominal Wound Dehiscence

SIR,—Mr. A. W. G. Weir (August 19, p. 520) reports a low incidence of dehiscence in lower abdominal wounds repaired with catgut, but his conclusion that the suture material used does not influence the frequency of dehiscence is a complete *non sequitur*, since he has no series sutured with other materials to use for comparison. The basic points of wound repair which he

mentions—that is, secure knots, absence of excessive tension, and haemostasis—would not affect the early digestion of catgut which is a common feature of disrupted wounds, even when there is no infection.

It is generally accepted that vertical wounds in the upper abdominal wall are much more liable to dehiscence than those in the lower abdomen, presumably because they are subjected to tension on expansion of the thoracic cage. My own studies have been mainly on upper abdominal wounds, and the conclusions (July 29, p. 308) apply with greater force to those whose work involves the repair of incisions in the upper abdomen.—I am, etc.,

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HERBERT HAXTON.

* * * This correspondence is now closed.—Ed., B.M.J.

Peritoneoscopy

SIR,—Professor Rodolfo Herrera-Llerandi's article (September 9, p. 661) has made me feel it worth mentioning that the Genito-Urinary Manufacturing Co. made for me a modification of an excellent instrument devised by Mr. R. Sampson Handley, Middlesex Hospital, which we propose to describe in the near future. It now consists of two introducing cannulae, both equipped with airlock levers so that the inspection telescopes—oblique and right-angled—can be exchanged. The second cannula enables an insulated shaft forceps to take a bite from the liver edge by diathermy. The current is surface-conducted, preventing destruction of the specimen contained within the bite. The forceps can be clearly seen during manipulation through the telescope. A special fitting for the instrument consists of a pair of beta-ray isotope probes with windows to place against tumours. The idea is to detect malignancy or residual malignancy after radiotherapy by its increased radio-phosphorus uptake.¹⁻³

It would appear that there is a case to support the contention of your writer that a peritoneoscope may be very useful in well-selected cases free from risk. This minor procedure from the patient's point of view may be preferable to laparotomy. On the other hand, a laparotomy (possibly of the peep-hole type) may sometimes be safer and surer, though it cannot be said that this is entirely without risk.—I am, etc.,

London N.7.

A. GREEN.

REFERENCES

- ¹ Green, A., *Proc. roy. Soc. Med.*, 1959, 52, 482.
² — et al., B.E.C.C. Annual Report, 1960, p. 707.
³ Hale, B. T., *Lancet*, 1961, 2, 345.

SIR,—The conclusion proposed by Professor Rodolfo Herrera-Llerandi in his excellent account of this technique (September 9, p. 661) may seem over-enthusiastic to British readers, yet it will be readily accepted over most of Continental Europe, where the technique is extensively practised by both surgeons and physicians, especially since colour photographic records of the field of view have become possible as a routine procedure. From his reference to his difficulties from misting of his telescope, it must be assumed that Professor Herrera-Llerandi has not yet experienced the Universal Endoscope System. In this design a small steady stream of air is continuously directed across the telescope lens, so keeping it mist-free. This same channel can be used for introducing the air or other gas of choice from an anaesthetic machine to maintain the pneumoperitoneum; it is a great convenience. The