the inside of the nose, the conjunctivae, the auditory meatus, the pharynx, and each time there was an intense feeling of oppression at the epigastrium and some nausea. I restrained with difficulty the desire to vomit. At the same time I had some difficulty of breathing and my throat was sore, and am convinced these symptoms were caused by an urticarial eruption on the gastric and respiratory mucous membranes. My condition was almost serious. I could get little sleep, and the gastric and respiratory symptoms were so severe as to occasion considerable anxiety. The temperature rose again to a little over 101°. On the morning of the third day since the second injection I remembered that I had read an article in the BRITISH MEDICAL JOURNAL by a gentleman who stated that salts of lime were a specific for urticaria. Research discovered some glycerophosphate of calcium, and I had a mixture made containing ʒij in the ʒvj. The first dose I took stopped the urticaria. It made two or three feeble attempts to return, but they aborted. I continued the calcium salt gr. x ter die, and from that time I rapidly convalesced, and in a month was much better than even before I became the victim of this series of painful experiences.

Now I want to know, Was this a case of anaphylaxis, and what will happen if I have another inoculation, as I had intended if I should be attacked with influenza again?

It appears that the arthritis, the diarrhoea, the coryza, and the pneumonia were intimately related to each other. Were they all caused by the pneumococcus?

A very interesting fact in my case is the effect of the calcium salt. When I was at the worst I wrote Sir Almroth Wright, and he replied advising a lime salt, but before I got his advice I was cured.

Is it possible that the anaphylactic predisposition is caused by a deficiency of lime in the blood and tissue? If so, the obvious suggestion is to combine inoculation with the administration of a lime salt—as, for instance, the lactate.

Dr. Goodall's anaphylactic cases were, I think, all caused by antidiphtherial serum, but mine by anti-pneumococcal serum. Probably any vaccine with a horse-serum basis would be liable to cause these untoward effects.—I am, etc.,

Blackpool, March 7th. WM. HARDMAN.

BLEEDING IN CEREBRAL HAEMORRHAGE.

SIR,—In Allbutt's *System of Medicine* (1899), in the article Treatment in Cerebral Haemorrhage, Dr. H. H. Tooth writes:

Bleeding in cerebral haemorrhage, as in everything else, has passed through a long period of disrepute, brought about by its indiscriminate use. . . . On physiological grounds it is difficult to see that it can do anything but good.

I noticed lately the announcement of the death, at 78 years of age, in the Midlands, of a gentleman to whom I was called at Cap Martin just seven years ago, and found unconscious from a severe attack of cerebral haemorrhage. As Dr. Philip Hensley was staying in Mentone, I asked him to see the patient, and he was strongly of opinion that he would die. The next day he was even worse, so I bled him to 16 oz., when he became semiconscious, and resisted further interference. He then made a slow but steady improvement, and returned home. Since that time he has taken, as before, an active part in municipal life. His medical man says that he did not die from any return of the cerebral haemorrhage, but from independent causes. I have no doubt that he owed the last seven years of life entirely to opportune bleeding.

In a bad case of dilated heart the best result from any treatment I also obtained by bleeding.

Perhaps our successors will fear fresh cold air as we do bleeding when the folly of the present day indiscriminate advocacy of it is fully revealed. If, however, they swing to the extreme of condemning it altogether, they will miss its obvious utility, as we have that of bleeding, through an unreasoning prejudice.—I am, etc.,

Mentone, Feb. 28th. D. W. SAMWAYS.

ETIOLOGY AND TREATMENT OF ACUTE POLIOMYELITIS.

SIR,—I have read with great interest the papers upon infantile paralysis by Drs. Geo. Parker and Vipond appearing in the JOURNAL for March 18th, especially in view of the theory of Flexner that the infection is conveyed by the naso-pharyngeal mucosa. This theory is mentioned by Dr. Parker, but not by Dr. Vipond.

In the *New York Medical Journal* for December 17th, 1910, there appeared an article upon epidemic poliomyelitis from the pen of Dr. Sohier Bryant, and his observations will, I think, be of interest to readers:

Eighteen months of careful clinical observation led him to the belief that the disease is infectious and contagious, and that the contagion emanates from the naso-pharyngeal secretions. From observations made in 1898, whilst acting as chief surgeon of the Seventh Army Corps at Savannah, he has concluded that poliomyelitis, with regard to its inception and development, is analogous to epidemic cerebro-spinal meningitis, an outbreak of which occurred among the United States troops. In this epidemic it was observed that the disease always began with naso-pharyngitis, spread chiefly among associated soldiers, and the meningeal affection was transmitted by individuals who showed none but the naso-pharyngeal symptoms. Further, local treatment by mild nasal antiseptics gave good results. Dr. Bryant found that the course of epidemic poliomyelitis in the recent outbreak in America resembled exactly that of the cerebro-spinal meningitis in Savannah. From his observations he concludes that, in epidemic poliomyelitis, as in cerebro-spinal meningitis, lobar pneumonia, true influenza, and diphtheria, the symptoms remote from the naso-pharyngitis are not really pathological entities of the disease itself, but are to be considered in the light of complications.

His treatment of epidemic poliomyelitis has, therefore, consisted of isolation during the whole of the naso-pharyngeal or active stage, mild antiseptic applications by a post-nasal spray, rest in bed, and restricted diet with a maximum amount of potable water. The effects of this treatment he has found to be restriction of the pharyngeal inflammation, rapid recession of the febrile conditions, and apparent prevention of paretic symptoms. He further considers that infantile paralysis should be included among those diseases for which children are excluded from school, and that in times of epidemic poliomyelitis all cases of naso-pharyngitis should be regarded as suspicious and treated promptly.

—I am, etc.,

London, W., March 18th. MACLEOD YEARSLEY.

LADY HEALTH VISITORS OR WOMEN SANITARY INSPECTORS?

SIR,—In the letter of mine which appeared in your issue of March 4th last I ventured to say that the subject was one of great importance to public health departments. This statement appears to be correct, as your own columns have already received communications thereon from Dr. Parkes, the Chairman of the Council of the Royal Sanitary Institute, and from my friend, Professor Bostock Hill, who is also prominent in that institute. They, naturally, are both on the defence. My letter has been quoted in the *Sanitary Record* and other journals interested in hygiene, with comments (in the main) supporting my views. Anyway, I am glad the subject is receiving the attention it merits.

My view, strongly held, is that there is no room on the staff of a public health department for a lady health visitor as distinct from a woman sanitary inspector. Is not the whole ever better than a part?

The regulations of the institute for the health visitors' examination are now before me. No. 4 says:

Every candidate is required to furnish the Board of Examiners with satisfactory testimonials of *recent* date as to *age*.

The italics are mine. I never had the good fortune to see such a testimonial, nor to be asked to furnish one. The latter, I judge, would be a dangerous task, if dealing with a militant member of the other sex. Regulation No. 5 says:

The candidate must be able to write legibly, spell correctly, be able to make an outline sketch to scale, read ordinary building plans, and must possess a fair knowledge of arithmetic.

But yet no preliminary test of her general education is made, as it is by the Sanitary Inspectors' Examination Board. Regulation No. 1 says:

Candidates are required to furnish satisfactory evidence that they have had opportunities of gaining a *practical* knowledge of the subjects set out in the syllabus.

Again the italics are mine. This regulation strikes one as excellent, until one sees on a previous page what kind of evidence the institute is prepared to accept as "satisfactory." The list is certainly varied. Any one of seven qualifications are accepted as evidence of a knowledge of hygiene. Amongst them are: (1) A certificate as midwife; (2) three months' training in a children's hospital, or a general hospital, or a Poor Law infirmary. The one certificate that should be required is not insisted on—