larity. Unfortunately they get by.

*Books and journals*

Medical books are of four types—textbooks that we know from student days—books that, if successful run through 10–20 editions—such as Conybeare, Price, Illingworth, Hamilton Bailey and Gray. Reference books such as various encyclopaedias, French's Index and the special regional books on skins and so on. Monographs on more special subjects such as Morris's *Use of Epidemiology* and my own *The Catarrhal Child.* Then there are other books such as general reviews, year books and collected papers. All these have their places on my bookshelves. We must buy these books and I suggest that each practice set aside at least £10 for books and a further £10 for journals each year.

*Journals*

For me the essential journals are the *British Medical Journal, Lancet* and *Medical News*, the 'weeklies'; *Medical World* and *The Practitioner* the 'monthlies'; *The Journal of the College of General Practitioners*, bi-monthly; and *Medical Care*, quarterly. I read all with great enjoyment and profit.

*Buy or borrow?*

We must all build up our personal and practice libraries but we must also use the libraries. I usually borrow a new book from a library before I buy it. I use libraries a lot for references and for reading up background papers for research and other writing, but they have a more limited use for me than my own collection.

*To summarize*

We owe it to ourselves and our profession to become good doctors and we can do so only by reading of medical progress in books and journals. Our reading habits must be formed in our early days in medical practice and unless an active effort is made we will tend to slip and give way. We must decide what we want to read and read regularly and selectively. We should all build up our own libraries and keep them up-to-date and in constant use.

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## A STUDENT PRIZE ESSAY

# A FATAL CASE OF CARCINOMA IN A YOUNG MAN

**Public Welfare Foundation Competition Prize-winning Essay 1964**

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THIS IS THE TRAGIC CASE of Mr George H., who was born in Poland on 23 April 1927 and prematurely died from carcinomatosis on 10 December 1963. He was 36 years old. With his parents and two sisters, Mr H. lived

a healthy life as a child and youth in Poland. During the Second World War he fought with the Polish Army, and at the end of the fighting he came to Britain and went to live in South Wales. There, at the age of 20, he met and married a young Welsh girl of 16. Mr H. worked as a plasterer, but when work became scarce in 1959 he took his family to M., where he obtained regular employment, earning a wage of between £20 and £30 per week. At his death Mr H. left a wife and five children, aged beween 2 and 15 years, living in a poor house in a slum area.

## Medical history

Prior to July 1963 Mr H. had been a very healthy man, complaining only of occasional heartburn from a duodenal ulcer which had been diagnosed by barium meal in 1959.

On 15 July he consulted his general practitioner, complaining of some epigastric pain associated with feeling generally unwell and tired. Antacids were prescribed, but did not relieve his symptoms. By mid-August he was obviously jaundiced, with pale stools and dark urine, and he was also losing weight. At this time a diagnosis of viral hepatitis was made, and liver function tests done.

| | |
|---|---|
| Serum albumin | 3.6 gs. per cent |
| Serum globulin | 3.4 „ |
| Serum bilirubin | 5.8 mg./100 ml. |
| Thymol turbidity | 0.5 units |
| Serum alkaline phosphatase | 84 K.A. units/100 ml. |

At the end of August his pain was severe enough to warrant pethidine 50 mg. p.r.n., and he was sent urgently to the casualty department of the local teaching hospital. Here again it was thought that he had a viral hepatitis, but with the possibility of an ampullary carcinoma of the pancreas it was decided to refer him to a consultant surgeon, who saw him on 5 September and advised urgent admission to hospital for further investigations.

Mr H. refused to come into hospital initially because he did not think it necessary and because he was afraid, never having been under a doctor before. Eventually he was admitted to hospital on 10 October and on 16 October a laparotomy was performed. A liver full of secondary carcinomatous deposits was found, together with an oedematous mass involving the hepatic flexure of the colon, the second part of the duodenum and the head of the pancreas. It was not possible to determine the exact site of the primary tumour. The spleen was enlarged three to four times, and ascites was present. A biopsy was taken from a liver secondary and this showed an anaplastic secondary adenocarcinoma.

Postoperatively he did quite well, and his appetite remained good. However, his jaundice remained unchanged, and he was troubled with bouts of severe epigastric pain, which were successfully treated with Mist. Brompton.

His wife was very distressed and, after expressing her opposition to caring for her dying husband at home, went off to South Wales to her relatives. However, it was decided that it would be wrong to send such a young man to a hospital for incurables, and he was discharged on 30

October. His 15-year-old daughter looked after him until his wife returned after a few days. His physical condition deteriorated slowly at first, and very rapidly in the last three weeks. He lost a tremendous amount of weight from the upper half of the body, whilst his abdomen and lower limbs became grossly oedematous as a result of vena caval obstruction. His morale remained high until the end, and he was surprisingly pain free until the last 36 hours when morphine gr. ½ was required. He became very weak, and finally died on the evening of 10 December just five months from his initial symptoms.

## Social problems

The clinical aspects of this case are as interesting as they are tragic, but the social aspects outweigh all else, particularly as far as the general practitioner is concerned. The social problems will be considered under two headings:

1. Those problems affecting the family.
2. Those problems affecting the community.

### 1. *The family*

Prior to the death of Mr H., the family consisted of seven members:

*Mr H.* was a sensible man, loved by all his children, and nearly all the responsibility for the welfare of the family fell on him. His wife certainly relied on him a great deal. The suggestion by his wife that he got drunk, had a bad temper and ' knocked her about ' was probably much exaggerated.

*Mrs H.* She came from a very poor class Welsh family, described by her husband as a ' gypsy family '. She was of low I.Q. and relied far too much on her husband. She was not fully capable of managing the home properly, and had particular difficulty in managing the house-keeping money. However, she was a reasonably clean woman, if somewhat untidy, and a warm mother to her children. She was terrified of illness, in particular seeing her husband in the agony her mother was in when she was dying from a carcinoma of the stomach. This explains why twice she ran off to South Wales, leaving her sick husband in the capable hands of her 15-year-old daughter. On returning the second time she brought her sister and her sister's four children. This put a great strain on the family finances, and worried Mr H. It was probably the fact that his wife ran off twice, for to him no apparent reason, which gave him a clue to the more serious nature of his illness. Initially Mrs H. had difficulty in coping with the situation, but towards the end she was managing much better.

*The children.* Barbara, aged 15 years, was very sensible and upon her and her aunt fell most of the responsibility of nursing her sick father. Barbara, George (13), Bernadette (9), and Richard (8), were at school, leaving Mark (2), at home. The children were all healthy and well-cared for as far as food, clothes, warmth, cleanliness and schooling were concerned.

*Finances*

*(a) Prior to illness*

Mr H. was earning £20 to £30 per week, which together with their family

allowance was quite adequate for all their needs.

(*b*) *During illness*

When Mr H. stopped work there was marked reduction in the money going into the house. In spite of this Mrs H. insisted that she was able to manage adequately.

Analysis of income per week:

| | |
|---|---|
| National Assistance Board | £3 16 0 |
| National Insurance | 8 4 0 |
| Family Allowance | 1 18 0 |
| | £13 18 0 |

Also a grant was obtained from the National Society for Cancer Relief. This was a block grant of £3 and 30/- per week for two weeks prior to the death of Mr H.

(*c*) *After Mr H's death*

The family could not afford the £40 required for the funeral. This was paid for by the State.

Analysis of income per week (after first 13 weeks)

| | |
|---|---|
| Widow's Pension and dependent child allowance | £9 5 6 |
| Part-time job, wage approx. | 3 10 0 |
| Barbara's wage, approx. | 1 0 0 |
| Family Allowance | 1 10 0 |
| National Assistance (if required) | — |
| Total | £15 5 6 |

(For the first thirteen weeks, without part-time job money, £12 11s. 0d. will be received from Widow's Pension and Family Allowance.)

The children will be eligible for free school meals, and financial help for their clothes through the school welfare department.

Obviously, money is going to be a huge problem to the family, in spite of the help given to them by the State. Mrs H. relied on her husband completely to manage the family finances, and to have to manage on them herself on a much reduced budget will present her with many difficulties. The problem will become more acute as the children grow older and require pocket money, more feeding, more clothing and so on. Also the family will have to sacrifice nearly all those little luxuries, holidays etc., which are so necessary to the well-being of the family, and to each individual member.

*Housing*

The family of seven lived in a dirty, damp, old house, which, Mrs H. said, was to be pulled down within the next year. For this reason she had not put her name on the long council housing list, since she was convinced that alternative accommodation would have to be found when they pulled her house down. The house consisted of two damp, poorly decorated, dismal ground floor rooms, two bedrooms, a small scullery and an outside toilet. There was no bathroom or hot water on tap, or indeed reasonable facilities for washing clothes. The rent for this was £3 5s. 0d. per week. The physical and psychological problems of such poor housing are made more acute by the lack of money.

Apart from the huge problems of finance and housing, many more less tangible but nevertheless important problems face the family:

(*a*) *Affecting the mother*

(i) The problem of a widow of less than average I.Q. who relied so much on her husband, having to cope with the family herself.

(ii) The problem of the mother's physical and mental health when so much more is asked of her.
(iii) The immediate and late problems associated with the loss of a husband, e.g., loneliness, lack of care of herself.
(iv) Problems of the working mother and her family.

It may be noted that Mrs H. did not have any friends in M., and was not on good terms with her own family in South Wales, and thus she has to face her problems completely on her own.

(*b*) *Affecting the children*
(i) The problems of children growing up without a father. They may develop inadequate and incomplete personalities. It has been said that this situation can cause unhappiness in their own future married lives.
(ii) Possible problems of neglect, delinquency, premature school leaving, etc.

2. *Affecting the community*

This family deprived of a father may be considered as vulnerable, as much as other vulnerable groups of society, e.g., the aged, the handicapped etc. They will therefore make more demands on the community services than normal. It is likely that the general practitioner will be required more often, especially for seemingly trifling complaints. The school teacher should spend more time with the children in an effort to compensate in whatever small way for the absent father. Demands may be made for school welfare, financial help, social workers, health visitors, child guidance officers, housing help.

Thus it can be seen that the problems concern the community as well as the family.

## The general practitioner aspect of the case

The role of the general practitioner in this case, can be divided chronologically into three:

1. *From the first presentation to hospital admission.* This was a period of 12 weeks, and posed several problems:

(*a*) Early and accurate diagnosis, with subsequent correct treatment. Short of laparotomy, it was impossible to diagnose carcinoma when Mr H. first presented.

(*b*) When the unremitting jaundice gave cause for anxiety in mid-August, it took two weeks to persuade Mr H. to attend the hospital. He refused to attend because he was afraid, and only severe pain and deep jaundice eventually forced him to go.

(*c*) After being advised to go into hospital as an inpatient, he again refused, and the general practitioner by now suspecting a disease process more sinister, was faced with the problem of coaxing the patient to go into hospital.

2. *During hospital admission.* For this period of three weeks, the general practitioner was kept informed of the findings in hospital. The biggest problem in this period was explaining to Mrs H. that her husband had an illness from which he would die. It took her at least two months to adjust herself to this. The next problem was whether to send Mr H. home or to a hospital for incurables. This problem was aggravated by the attitude of Mrs H. However he was sent home.

3. *From discharge to death.* Initially conditions at home were not

adequate for the nursing of Mr H. However, gradually, Mrs H. was able to cope, with the capable help of her eldest daughter. The problem of coping with pain killing injections was easily solved in this case, since fortunately pain was absent until the last three days. A district nurse then administered morphine injections. Mr H's morale was quite easily maintained until the last few days. Expert nursing care at home was never really needed.

In fact, medically speaking, Mr H. did not present a very big problem, but as has been indicated already, the social problems were many. The general practitioner indicated that his own feelings of helplessness, hopelessness and inadequacy, bothered him as much as anything else.

Of the future the general practitioner did not anticipate any particular medical problems, but bearing in mind the social problems, he would instruct a social worker to keep an eye on the family, and a health visitor to keep an eye on the young children.

## THERAPEUTIC TRIALS

# A TRIAL OF IMIPRAMINE IN THE TREATMENT OF PSORIASIS

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IN 1963 IT WAS REPORTED that imipramine (tofranil) prescribed for depression produced an improvement in the psoriasis from which two patients happened to have been suffering (*Journal of the College of General Practitioners*). A similar case had been reported previously by Bethune and Kidd (1961). In view of these observations it was decided to see if imipramine was of value in the treatment of psoriasis in general practice.

In a preliminary investigation seven out of eight patients claimed that their psoriasis improved while taking imipramine. As these patients were also receiving local treatment for their lesions and in view of the psychological effect obtained when any new treatment is given it was decided to institute a ' double-blind ' trial.

*Method*

Each patient was given a week's supply of tablets (one to be taken three times a day, except a child who was given a twice daily dose only). When the patient returned at the end of a week the response to treatment was