

The Unborn Patient

To the Editor:—Dr. Warren J. Warwick's editorial, "The Unborn Patient" (209:1081, 1969), is a thoughtful, sensitive appraisal of one possible impact of the new technology in the care of the fetus. The fundamental question which he raises could be stated as follows: Will accurate diagnosis and effective therapy of fetal disease, earlier in pregnancy than now, make therapeutic abortion for fetal disease in appropriate and unethical?

It has been considered—obstetrically, ethically, "vital statistically"—that an abortion is distinguished from a birth by whether the pregnancy terminates—or is terminated—when the fetus is viable (ie, capable of survival). This is clearly obvious in the regulations which exist in many, if not most states, requiring the certification of a birth only after a prescribed period of gestation. When Dr. Warwick refers to "the time when patient-doctor contract can be made," he refers to the time in pregnancy when the physician attains the ability to discern a fetal disease and effectively treat it. If such technology makes it possible to prevent a congenital malady in this future person, then, indeed, therapeutic abortion, *specifically intended to prevent the birth of a defective child*, would be inappropriate and undesired, by patient and physician alike.

However, if the technology allows only for the diagnosis of the defect without any potential for prevention, or if the pregnancy is undesired for any other legally justifiable reason, and if the time in pregnancy is prior to viability, then the decision to abort remains one to be made by the patient and her physician, based only on her needs and the physician's evaluation of them. This decision should remain unencumbered by any law or by any concept that potential technology renders such action as equivalent to murder. Has society of the past century ever looked upon abortion as murder? If so, why do existing abortion laws exist? Why are abortions allowable for any reason? Why is the crime of

abortion not murder? Why is the penalty not death?

Dr. Warwick does us a great service to point out the need for constant evaluation and reevaluation of medical ethical principles as we are confronted with increasing knowledge. However, in relation to the contemporary dialogue regarding the role of induced abortion in medicine and in society, he does this subject a great disservice to "muddy the waters" by applying the new fetology to all induced abortion, regardless of the reasons for their need.

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Hydroxyurea in Nasopharyngeal Cancer

To the Editor:—Due to the anatomic location, malignant nasopharyngeal tumors are frequently silent for some time and are only recognized when they have extended beyond the limit of surgical correction. Hydroxyurea (Hydrea) has been found particularly useful for chemotherapy of head and neck malignancies in combination with irradiation.^{1,2}

Report of a Case:—In 1967 a 53-year-old Chinese psychiatric patient (schizophrenic) was noted to have a dense leukoma in the right cornea relative to an ulcer which had been cauterized about five years before. A disturbance in extraocular motility was manifested by sixth nerve palsy bilaterally. Approximately seven months later serosanguineous discharge and difficulty in swallowing occurred. Enlarged lymph nodes over the posterior triangle were noted bilaterally.

X-ray films of the sinus and skull revealed marked tumor invasion in the base of the skull and paranasal sinuses, later diagnosed as a poorly differentiated infiltrating squamous cell carcinoma. An extrinsic compression of the middle cerebral artery on the left was revealed by bilateral carotid arteriograms.

HOSPITAL CARE:—A tumor dose of 6,000 roentgens was delivered to the nasopharynx through opposing fields for approximately two months; a slightly higher dose (6,800 R) was applied to the neck nodes. Hydroxyurea, 80 mg per kilogram of body weight, was given every other day for approximately three weeks, until the white blood cell count of 2,400 and the platelet decrease to 100,000 forced the permanent discontinuation of the chemotherapy. Irradiation was also interrupted at that time for approximately ten days. With

the restoration of a normal complete blood cell count, only the irradiation treatment was resumed for another three weeks.

Despite the destruction of the base of the skull, the patient has mild complaints of occasional pains about the upper part of the face at this time. The described therapy appears to be relatively successful up until now.

Comment:—Additional cases are needed to prove the effectiveness of hydroxyurea treatment in nasopharyngeal malignancies which have a poor prognosis even when recognized before the destructive invasion of the base of the skull (CNS extension).³ The precise mechanism of hydroxyurea is not known at this time. Its clinical success depends on the simple fact that it is destructive to the radioresistant cancer cells and affects synchronization of non-deoxyribonucleic acid synthesizing cells, thus permitting subsequent irradiation to be more effective.

Consequently, it might be possible that drug administration divided in doses, given orally or by prolonged intravenous injections, may provide a tissue concentration which would increase the final drug effect even more. The prompt hematopoietic rebound (independently from irradiation) is also known to occur after administration of many other alkylating agents which are reported to be far less effective in this kind of malignancy.

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1. Lerner, H.J., and Beckloff, B.L.: Combined Chemotherapy and Radiotherapy: Preliminary Results of Clinical Trial of Hydroxyurea and X-irradiation in the Treatment of Epidermoid Cancers of the Head and Neck, *Amer Surg* 33: 165-169, 1967.

2. Squibb Hydroxyurea (Hydrea), *Clin Pharmacol Ther* 10:142-146, 1969.

3. Sinclair, W.K.: Hydroxyurea: Differential Lethal Effects on Cultured Mammalian Cells During the Cell Cycle, *Science* 150:1729-1734, 1965.

Marihuana Psychosis

To the Editor:—The communication entitled "Marihuana Psychosis" by Drs. Talbott and Teague (210:299, 1969) is both important and timely in view of the public debate about marihuana. The authors record surprise in finding "the literature so lacking in regard to adverse reactions to smoking marihuana." In fact, the literature, both current and old contains many more references¹⁻⁶ to adverse reactions than Drs. Talbott and Teague note in their bibli-

ography. If the medical community were more aware of the cumulative experience with acute psychotic reactions both in this country and world-wide, there might be a more informed debate about the pros and cons of this drug.

A fact not sufficiently emphasized is that marihuana reactions, like those of most other drugs, are dose-related. Hence, the American experience is less impressive than that in Far Eastern areas because here the potency of the drug is less strong and less constant owing to different growing conditions and to adulteration by local distributors.

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2. Keeler MH: Marihuana-induced hallucinations. *Dis Nerv Syst* 29:314, 1968.
3. Grossman W: Adverse reactions associated with *Cannabis* products in India. *Ann Intern Med* 70:529, 1969.
4. Perna D: Psychotogenic effect of marihuana. *JAMA* 209:1085, 1969.
5. Bloch HS: Army clinical psychiatry in the combat zone. *Amer J Psychiat* 126:289-298, 1969.
6. Milman DH: The role of marihuana in patterns of drug abuse by adolescents. *J Pediatr* 74:283, 1969.

Idiopathic Hemochromatosis

To the Editor:—Your editorial, "Hereditary and Environment in Idiopathic Hemochromatosis" (210:898, 1969), is correct in citing evidence that hemochromatosis occurs in the absence of dietary sources of excess iron, and in questioning the attribution of too many "idiopathic" cases to excess dietary iron.¹ The environmental hypothesis was more fully stated elsewhere as "... a variant of portal (alcohol, nutritional) cirrhosis or, more important, accompanying the factors that cause certain kinds of cirrhosis; occasionally it is the result of two coexisting conditions, one causing cirrhosis and the other excess tissue iron" (*Arch Intern Med* 112:184, 1963). It has been found that iron absorption is increased in cirrhosis (*Gastroenterology* 43:385, 1962) and in chronic pancreatic disease (*Lancet* 2:6, 1962), both of which are present in hemochromatosis.

An important aspect of the publication cited in the editorial that requires critical examination is equating an abnormal laboratory test, such as elevated serum iron, or slight stainable iron in a liver biopsy, with the morphologic disease of

hemochromatosis. Such a laboratory finding is not synonymous with the disease, and when it is used as if it were, the family clusters and pedigrees that are collected may not be specific for the disease in question.

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1. MacDonald RA: *Hemochromatosis and Hemosiderosis*. Springfield, Ill, Charles C Thomas Publisher, 1964.

Sulfonamides and Aspergillus

To the Editor:—In THE JOURNAL (209:1191, 1969) a case of pulmonary aspergillosis is reported. A number of articles on systemic aspergillosis cite the various types of therapy during the past few years. None has mentioned the use of sulfonamide drugs.

The studies and observations, made in the bacteriology laboratory of the New England Baptist Hospital, on a strain of *Aspergillus* isolated from a case of pulmonary aspergillosis noted that the organism was very sensitive to sulfonamides. A number of strains of *Aspergillus* were obtained and most of them were found to be sensitive to sulfonamides. We had hoped to test the clinical success of this therapy but have not had any cases of aspergillosis for treatment.

We should like to report this experience in the hope that this type of therapy might be found useful. We realize that sensitivities on an agar plate might not reflect in vivo sensitivities. However, it does seem worth evaluation.

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Influenza Vaccination

To the Editor:—One reason that some patients fail to take "flu shots" is that they object to the rather severe pain that follows at the site of the injection in the arm or buttock. This fall I started giving the injections on the lateral aspect of the thigh. With a 1-inch, 22-gauge syringe, I insert the needle vertically through the skin, fat, and fascia lata, and deposit the vaccine deep to the fascia lata. This procedure is almost painless at the time, and the patient suffers very little pain thereafter.

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Reports of Propoxyphene Dependence

To the Editor:—In a case report by Salguero et al (210:135, 1969) of propoxyphene dependence, the following statement is made: "Almost no data that propoxyphene hydrochloride can produce drug dependence in man are available."

It is true that case reports are scanty. I should like to add one reference to those supplied by the authors.

Wolfe et al reported a case of propoxyphene addiction and withdrawal syndrome (*Ann Intern Med* 70:773, 1969) with an estimated daily intake of 2,300 mg. The patient was maintained in the hospital on a regimen of 1,300 mg daily. Abrupt discontinuance produced psychic and physical withdrawal syndrome.

It would appear that propoxyphene dependence is more frequent than published reports would indicate.

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Pneumothorax Following Induction of Anesthesia

To the Editor:—I was most interested to read the article by Christian et al on "Pneumothorax Following Induction of Anesthesia" (209:1710, 1969).

The patient they described was already known to be unwell prior to anesthesia. It should, however, be noted that this complication may follow the induction of anesthesia in previously healthy patients.

Together with my colleague, Dr. Cleave, I have described (*Brit Med J* 2:1386, 1963) the case of a healthy 48-year-old woman who sustained a cardiac arrest during the induction of anesthesia for a gastric operation. When performing a thoracotomy for open cardiac massage, a pneumothorax was found that was due to rupture of an emphysematous bulla. After the circulation had been re-established, a pneumothorax was found on the other side of the chest, and both sides of the chest required drainage.

The patient made a complete recovery and was able to have her operation one year later.

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