was no need to vary the insulin dosage accordingly—on the contrary very rapid changes were necessary; and (2) he gave the insulin and glucose hourly throughout the day and night.

Nevertheless, it is true that when Porges and Adlersberg first suggested high carbohydrate diets in diabetes there were objections raised on physiological grounds. It may be that further clinical experiments will justify Crooke's suggested innovation, but until then I think it more prudent for those in charge of diabetic patients to adhere to present practice.—I am, etc.,

London, W.1. S. L. SIMPSON.

SIR,—Dr. A. C. Crooke (Jan. 16, p. 64) proposes an interesting revolution in diabetic dietary, and claims that he has shown this revolution to be successful in a number of cases. In fact he has shown no such thing. He claims that protein, fat, and carbohydrate are interchangeable in a diabetic diet so long as the calorie intake is constant. This is a remarkable claim, and it is made without evidence, for he gives no details of the actual carbohydrate, protein, and fat intakes of his patients. Dietary habits are hard to alter, and it is most likely that the majority of his patients retained their previous diets more or less intact. Who would choose to have nothing but bacon and butter for breakfast if cereal and bread are available? Further, wartime restrictions (even with the extra allowances for diabetics) make it impossible to subsist entirely on protein and fat. The diabetic ration allows about 75 g. protein and 100 g. fat. This gives 1,200 calories, so that 200 g. carbohydrate are necessary to make up a diet of 2,000 calories. This is a reasonable orthodox diet and may well have been the diet taken by Dr. Crooke's patients, who were allowed 2,000 calories.

To substantiate Dr. Crooke's claim it would be necessary to study in-patients (who alone can be brought under accurate dietary control), to balance them with insulin on pure carbohydrate diets, and to estimate their blood sugar throughout the day. Then they would have to be put on to pure protein and fat diets of the same calorie value with the same insulin dosage. If his hypothesis is correct then the blood-sugar levels throughout the day should remain unchanged. Until such evidence is forthcoming it would be foolish to accept Dr. Crooke's revolutionary hypothesis. In peacetime, with unlimited protein and fat, it might be dangerous. There is, however, one inference that may be derived from his paper, and that is, that diabetics are very conservative in their dietary habits. It is important to remember this when conclusions are reached as the result of experiments with out-patients.—I am, etc.,

St. Bartholomew's Hospital, E.C.1. C. M. FLETCHER.

Nomenclature of Typhus Group

SIR,—In your issue of Nov. 21 (p. 597) Dr. A. Felix, in discussing the nomenclature of the typhus group of fevers, takes me to task for the alleged recent introduction of the term "exanthematic" typhus as a synonym for louse-borne typhus. The propriety of using the adjective "exanthematic" in speaking of the relationship between louse-borne and flea-borne typhus, in which latter condition the rash is as a rule less in evidence than in louse-borne typhus, may be open to question. It is, however, incorrect to assert that "exanthematic" as applied to typhus is "a new invention." Dr. Felix can hardly have forgotten that on the Continent "typhus exanthematicus," "typhus exanthématique," and "tifus exantemático" have been in use for many a long day. An examination of past volumes of the *Tropical Diseases Bulletin* and of standard English textbooks here available, many of them by no means recent, shows that the term "exanthematic" applied to louse-borne typhus is of such an age that I cannot well claim its parentage even if I had wished to do so.—I am, etc.,

G. M. FINDLAY.

Eventration of the Diaphragm

SIR,—I venture to think that Dr. Mills (Jan. 23, p. 97) is incorrect in regarding his interesting case of eventration as congenital in origin. The clinical and radiological features are rather more in keeping with a diagnosis of *aérogastrie bloquée*, which he dismisses, I think, too lightly. I am not familiar with the occurrence of the cup-and-spill or cascade type of stomach in congenital eventration of the diaphragm, but it has been a feature of all of the four or five cases of *aérogastrie bloquée* that I have seen. The loculation is due to the pressure of gas in the splenic flexure of the colon and has been well called the pressure hour-glass effect. It is my belief that the condition of *aérogastrie bloquée* starts in an upper gastric loculus formed in this way. In this loculus gas is trapped, and as its pressure increases the cardia becomes displaced and relief by belching is prevented. Two of my patients could not belch wind and never had been able to as long as they could remember. The upper loculus gradually distends backwards and upwards, pushing the left dome of the diaphragm into the thorax and the heart over to the right. Pain, and sometimes very severe pain, is a common though not invariable symptom; fullness and distension are usual, and sometimes an upper abdominal tumour may be visible. In my view, then, Dr. Mills's case is one of eventration of the diaphragm secondary to *aérogastrie bloquée*.

I was not aware of Korns's sign, but the divergence of the costal margin on inspiration is an interesting and somewhat neglected physical sign in diagnosis, occurring to a greater or less extent in all cases where contraction of the diaphragm is exerted through an arc greater than normal, thus offering less than its usual antagonism to the intercostal muscles. The movements of the costal margin as an aid to diagnosis are well described by Charles F. Hoover in the Nelson *Loose Leaf Medicine*, Volume III.—I am, etc.,

Birmingham. T. L. HARDY.

Houses to Live In

SIR,—"Homes to Live In" would have been even better for the title of your leading article (Jan. 30, p. 136). You will say that that was not the question asked, but I reply that it ought to have been. We are all out for that "harmony of human relationship" mentioned in the review of *Psychological Effects of War on Citizen and Soldier* (Jan. 30, p. 133), and here is a great opportunity for our profession not to accept calmly the *status quo* or to stand by while grievous wrong may be done to the body politic. Every person is entitled in a democracy to be recognized as a personality, the roots of which are embedded in family life. We may play a large part in insisting upon this. The College should emphasize the fact that tenement flats are destructive of family life. The sound instinct and knowledge of the people recognize this, and over 90% of them have said so. Warehousing our peoples does not make for a vigorous people full of initiative.

You may wonder why I say this, but it is not possible to argue this question without the knowledge that vested interests in the land of great cities and in the materials of which flats are made are looking for encouragement just now, and it should be our business not to appear as "appeasers." Harmony of social life demands a positive policy. We do not want to wake up to find that damage has been inflicted upon people by foisting on them a sterile unimaginative static condition which need not exist.—I am, etc.,

Letchworth, Herts. NORMAN MACFADYEN.

Sulphonamide-resistant Bacteria

SIR,—I was much interested in the article by J. Petro (*Lancet*, 1943, **1**, 35) on the increasing incidence of a strain of gonococcus which is resistant to the action of the sulphonamides. I think a fair inference is that this strain has become resistant due to the ineffectual treatment of patients by too small doses of the sulphonamides. Is it not time that the medical profession at large realized this danger, and took greater care to avoid breeding strains of organisms which may spread, and thus give rise to a state of affairs approximating to the pre-sulphonamide era?

I have in mind particularly the treatment of streptococcal sore throats by means of these drugs. It was, and to some extent still is, the practice of many nurses, medical students, and even medical men to take a sulphonamide whenever they have a sore throat. The doses are nearly always much too small, so as to avoid the unpleasant side-reactions. Even with the very best use of these drugs, it is practically impossible to remove all haemolytic streptococci from an infected throat, and those which remain are resistant to further dosage. If this germ is now coughed on to the perineum of a puerperal woman she is likely to have puerperal sepsis of the resistant type. Only a day or two ago I came across a case of a medical