

The cutting edge of medicine 50 years ago

An interesting exercise in looking back into the past is to read the reports of the large national and international conferences of former times. This article goes back half a century, to the annual British Medical Association meeting, which was held in Belfast in July of 1962. To many readers of the *British Journal of Hospital Medicine* this may seem an age ago; in fact, it was the year that I was appointed Professor of Surgery at the old Westminster Medical School. I recall the speakers and the 'cutting edge topics' that they discussed with considerable nostalgia.

There was a particularly lively session, chaired by Sir George Pickering, Regius Professor of Medicine at Oxford, on coronary occlusion. Much of the time was spent discussing the use of long-term anticoagulants in this condition. Professor

RB Hunter, of Dundee, noted that reported death rates from this condition in the days before anticoagulation therapy varied from 19% to 78%, presumably as a result of population differences and type of disease. Used in the early phase of the disease, the beneficial effect of anticoagulant treatment (in those days, heparin and dicoumarin were available) would in large part be the result of the prevention of thromboembolic complications. (Let me add a note here that standard treatment of a 'coronary' in those days was up to 6 weeks strict bed rest – elastic stockings, thrombolysis and the rest were for the future.)

Professor Hunter quoted the Medical Research Council trial published in 1959; under the case selection and conditions of the trial, there appeared to be 'some benefit' from anticoagulants in the under 55-year-old age group. He noted that extensive trials were in progress, both in the UK and USA, but results were not yet available. He concluded that:

'anticoagulation therapy should only be embarked upon in special centres

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as part of a controlled trial. Only in this way could the real benefit, if any, be determined and a balance between benefit and risk be made'.

Dr Tage Hilden, from Copenhagen, reported on a 4-year trial in two hospitals, using two wards in each. All patients with coronary thrombosis admitted to one of the wards in each institution were anticoagulated, the other ward's patients acted as controls. After 2 years, the wards swapped over. The anticoagulated group comprised 371 patients, the controls numbered 429. No difference in mortality or clinical thromboembolic complications was

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found. However, those patients dying and subjected to autopsy had a lower incidence of thromboembolic complications in the treated group.

Professor (later Sir) John McMichael, of the Postgraduate Medical School, quoting these and other figures, considered anticoagulant therapy in coronary disease to be dangerous, ineffective, a burden to the doctor, to the patient and to the laboratory and should be stopped. The panel was asked what each member would choose if they had an acute myocardial occlusion. The two Scandinavian speakers would not wish to receive anticoagulants. Professor McMichael's reply was – if small, he would stay in bed for a few days and not tell anybody. If medium, he would stay in bed and call his GP. If collapsed and shocked, he would agree to go to hospital and be anticoagulated to limit thromboembolic complications, but he would prefer not to have this unless he were to be likely to be bedridden for many weeks.

An interesting symposium on the management of advanced cancer concentrated principally on tumours of the breast and prostate. The background to this discussion was that advanced prostatic cancers had been shown to regress following cas-

tration or administration of stilboestrol in the 1940s. The availability of cortisone replacement therapy enabled Charles Huggins, in the USA, to carry out bilateral adrenalectomy in women with advanced breast cancer and to report, in 1952, temporary regression of the disease. More recently, hypophysectomy had been used in both these diseases.

Hedley Atkins, of Guy's Hospital, summed up the current practice by advising stilboestrol to be prescribed for patients with prostatic cancer when symptoms called for treatment. Bilateral orchidectomy should be carried out in relapsed cases.

For younger women with advanced breast disease, ablation of the adrenals or the pituitary was advised. In older patients, oestrogens were prescribed and regressions of up to 5 years might be observed.

Adrenalectomy or hypophysectomy were used in relapsed cases. Either must be performed by an expert surgeon.

J Angell James discussed trans-sphenoidal pituitary ablation and pointed out the urgent need for a reliable method of estimating the likelihood of response in order to avoid subjecting patients to a major operation which might have no benefit in a third or more of the cases. (Indeed, this problem remains with us today in the whole field of therapy in advanced cancer management.)

Fifty years ago cytotoxic therapy was at its early stage of development. Professor of Surgery Harold Rogers, of Belfast, summarized the two groups available: those that prevent DNA division, comprising nitrogen mustard, and the ethylenimines, and metabolic antagonists, such as pyrimidine. A small and not very effective armamentarium.

Finally, in the poster exhibit section, must be mentioned a poster from Guy's Hospital of waiting times in its Medical Outpatient clinics. The average was 72 minutes, of which 57 minutes were spent with the consultant in taking a history. How times have changed. **BJHM**

Conflict of interest: none.