

Topics in medicine 50 years ago

Fifty years ago was an exciting time to be practicing medicine. Advances in many fields were promising real progress in the diagnosis and rational treatment of many common and important problems. Moreover, the NHS seemed to be doing an excellent job in running the hospitals and general practice, and morale was high. I was then a young professor of surgery, having set up the Academic Surgical Unit at the old Westminster Medical School (now sadly no more) just a few years earlier, and both myself and my team felt we were working at the best possible time to be practicing hospital medicine.

A useful way of determining the topics of particular interest in medicine at a certain time is to look through the leading articles in the *Lancet* of that year. So what were some of the headlines of 50 years ago, in 1966? Pulmonary embolism was an ever-present, all too common and all too fatal complication in both the medical and surgical wards. I remember only too well losing young and previously fit patients to this complication a week or so after surgery.

A *Lancet* leader in 1966 begins: 'the resurgence in interest in acute pulmonary embolism continues unabated, and rightly so; for it is an extremely important cause of pulmonary disease and death in hospital patients. Yet there remains large areas of ignorance and uncertainty and the need is plain for long and controlled prospective studies of the natural history of the disease and various forms of treatment and prophylaxis.'

It goes on to state that evidence is strong that prophylactic anticoagulants for patients with femoral neck fractures are effective, although most of the early work did not have a control arm. It points out that evidence for measures such as limb elevation and exercises is

less good. The leader goes on: 'anticoagulation therapy should be based on a well defined and strict protocol and not on the whim of individual consultants and house officers.'

The leader also discusses the use of vena cava ligation in patients who have suffered a pulmonary embolism, states that this requires controlled studies and notes the recent use of a serrated Teflon clip for partial occlusion of the vena cava in thromboembolic disease.

All this preceded the exciting studies over the next few years of the natural history of deep vein thrombosis by giving the patients radio-labelled fibrinogen and serially monitoring the legs with a Geiger counter to pick up clinically silent calf thrombi. This rapidly led to effective clinical trials on the efficacy of low-dose heparin, graduated elastic stockings, calf muscle pumps and so on in the effective prophylaxis of deep venous thrombosis.

An interesting leading article was entitled 'Health hazards of asbestos'. This pointed out that reports were appearing from many countries which described mesothelial tumours of pleura or peritoneum in subjects who had been exposed to this material. Usually the exposure was occupational but some examples were environmental. The latent period between exposure and disease was long, up to 40 years or more. The exposure could sometimes be short and insufficient to produce preceding asbestosis. The leader points out that the condition is still rare, with around 500 reported cases from all parts of the world. The article ends rather remarkably with the following statement:

'Asbestos is a valuable material for many purposes, for example, brake and clutch linings, for which, at present, there is no substitute. Many of its uses increase safety, especially by reducing fire risk. If we are to obtain from this remarkable material the best benefits with the least risk, awareness of the dust hazard and rigorous steps to eliminate all heavy or unnecessary exposure are essential.'

No doubt the author of this leader would later regret this optimistic advice and agree with the modern attempts to prevent the slightest exposure of the population to the slightest traces of asbestos.

The *Lancet* leader writer of 1966 had a rather poor opinion of the place of coronary angiography in clinical practice. It was noted that coronary arteriograms were obtained in the 1940s via a catheter threaded into the thoracic aorta but this procedure was hazardous and not particularly accurate. By 1958 selective angiography was being used, via cannulation of the coronary ostia. However, the writer states 'as an aid to diagnosis in ischaemic heart disease, it seems at present to offer little that cannot be more easily obtained by much simpler means such as good history taking and electrocardiography'. Moreover, the leader goes on to state that: 'very few patients with ischaemic heart disease have a pattern of coronary atheroma sufficient to permit endarterectomy or grafting'. The author points out that at the Cleveland Clinic, of 1500 patients studied by coronary angiography between 1959 and 1963, fewer than 1% had segmental coronary arterial disease that was judged amenable to direct operation and only four patients were, indeed, submitted to surgery in this, the largest series studied to date. The author concludes 'many feel that the ultimate treatment of ischaemic heart disease is so obviously non-surgical that elaborate methods for injecting the coronary arteries are unlikely to be clinically rewarding'. Fortunately the leader writer was anonymous – he/she would be amazed at today's brilliant urgent coronary angiography service, with stenting of occluded coronary arteries being achieved within hours of the ischaemic episode.

Today's readers of *BJHM* may conjecture what their children and grandchildren are going to think about the leading articles in the *Lancet* of 2016 when they glance through them in 2066! **BJHM**

Conflict of interest: none.

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