Thermometry

Mr. F. R. WALTERS, F.R.C.S. (Farnham) writes: Your contributor (*Journal*, Feb. 10, p. 206) who answered questions about clinical thermometry has not taken into account the atmospheric and other conditions affecting mouth temperatures. In a cool room, or out of doors, misleading readings will follow if the patient opens his mouth for any purpose with the thermometer in it, or shortly before the test; so that repeated inspection of the thermometer is inadvisable in such a place, and where more accurate results are important rectal temperatures are more reliable. Your contributor also writes as if there were a constant difference between rectal, mouth, and axillary temperatures; but this is not the case. In pulmonary tuberculosis, for example, it often happens that rectal temperatures are the same as mouth temperatures in the same patient at the same time; while at other times (perhaps the same day) there may be several degrees of difference. Febrile rises and warnings of complications may be missed if mouth temperatures are relied upon. After exercise, mouth temperatures may be lowered while rectal temperatures are raised. I refrain from giving illustrative cases.

Artificial Respiration and First-aid Instruction

Dr. J. L. BARFORD (Stoke Park, Guildford) writes: As it may be a novelty I venture to mention a very small "tip" which I have employed recently when demonstrating artificial respiration. It simply consists of putting (smuggling, for dramatic effect) a whistle into the casualty's mouth. On expiratory effort the clearness of the airway is made abundantly clear and impresses the students remarkably. It can be employed in Schäfer's, the rocking, or any other method, except, of course, Laborde's! Other instructors might like to copy. Incidentally I note that Dr. F. C. Eve (Jan. 6, p. 21), when describing the successful revival of a drowned child by rocking, states that this was the first (successful) resuscitation by manual rocking. Surely the rocking and swinging employed to induce the newborn infant to breathe, although not strictly a resuscitation, comes under this category? Perhaps I am so old-fashioned that this procedure, which I remember employing successfully, is now superseded.

Hydatidiform Mole

Dr. C. W. F. BURNETT (West Middlesex County Hospital) writes: The answer given under this heading in your issue of Jan. 20 (p. 105) contains no reference to modern theories of aetiology. The most convincing of these—formulated, I believe, by Mr. Barton Gilbert some seven years ago—ascribes the mole formation to the failure of development of embryonic blood vessels in the trophoblast. Food substances passing from the maternal blood through the villous wall by the vital activity of its constituent cells are, therefore, not conveyed to the embryo, which rapidly dies and disappears; the mesoderm of the villus retains the food products, and by a process of osmosis becomes oedematous and cystic. The cytotrophoblast, thriving on the highly nutritious contents of the villus, grows rapidly, assumes invasive characteristics, and secretes increased quantities of chorionic gonadotrophin as your answer describes. The suggestion has been made that this failure of formation of vascular tissue may be one of the results of Rh incompatibility in the parents; however, recent research does not confirm this hypothesis.

Pyretotherapy

Dr. W. F. COOPER (Kingston Hill) writes: Dr. J. R. Edge (Jan. 13, p. 61) suggests that pyretotherapy might be "worthy of a trial." Though the method is used in many cases, no one seems to consider what it is that produces the good effects, or *why* it is suitable in some cases and not in others, except, perhaps, as to antagonism between malaria and spirochaetes. By merely raising the temperature of blood and also of tissues, by whatever means, certain changes must occur; we do not know them all, but do know some of them. For instance, there will be an increase in the number of ions per unit volume, in ionic activity, giving rise to variations in physical effects such as conductivity, *p*H, Eh, and so on. Some of these changes can be brought about by ordinary therapy, and my experience is that they are effective. Information valuable for treatment would result if more attention were given to the effects of raising the temperature. Then one would not consider whether cases were "suitable to" pyretotherapy, but whether pathological conditions would be ameliorated by the effects of it. I consider that cases that are "susceptible" are those due to infection and/or inflammation; but it is not necessary to adopt the higher temperature. This is hinted at in Dr. Edge's letter, but insufficient data are given. A suitable examination of blood should have been helpful; that alone might have made it certain whether his children had an infection or not, and also whether any of the factors produced in pyretotherapy would have been beneficial.

Occupational Cause of Raynaud's Disease

Dr. D. H. MACCORMACK (Manchester) writes: With reference to the answer given under this heading (Jan. 20, p. 106), it is not made clear whether or not Raynaud's disease and "dead hand" are phases of one and the same condition. This is a point on which most textbooks still appear to be vague. However, I have personally no doubt that "dead hand" is merely an early stage, and that unless the causative factors are removed, it may, in many cases, develop into Raynaud's disease proper. Incidentally, I believe that "dead hand" is listed as an industrial condition in Germany and other countries, and it is difficult to understand why it has so far not found its way into the British schedule.

Romberg's Sign

Dr. E. W. SQUIRE (Reading) writes: Is the answer (Jan. 20, p. 106) relative to Romberg's sign complete? What of the afferent tract through the retina and optic nerve to the visual centre, thence to the cerebellar centre controlling balance? Does not this tract play an important part in maintaining balance in conjunction with the special sensory nerves? Apropos of this sign I have found it marked in only two cases on the Military Service Boards during the last 5¾ years—i.e., since May, 1939—during which time some thousands of recruits have passed under my observation.

Translation, Please

Dr. F. DURAN-JORDA, M.D.Barcelona, writes from Manchester: I think I can enlighten Dr. Maurice McElligott in regard to the Spanish words for diseases produced by *Bacillus anthracis*. *Bacillus anthracis* is known as "carbunco o pustula maligna," and the common name for this is "carbon." In Catalan the scientific title is "carbuncle" and the common name "carbo." For the staphylococcal infections equivalent to a boil the word in Spanish is "forunculosis," commonly known as "grano." A group of boils together is "antrax." In Catalan the corresponding names are "foruncle" and "antrax," the latter being referred to generally as "vesper," coming from "wasp." As I am not a surgeon myself and have not treated any of these cases there may be more names in use, but the general scientific terms are as given here.

Dr. H. A. FULLER, M.D.Paris, writes from Glasgow as follows: I quite appreciate Dr. McElligott's difficulty (*Journal*, Jan. 13, p. 70) over the words "charbon" and "anthrax" as used in France, and he may find the following helpful. He is quite right in translating "charbon" as the equivalent of the English word anthrax, and "anthrax" as meaning "carbuncle." Those are the meanings of these two words in France to-day; but it was not always so. Formerly, in pre-bacteriological days, the word "charbon" (from Latin *carbo*) was applied not only to malignant pustule but also to boils, carbuncles, and the buboes of plague, in France and, apparently, from what he says about Ireland, in other countries as well. Evidently the word was applied to any small *hot* tumour (a burning coal). "Carbuncle" (from *carbunculus*, diminutive of *carbo*) was retained in Britain to designate the multiple boil, whereas in France it is the Greek word anthrax (also meaning coal, of course) which was retained for this. Maxwell and collaborators (*Terminologia Medica Polyglotta*; Churchill, London, 1890) give: French, anthrax (*bénin*); English, carbuncle; German, Anthrax, Karbunkel, Brandschwär; Spanish, antrax, avispero (wasps' nest) and for: French, anthrax (*malin*), charbon; pustule maligne; English, anthrax (malignant); German, Milzpocke, Milzpustel. They also give: French, pustule maligne, sang de rate; English, malignant pustule, charbon, splenic fever, woolsorter's disease, malignant anthrax; German, Milzbrand, Karbunkelkrankheit, Brandblatter; Spanish, pústula maligna.

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Corrigenda

Owing to delay in the receipt of corrected proofs there were three errors in Dr. M. N. Pai's article "Changes in Personality after Cerebrospinal Fever" published last week. In the table showing changes in personality after C.S.F. the figure opposite "Fairly good" in the second column should be 10; in the last paragraph of the section on headache the word "post-confusional" should be "post-contusional"; the name "Rosenoff" in the bibliography should be "Rosanoff."

In his letter on selenium poisoning in the *Journal* of Feb. 24 (p. 276) Mr. A. L. Bacharach meant to write "selenium might thus interfere with the *in vivo* synthesis of cystine"—not *in vitro*.