in saying I was sure it would. And that I would make the necessary arrangements.

Albert only needed three ECTs, and then cheerfully went back to work and I lost sight of him. In fact I quite forgot about him until recently when I ran into him in the post office near his home. I did not recognize him but he recognized me, and he came grinning up to me and said, " Master, one wife is quite enough for any one man." He had two lovely children and was happy in his work. Since the creatures behind bars in post offices have ears I did not ask him if he still masturbated. In any case this was now a question of less than academic importance.

I have mentioned five cases. In two of them—that of the sailor whom I manipulated and the typist whose back was explored—I'm prepared to believe that the patient's illness had achieved its mysterious ends, whatever they may have been, so that the patient was ready at that moment to get well. In the other two, the unmarried mother and the masturbator, the disability was symbolic. Each case stemmed from guilt-feeling and fear and promptly resolved when these emotions were ameliorated, in the one case by counselling and in the other by ECT. About my own case I am not qualified to express any opinion. But all five cases have one thing in common: I was extremely lucky to get away with them.

DISCUSSION

Chairman: I cannot be alone among the practitioners present here in wishing that we could see this point of view of prompt surgery when surgery is inevitable put into practice. The difficulty in getting things done until a long interval has intervened sometimes makes the results of operations less good.

With regard to Dr Blair's study of backache in general practice, especially in women, what part did he find was played by skeletal proportions? I am referring to length of shank and the vulnerability to backache of women with long femurs when so much of their work has to be done stooping, especially when they have not learnt to stoop down with their knees bent. And this also applies to schoolgirls, with those wretched physical trainers who think it is ideal for every girl to touch the floor with her fingers or preferably with the palms of her hands.

Dr Blair: There is no doubt that length of leg is very important because

things like ironing boards and sinks and other household furniture are designed for the average person and not for taller people at all. Toe-touching of course is a pernicious exercise.

Dr S. L. Frank (*Preston, Lancs.*): I would like to slightly restore the balance as a general practitioner who has used the methods of Dr Cyriax with great and often dramatic success in my own practice. I have also been myself a patient of Dr Cyriax, and have been so greatly improved in a few seconds, after weeks of agony, that I feel my patients should have the same benefits. I use his methods in any case that I feel would benefit. The treatment is very simple—there is no great skill required, no magic hands. And I do not use it where there are any neurological symptoms. In nine cases out of ten the results are dramatic. It is a great pleasure to a practitioner to have a patient walking out in comfort after coming in in agony, and I feel we should pay more attention to this form of treatment in suitable cases.

Dr J. M. Clow (*Caistor, Lincs.*): We are sailing in this subject on a sea uncharted by the pathologists, and I think this explains a good deal of the trouble in defining this problem. The sair back is an extremely common condition, it is related to a great number of factors, and it seems to me terribly important that we should continue to study its natural history. Recently in the North Midland Faculty of the College we have completed a survey of about 1,000 cases from 13 different practices. This was done in co-operation with Mr Sherrard, the Sheffield orthopaedic surgeon. We tried to show in this survey that a great deal of backache was caused by the person who had not been taking any particularly energetic exercise and suddenly went and dug in his garden, or went in for some other unusual occupation. The results did not show that this factor had any bearing on the subject at all. One of the interesting things which came out of the survey was the great variation in incidence in different practices. I think this depends on the doctor's interest in the condition. Somebody today has talked about the 50 per cent of cases which never come to the doctor. If the doctor was interested more of these people would consult him on this subject. Now the question I would like to put to the speakers is this. Sciatica or disc lesions with neurological signs are clearly defined; lumbago is not, but these two conditions are related. What is the relationship between lumbago and the disc lesion with or without neurological signs?

Mr Paterson: I thought Dr Cyriax's name would come up inevitably in this discussion and you say that you have most dramatic results. This occurs time and time again and I am not disagreeing about that. What I'd like somebody to explain to me is what they imagine happens? And I think we should make it clear that Dr Cyriax himself is very definite that if there are neurological signs he does not carry out manipulation. This is the point I really wanted to get across—that surgery is not the answer to every type of low back pain, and neither is manipulation. There are areas where the indications are quite clear and distinct and I do not think manipulation has any place where the root is involved. If it is not involved I am prepared to have an open mind, but I have not had it satisfactorily explained to me. It seems an extraordinary pathology that

will produce pain for this length of time which will disappear in seconds. I think everyone agrees that the pathology of low back pain has not yet been worked out, and that there are far too many ideas floating around without any sound basis for them. We know why the patient has root pain—the pathology is absolutely clear, and if you operate on these patients it is abundantly clear that there is a prolapse of the disc pressing on the root. What causes this continual attack of low back pain is a very different matter, and I think perhaps we are taking too narrow a view of this. I think there may be many pathologies involved in low back pain and yet we are trying to fit it into one. This deserves a great deal more investigation than it gets, but it is the old problem that surgeons particularly are prone to—that if the condition is not malignant or fatal it gets far less interest than those that people have to go on suffering quietly and can carry on with. This is perhaps a slant of the subject we ought to look at more often.

Dr Alan Wilson (*Innerleithen*): Dr Blair has given us a list of 232 patients, with three carcinomas, two Paget's and one ankylosing spondylitis. I don't think he gave us figures on size of practice or duration of this study.

Dr Blair: The duration of the study was five years. The size of the practice 2,500.

Mr Paterson: I'm very glad that this question of malignant disease has been raised. At the unit at Killearn we admit something like 200–250 discs a year, and something like half a dozen of these turn out to have malignant neoplasm. Now the fact is that a malignant neoplasm can mimic disc disease exactly, even to following a lifting strain, and the history is exactly the same as a disc. But the clue in the history is very often the fact that the patient is in the older age group and has never had any previous back trouble at all. One should be suspicious about a disc lesion that appears for the first time at the age of 50, 55, or 60 in somebody who has never had any suggestion of back pain or sciatica before. Unfortunately there is no easy way of diagnosing this condition early. We recently had a man who was admitted to the unit at the age of 53 and who got his back pain when lifting a heavy steel plate. As far as the history was concerned this was a classical case of disc prolapse. He had lost a little weight before this and did not look generally well, so we admitted him and investigated him very thoroughly indeed, and the only positive finding we found was an ESR of 100, but myelography was negative, bone-marrow studies were negative, straight x-rays were negative, every other thing was negative. We had to wait two months for this patient to have a repeat myelogram to show up his malignant neoplasm. It is now showing both in his spine and in his lung. So in the case of an elderly patient with signs and symptoms for the first time there should always be a vague suspicion of neoplasm at the back of one's mind. And this suspicion should never be removed, because once the diagnosis of a disc is made people tend to go on thinking that this is the diagnosis and the other possibility is ignored.

Dr J. H. Hunt (*London*): One of the best clinical descriptions of a prolapsed lumbar disc I have read was written long ago by a doctor whose golf was being spoiled by lumbago, until he discovered that when he was

halfway round the course if he hung himself up by his arms on a bough of a tree for a few minutes he could then finish his round in comfort. I would like to ask Mr Paterson what experience he has had with simple traction in the treatment of discs. I have myself found it very useful.

Mr Paterson: We at Killearn do not use traction at all in the treatment of lumbar discs, though we do use it for cervical discs. So I cannot speak from a great deal of personal experience, but I have seen cases treated elsewhere by traction, and it does sometimes seem to help. I am again doubtful as to exactly how this works. It seems pathetically hopeful to think you are going to alter the mechanics of a back which is so well supported by extremely powerful muscle by dragging on a leg. I do not see how this can really produce any great change. This again carries us back to our lack of knowledge of the pathology; we do not really know what is going on in these cases. Traction and other mechanical means seem to be accepted rather too easily. One should really stop and think what one is trying to do with these measures and whether in fact one is doing it. It seems to me impossible to make any difference to a back by dragging on a leg without an anaesthetic.

Dr Primrose (*Glasgow*): Would Dr Blair say anything about the usefulness of the so-called skeletal muscle relaxants which are usually combined with simple analgesics?

Dr Blair: I would be very sceptical about them. I think their value depends on the fancy colour of the tablet rather than any efficacy. And of course on the aspirin in the tablet. I do not think there is anything better than aspirin for the purpose.

Dr H. A. Lang (*Newton Stewart*): Twenty years ago when we thought of sore backs we occasionally thought of the possibility of a disc lesion. Now when we think of sore backs we occasionally think of the possibility of something other than a disc lesion. My interest in this subject was aroused about 15 years ago when I saw a report of an insurance company meeting at which a speaker said that before the war people got sciatica and got better in six weeks whereas they now get slipped discs and get better in six months. My own practice has been wherever possible to conceal from the patient that this may be a disc lesion unless I am quite definite that there is neurological involvement. And it is really remarkable how many express obvious relief because they have been worried about the possibility of a disc, which they automatically associate with a long period of disablement.

Dr MacSween: My policy is to tell these patients the truth and let them understand their condition completely. I feel that when a lesion has gone on for a certain time there comes the stage for investigation, so the patient has to be told the truth.

Dr H. N. Levitt (*London*): We have heard some comment on the natural history of the sore back, but no one has said anything about family histories, though we know there are families who suffer from back pain.

Mr Paterson: I have never been convinced about a family history in back cases. Back pain is so common that it would be very difficult to disentangle this from the general incidence, but even in the large number of cases we see at Killearn we have not had any convincing history that would suggest the condition was familial.