As a sufferer for seven years I invariably obtained instant relief by neutralizing the hyperacidity; a strong saline draught would not stop the peristalsis of the stomach—if anything, it would rather stimulate it—and yet the pain disappeared without fail. Again, if the stomach be washed out during the crises of pain and freed from the acid-sour residue, pain will at once subside and be replaced by a feeling of comfort, and if the patient now takes a meal the pain will not return until two or three hours afterwards, when digestion is finished and the acid residue is again passing over the ulcer.

A symptom which I have observed in others and have experienced, but which I have never seen mentioned, is that at the time the pain and pyloric cramp is at its height there is often a copious flow of saliva; it will run from the mouth in a stream, if the patient swallows the saliva he will experience instant relief. This always struck me as being Nature's relief.

After operation the pain disappears long before the ulcers could possibly have healed; is not this due to the acid being neutralized, or, by passing through the new opening, not coming in contact with the ulcers? At the same time the patient is conscious of markedly increased peristalsis.

Hyperacidity might be a contributory pathological cause, but it would also appear that the presence of an ulcer in an organ would necessarily increase its secretion; such is the case in ulcers of tonsils or mouth and also in dysenteric ulceration of the bowels, etc. Therefore it is reasonable to conclude that a gastric or duodenal ulcer is the cause of hyperacidity.—I am, etc.,

Falmouth, March 25th. A. WRIGHT, Major R.A.M.C.

PULMONARY TUBERCULOSIS IN CHILDREN.

SIR,—In Dr. Walter Carr's letter in your issue of February 20th he states that my figures from foreign sources in regard to the number of children found at autopsies to have tuberculous lesions in the lungs correspond, in the main, to those from London hospitals.

The figures I gave were for children dying of various diseases, or from accidents, and Dr. Carr now admits that autopsies show that some 30 per cent. of children dying from various causes show tuberculous lesions in the lungs. But if these children are representative of the general child population, then it follows that 30 per cent. of children living have pulmonary tuberculosis.

Deaths certified as being from phthisis in children are far less than 1 per cent.

If these children are not representative, then we must hold that the existence of this pulmonary tuberculosis has been the determining factor in causing the deaths—that is, that children with pulmonary tuberculosis are specially liable to die from other causes. This is true to a certain extent for one or two diseases, such as measles, but cannot hold for deaths from diphtheria, accidents, etc. Let us grant, for the sake of argument, that it is a factor in so high a proportion as one-third of the cases. That only brings our percentage down from 30 per cent. to 20 per cent. Hence it appears clear that autopsies show that at least 20 in every 100 children have pulmonary tuberculosis. I say that we ought to be able to detect this disease during life in children; and if Dr. Carr would spend a few days examining school children I am certain he would do so. As it is, he probably only sees children seriously ill, and hence forms an erroneous conclusion.

My "rule of three" method of calculation has been much criticized. In my original paper I stated that the deductions were only meant to be very roughly approximate, and that it would not affect my argument if the results were halved or quartered.

I have only ventured to urge that we should diagnose this disease as soon as physical signs appear. Sir Clifford Allbutt would think I am deplorably behind the times, for he writes me that "the case in which physical signs have appeared without systematic treatment is a bungled one."

On referring to my notes on 65 autopsies in an asylum on persons found to have pulmonary tuberculosis (in 63 of which tubercle bacilli were found), I find that the existence of this disease was diagnosed as long as one month before death in only 10 cases. Is it not time that some one called the attention of the profession to our failure of diagnosis in this matter?—I am, etc.,

Droitwich, March 22nd. MARY HAMILTON WILLIAMS.

INFANTILE MORTALITY IN POOR LAW INSTITUTIONS.

SIR,—The figures published in the Minority Report of the Poor Law Commission as to the Infantile Mortality in Workhouses and Poor Law Infirmaries obviously require careful investigation. There are, however, certain considerations which make it highly probable that the deductions drawn from them by the Minority Commissioners and by some writers in the public press are not justified. For instance, the whole of the figures after the first three weeks of life are obviously erroneous, because the report states that they have been obtained by assuming that the death-rate amongst the children discharged is at the same rate as amongst those detained in the infirmary. The fact is, however, that infants are not detained as a rule in the infirmary after the first three weeks unless the child is ill. Obviously, if the death-rate of these sick children is assumed to apply to the healthy children discharged, the death-rate so obtained will be very much greater than the real death-rate. Again, some of the figures are so extraordinary that they can hardly be accepted until verified and the methods of recording the births and deaths have been critically examined.

However, confining one's attention to the death-rate during the first three weeks of life, the figures given show that the death-rate is higher in infirmaries and workhouses than it is amongst the general population. The cause of this is fairly obvious. Amongst the women received into the maternity wards of workhouses and Poor Law infirmaries are many who have been underfed and overworked throughout the period of pregnancy and many who have been admitted to the infirmary owing to syphilis and other diseases; the majority of them are unmarried, and in the case of many, owing to disease or to deliberate interference on the part of the mother, the child is born prematurely. It is manifestly unfair to compare the infantile death-rate of such a population with the infantile death-rate of the general community. The same influences do not affect to anything like the same extent the voluntary lying-in hospitals or maternity charities; first, because the benefits of such charities are usually reserved to respectable married women, and, secondly, because pregnant women suffering from concurrent disease tend to be weeded out from the *clientèle* of such charities and sent into Poor Law infirmaries and general hospitals. Nevertheless, one lying-in hospital, quoted in the report, shows a mortality-rate of 59.3 per 1,000 for the first fourteen days of life, as compared with a mortality-rate for the same period in Poor Law institutions of 46 to 53 per 1,000.

How impossible it is to found any certain conclusions upon the figures supplied is well shown by the returns obtained by the Minority Commissioners from the Plaistow Maternity Charity. In this charity only 15.33 per 1,000 of the children died during the first fortnight—that is, about half the infantile death-rate in the general population of that period. From this the writers of the report draw the conclusion that it is better the mothers should be attended in their own homes than sent into hospitals or infirmaries. On the same lines one could argue that, in order to reduce the infantile death-rate in the general population, all mothers should be confined in what the Minority Commissioners describe as the "poor and wretched homes" of Plaistow.—I am, etc.,

C. T. PARSONS.

Fulham Infirmary, Hammersmith, W., March 19th.

SIR,—With reference to Mr. F. Lawson Dodd's letter of March 6th concerning the high infantile mortality in workhouses, as suggested in the Minority Report, great publicity on this subject has lately been given in the public press (*Daily Mail*, March 3rd) by the Honourable Sydney Holland and others. But this paper apparently does not wish to publish any reply from the other side. In answer to these statements, and on behalf of one of the many people engaged in Poor Law work, I would like to point out that the high infant mortality complained of is not found in every workhouse. Of the 103 children born in Oulton Workhouse, Lowestoft, during the past ten years ending Christmas, 1908, there were only six deaths during the first year of life, and of these five died within the first fourteen days of life, death being due to some unnatural weakness present at birth, which could not have been influenced by the child's surroundings. This only deals

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