medical friends with whom I have discussed the subject have had a similar experience. The subjects of addiction to this group of drugs are often brain-workers and people of high intellectual grade. In addition, I have very strong grounds for believing that veronal addiction, like other forms of drug addiction, is relatively common amongst the pleasure-seeking class of the night-club type.

I have on several occasions seen dangerous nervous symptoms, such as ataxy, anarthria, diplopia, etc., result from the daily use of the drug in therapeutic doses. Some of these cases were quoted in my paper, and others have observed many similar cases.

I am fully aware that persons suffering from active mental disease can often tolerate large doses of hypnotic drugs over relatively long periods, and that it may be necessary and advisable in such cases to use the barbitone group of drugs daily over long periods, provided that the patient is under close medical observation. This may explain the wide discrepancy between the experience of Sir Maurice Craig and myself.

I stated in my recent paper (which unfortunately Sir Maurice Craig has not read) that

> the barbituric acid compounds "are rapidly acting and fairly certain hypnotics. It is for this reason that they are so commonly used. A single therapeutic dose is usually followed by a satisfactory period of natural sleep, and no marked after-effects follow when the therapeutic action has passed away, which should be after six to twelve hours."

The view that these drugs may be given in therapeutic doses daily over long periods to persons who are not suffering from active mental disease is, in my judgement and experience, most dangerous and misleading teaching.—I am, etc.,

London, W.1, June 20th. W. H. WILLCOX.

MINERS' NYSTAGMUS.

SIR,—Appearance of the articles dealing with miners' nystagmus in your issue of June 18th prompts me to send you the following paragraph taken from some notes (already in print) based on observations made by me during a short visit in the early part of this year to the United States:

> "*Miners' Nystagmus.*—Opportunity was seized while at Pittsburg of gaining acquaintance with the coal-mining industry. Here, also, more medical services are provided than in this country; but the most striking difference in underground practice is the illumination provided. There was no need for waiting on leaving the cage to 'get your eyes'; the walls of the workings were white, and reflected the light from the lamps, stone dusting being always done with limestone or gypsum. The electric safety lamps used gave more light than ours, and were different in shape, being worn in the cap with the battery attached to the waist. This is the position which of old the miner chose for his naked candle, and still chooses in naked-light pits. No further reason need be sought for the entire absence of nystagmus among American coal-miners. One miner said that he and his son while mining in Yorkshire had suffered with eye movements, but that both had lost their troubles within two months of taking up mining work in America."

—I am, etc.,

Cardiff, June 18th. EDGAR L. COLLIS, Member of Miners' Nystagmus Committee.

SIR,—I wish cordially to support the plea of Dr. Freeland Fergus in the JOURNAL of June 18th (p. 1092) for a thorough investigation of miners' nystagmus. There seems no other disease in which is to be found such a tangle of contradictory observations and beliefs. Even the official definition contradicts the term it should define: "The disease known as miners' nystagmus, whether occurring in miners or others and whether the symptom of oscillation of the eyeballs be present or not." The consensus of ophthalmological opinion is that bad illumination is the cause of the trouble, but Dr. Fergus shows that improved illumination is often followed by the onset of symptoms.

Dr. Robson in his article says "... the pathological entity round which this complex revolves is involuntary oscillation of eyeballs." Dr. Fergus writes on the previous page: "cardiac instability is much more frequently present than rotation of the eyeballs." Dr. Robson adds to the confusion when he notes that "subjective symptoms without objective signs may be the chief determining characteristic."

The absence of *post-mortem* examinations is a startling revelation: yet material has been provided by suicides ascribed to this mysterious disease. It appears from these articles that research hitherto carried on has been worse than useless, and that the only course is to scrap all our present beliefs, disregard all previous observations, and start afresh.—I am, etc.,

Southsea, June 21st. W. S. INMAN.

PALATE OPERATIONS.

SIR,—Sir Robert Woods, in your issue of February 26th, writes an interesting note on aids to palatal sufficiency after cleft palate operations, but he twice makes the statement that a cleft palate operation may be quite "good" and "successful" and yet leave a "hiatus behind the palate" either "literally huge" or "so great as to look quite hopeless." It is difficult to reconcile the two portions of the statements—for how can any operation be deemed to be successful if its primary object is not attained? As I have pointed out (*Der Wolfsrachen und Seine Behandlung*, 1913, *Stomatology*, 1912 and 1924, *Facial Surgery*, 1924), the primary object of any cleft palate treatment is to enable the posterior margin of the soft palate to approximate to the posterior pharyngeal wall; it is infinitely more important to attain this than to close the cleft in the palate.

Some of my patients who have fully functional soft palates after operation, but in whom, for one reason or another, I have not touched the cleft in the hard palate, speak, even without a plate, with most extraordinary distinctness. Anyone can "close" any cleft by utilizing all the available tissue in a lateral direction at the expense of the antero-posterior direction—at least the "hole in the palate" looks closed to the parents and friends; but it is not closed, it is merely *transferred* from the palate to the oropharynx. This mere transference of the cleft from one position to another is brought about too often, I think, by the rigid adherence to the Langenbeck operation. The antero-posterior measurement from the hard palate to the pharynx differs considerably in different patients. When it is not long and there is sufficient tissue, the Langenbeck is a perfectly good operation; where, however, it is longer than usual, and/or the tissue available is less than normal, then the Langenbeck operation gives bad results, a short or a rigid soft palate inevitably resulting, with consequent loss of function. In the latter type of case either a "bar-velum" operation only should be done—with subsequent provision of a hinged artificial palate—or a skin-grafted flap operation. In very wide clefts, in order to avoid using up too much tissue in a lateral direction, a preliminary partial Brophy operation is also often a necessity, the indication being that the lower jaw fits up inside the upper jaw. Used with discrimination, I have never seen other than the most beneficial effects follow this operation. In any case there should be no tension; tension and function in any plastic operation are incompatible. I agree that the treatment of these short and functionless palates (after unsuccessful operation) is very difficult.

The paraffin wax injection suggested by Sir Robert Woods might help considerably, I should imagine, if it does not interfere with the function of the superior constrictor of the pharynx. I have usually contented myself with lengthening the palate by flaps from the pillars of the fauces or by having a solid obturator made, attached to an extension from a dental plate, on to which the superior constrictor may close, and I must say that I think the latter plan gives the better functional speech result. In planning any cleft palate operation I usually tell students that they should choose that form which will best please the child in ten years' time, not that which will best please the parents at the moment.—I am, etc.,

University of Otago, April 27th. H. P. PICKERILL.

THE SCHICK TEST.

SIR,—A ward maid at the Croydon Hospital, at the time Schick-negative and quite well, was found on taking a swab to have in her throat virulent diphtheria germs, which killed a guinea-pig in thirty-six hours.

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