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EDITORIAL

CARDIOSPASM

Many theories have been put forward to explain the pathogenesis and aetiology of cardiospasm, but it still remains an unexplained disease. Other names have been given to the condition to emphasize different points of view on pathogenesis; hence such terms as achalasia, idiopathic dilatation, mega-oesophagus are to be found in the literature. Cardiospasm remains as the most widely used name for the clinical syndrome in which dilatation or obstruction occurs in the oesophagus. The term is not new; it was suggested by von Mikulicz in 1882. Arthur Hurst proposed the name achalasia—absence of relaxation—in 1913; he considered there was a disturbance of Auerbach's plexus in the condition and no true spasm. Holt has recently reviewed the problem in some detail and neatly presents the landmarks in the history of cardiospasm.[1]

The assumption that there is a disturbance of Auerbach's plexus in the wall of the oesophagus has caused many authors to compare the condition with congenital megacolon. There is a difference, however, in that in the latter condition the deficiency in the myenteric plexus is a local one, whereas in cardiospasm deficiencies occur throughout the length of the oesophagus—or perhaps not at all; or the changes observed may be secondary to inflammatory changes in the oesophagus. The term 'idiopathic dilatation of the oesophagus' may still be best as indicating our present unsatisfactory understanding of the condition.

The disease is believed to occur more frequently in females. The symptoms cause patients to seek advice in the 3rd or 4th decade, or sometimes at a much earlier age. The commencing symptoms are dysphagia and regurgitation, and pain which may simulate angina pectoris is in some cases an initial symptom. The site of the pain may vary, but substernal burning of persistent character is a usual complaint once severe inflammation develops. Exacerbations of spasm may apparently be produced by psychogenic factors, e.g. embarrassment during meals or from the patient's awareness of foulness of breath due to decomposing food in the oesophagus. While some patients remain well nourished, weight is usually lost from the regurgitation of food and varying degrees of hypoproteinaemia, hypovitaminosis and anaemia occur.

The narrowed distal part of the oesophagus is of varying length; it is just above the cardiac orifice and

VAN DIE REDAKSIE

MAAGMONDKRAMP

Baie teorieë is al geopper om die ontstaan en die oorsaak van maagmondkramp te verklaar maar sonder sukses. Om die verskillende standpunte i.v.m. hierdie siekte-ontstaan te beklemtoon is ander name aan die kondisie gegee. In die literatuur vind ons dus name soos achalasia, idiopatiese verwyding en mega-esofagus. Maagmondkramp is die benaming wat egter die meeste byval vind vir die beskrywing van die kliniese sindroom wanneer verwyding of verstopping in die esofagus voorkom. Mikulicz het dit in 1882 gebruik. In 1913 het Arthur Hurst die naam achalasia (gebrek aan ontspanning) voorgestel; hy was die mening toegedaan dat daar in hierdie kondisie 'n steuring in die Auerbach-pleksus voorkom en nie 'n ware kramp nie. Holt[1] het onlangs 'n volledige oorsig van die probleem gegee en die mylpale in die geskiedenis duidelik aangewys.

Die veronderstelling dat die Auerbach-pleksus in die esofaguswand versteur is, het daartoe gelei dat baie skrywers die toestand met aangebore megacolon vergelyk. Daar is egter 'n verskil. By aangebore megacolon is dit 'n plaaslike gebrek in die miënteriale vleg terwyl by maagmondkramp die gebreke langs die hele esofagus voorkom of miskien glad nie voorkom nie; of die veranderings wat waargeneem is kan ondergeskik wees aan veranderings wat aan inflammasie in die esofagus te wyte is. Die bewoording ,idiopatiese verwyding van die esofagus' is miskien die beste beskrywing van ons huidige ontoereikende kennis van hierdie siekte.

Sover bekend kom die siekte meer dikwels onder vrouens voor. Die simptome dwing pasiënte om in hul dertiger en veertiger jare advies te soek, somtyds nog baie vroeër. Slukmoeilikhede en terugvloeiing is vroeë simptome en somtyds is 'n pyn, wat dié van angina pectoris naboots, die eerste simptoom. Die pyn mag op afwisselende plekke voorkom maar as ernstige inflammasie eers aanwesig is word daar gewoonlik oor 'n aanhoudend brandende gevoel onder die borsbeen gekla. Oënskynlik kan psigogeenfaktore die kramp vererger, soos bv. verleentheid tydens maaltye of omdat die pasiënt bewus is dat sy asem sleg ruik as gevolg van kos wat in die esofagus ontbind. Sommige pasiënte bly goed gevoed maar die meeste pasiënte verloor gewig as gevolg van die terugvloeiing van kos. Hipoproteïenemie, hipovitaminosis en anemie kom in groter of minder mate voor.

may be near the diaphragmatic hiatus. The constricted portion is not of more than normal thickness but the part of the oesophagus proximal to it is dilated, hypertrophied and lengthened. A fusiform, flask-shaped or sigmoid distortion of the oesophagus may result in cases of long standing, with inflammation of varying degree as a further complication.

Diagnosis is established by radiography, but valuable information may be obtained from oesophagoscopy if this can be performed. While the majority of patients with cardiospasm derive benefit from non-surgical methods of treatment, such as a non-irritant diet, antispasmodic agents, antacids and psychotherapy, these are not curative. Dilatation or surgical measures become necessary to relieve obstruction and possibly restore normal function at the oesophagogastric junction. The relief of obstruction has not proved a great problem, but for proper correction of the disorder many operations have been designed. Reflux oesophagitis has frequently occurred after operative procedures for relief of the obstruction and is a most disabling condition, as uncomfortable as the original cardiospasm. Holt[1] has introduced an operation which is designed not only to relieve the obstruction but also to avoid this subsequent reflux.

1. Holt, C. J. (1954): Amer. J. Med. Sci., **228**, 218.

Die lengte van die vernoude distaal deel van die esofagus wissel; dit is net bo die maagmond geleë moontlik in die nabyheid van die diafragmatiese spleet. Die vernoude deel is gewoonlik van normale dikte maar dié deel van die esofagus proksimaal daaraan is verrek, verleng en oorvergroot. Gevalle van lang duur mag 'n verwronge spoelvormige, flesvormige of S-vormige esofagus ontwikkel en inflammasie mag as 'n verdere komplikasie voorkom.

Diagnose word deur radiografie bepaal maar as dit moontlik is kan waardevolle inligting met behulp van 'n slukdermkyker verkry word. Nie-chururgiese behandeling soos antikrampmiddels, nie-irriterende dieet, teensure en psigoterapie kan vir die meerderheid pasiënte verligting bring maar sulke behandeling genees nie. Chirurgiese optrede sal nodig wees om die verstopping te verwyder en moontlik normale werking by die slukdermmaagaansluiting te herstel. Dit is nie 'n moeilike probleem om die verstopping te verwyder nie maar baie operasies is al beplan om die ongesteldheid behoorlik te genees. Ná operasie vir die verstopping kom reflux oesophagitis dikwels voor en dié toestand is net so ernstig as die oorspronklike maagmondkramp. Holt[1] het 'n operasie beplan, om die verstopping te verwyder, wat hierdie reflux uitskakel.

1. Holt, C. J. (1954): Amer. J. Med. Sci., **228**, 218.

THE SPECIALIST QUESTION

Since the last meetings of the Medical and Dental Council and of the Federal Council of the Medical Association which took place in September and October last, no further decisions have been taken on the subject of specialist practice.

The Medical Council met in September a few days after the announcement of the results of the questionnaire which had been submitted to the medical profession of South Africa (published in the *Journal* of 18 September 1954: **28**, 815). This was also the first meeting of the Medical Council since the passing of the 1954 Act which amended the Medical, Dental and Pharmacy Act so as to legalize specialist registration. The Medical Council took no final decision on this subject, but in the meantime they decided (1) to continue the registration of specialists as in the past, and (2) to appoint a committee of the Council to investigate the subject and report to the Council. They also decided to invite the Association's Federal Council to express to this committee their views on (*a*) the interpretation of the referendum and (*b*) what steps should be taken.

The Federal Council met in October. No decision was come to on these points, but it was resolved to ask the scrutineers to analyse the voting papers again according to whether the voters were registered specialists or not, and according to whether they were in town or country practice.

This the scrutineers have done and we publish their report in this issue (page 263). The results will be before the Federal Council when it meets in Cape Town in a few days' time. Federal Council will then give further consideration to the Medical Council's request for its views. The date of the meeting was fixed so that it should precede the meeting of the Medical and Dental Council which is to take place, also in Cape Town, on 21 March and following days, when any decisions which may have been taken by Federal Council will be known to the Medical Council.

Comparing the way the general practitioners and the specialists respectively voted, it will be seen that they voted in conspicuously opposite senses in answering the question whether the voter was in favour of a register of specialists only, a register of consultants only, or a register of specialists plus a register of consultants. The results expressed as percentages were as follows:

	In favour of		
	Specialist Register only	*Consultant Register only*	*Two Registers*
Urban GPs	13	73	13
Country GPs	15	66	19
Specialists	64	14	22
Others*	26	48	26
All voters	26	55	18

* Full-time medical officers, interns and practitioners overseas.

Thus the general practitioners voted more emphatically against the continuance of a register of specialists than did the voters as a whole, who comprised not only the general practitioners, but also the specialists and 'others' (interns, full-time medical officers, etc.). The difference

between the voting of the urban GPs and the rural GPs on this point was only slight. (It will be observed that this analysis does not include the 292 voters who were in favour of a reversion to the system which existed before the introduction of the specialist register in 1938).

On the question of a statutory *versus* a voluntary register the specialists were overwhelmingly in favour of the statutory register, but the votes of the general practitioners, both urban and rural, were in favour of the statutory register by a narrower majority.

The voting against domiciliary visiting by specialists was also overwhelming, and the word can be fairly applied both to the GPs (20 : 1) and the specialists (7 : 1).

On all the questions at issue the difference between the voting of urban GPs and that of the rural GPs was not great enough to carry any significance.