several weeks or months. The negative blood findings and negative lymph gland cytology (puncture!) will differentiate this condition of as yet unknown aetiology from infectious mononucleosis.

To summarize, I would like to make the following points: (1) the blood count is the most important test of infectious mononucleosis and is the most likely to reveal the diagnosis at an early stage and during the whole active phase of the disease; (2) the agglutination test (Paul–Bunnell test), if positive, is additional evidence; (3) a negative Paul–Bunnell test does not exclude this diagnosis; (4) a positive Paul–Bunnell test can sometimes be found after convalescence when the blood count might have become normal; and (5) negative haematological findings in the presence of glandular enlargement (especially if repeated) exclude the diagnosis of infectious mononucleosis.

In conclusion, I would like to say that it should be kept in mind that while the Paul–Bunnell test is a purely "technical" test the opinion on the blood film in difficult cases belongs in the domain of the expert.—I am, etc.,

Sheffield. S. VARADI.

REFERENCES

1 *British Medical Journal*, 1952, **2**, 436.
2 Ravenna, P., and Snyder, J. (1948). *Ann. intern. Med.*, **28**, 861.
3 *Disorders of the Blood*, 1953, p. 607. London.

Pethidine for Pain and Insomnia

SIR,—We have noticed that even the most up-to-date textbooks advocate morphine in cases of pain and insomnia associated with pneumonia. However, it has been our experience that when we have given even small doses of morphine, especially in people over the age of 40, the condition has deteriorated rapidly, with death in a very high percentage of cases.

On the other hand, since we have started using pethidine in similar cases the response has been noticeably better and the death rate has been very low. In our opinion, morphine is contraindicated in all cases of pneumonia, especially nowadays, as we have other drugs to relieve pain and help sleeplessness which are not so depressant on the respiratory centre.—I am, etc.,

R. G. B. WIGODER.
H. JEFFS.

London, S.E.6.

Single Incision for Bilateral Orchidectomy

SIR,—Like Mr. C. J. Cellan-Jones (*Journal*, May 1, p. 1039), my own memories go back to 25 years ago, when I learnt from Mr. Kenneth Walker to approach the testes directly through the scrotum. I have been doing so ever since without any of the complications he describes. So I must admit that, for my part, I took quite seriously Sir Heneage Ogilvie's plea for this approach (*Journal*, April 17, p. 934).—I am, etc.,

London, W.1. REYNOLD BOYD.

Chronic Vasomotor Rhinitis

SIR,—The two syndromes described by Mr. P. Reading and Mr. K. Malcomson and Dr. D. O'Neill and Mr. K. Malcomson (*Journal*, March 6, pp. 552 and 554) as "non-specific paroxysmal sneezing and rhinorrhoea" and "persistent nasal blockage" respectively are believed by the authors to respond differently to treatment. In the case of the former the symptoms are controlled by antihistamine drugs and sustained improvement follows psychotherapy, whereas the latter requires surgical intervention or zinc ionization. In my experience the two conditions frequently merge and the characteristic symptoms of the two states may alternate in a single individual. I am myself an example of such a "mixed" syndrome, all symptoms being promptly relieved by antazoline hydrochloride, 0.1 g.

The authors might find it of value to investigate how many of their cases had used the "pocket inhaler" in the past. The recent survey carried out by the City Analyst of Birmingham (*Journal*, March 13, p. 616) shows that while some of the inhalers examined were deficient in amphetamine others contained an excess of up to 30%. I attribute my own condition to the excessive use of such inhalers to relieve "catarrh," and the amount of amphetamine absorbed in this way was sufficient to cause sleeplessness, abolition of fatigue, and restlessness. A friend of mine in Calcutta, who was incapacitated for days by rhinorrhoea until he took antihistamine drugs, also blames the condition on to the excessive use of inhalers.—I am, etc.,

Udayagiri, India. D. STEWART MCLAREN.

Bacterial Endocarditis Due to Chromobacterium Prodigiosum

SIR,—Drs. A. J. Hawe and M. H. Hughes (*Journal*, April 24, p. 968) point out that Wilson and Miles were, in 1946, unable to quote any indubitable report contradicting the view that *Chromobacterium prodigiosum* was non-pathogenic for man. A patient died of septicaemia due to *Bacillus prodigiosus* in 1934 in a London teaching hospital, and the death certificate was lying on the desk of the local registrar of births and deaths when I went in to register the birth of a child. The registrar showed me the certificate (having found out that I was a doctor) and remarked that he had never heard of the condition. I told him that he was probably in the unique position of being the first to register a death from this cause, and I eagerly searched medical journals for some months in the hope that the case would be published. It apparently never was, which is a pity, as it would presumably have been the first of its kind.—I am, etc.,

London, W.1. J. C. HAWKSLEY.

SIR,—It may be of interest to Drs. A. J. Hawe and M. H. Hughes (*Journal*, April 24, p. 968) to draw their attention to a case of acute fatal septicaemia due to *Chromobacterium prodigiosum* which I published in the *Lancet* in 1935.[1] This was probably the first case of fatal infection with this organism ever published. The point of interest is that it was associated with agranulocytosis, and it seems possible that their case may have had chloramphenicol-induced agranulocytosis and developed endocarditis due to this organism only in the later stages of the illness.—I am, etc.,

Guildford. C. RICKWORD LANE.

REFERENCE

1 *Lancet*, 1935, **2**, 20.

Racial and Religious Tolerance

SIR,—It is a sad reflection on the ability of the medical profession to think rationally that out of the fourteen advertisements for assistants in the *Journal* of April 10 seven implied preference for a particular race or religion. What does this imply? Does it imply that each of these doctors believes that a particular race or religion is more likely to supply a compatible colleague, or that it is easier to work with a person of one's own (or possibly not one's own) nation or creed? If this be so, have those concerned bothered to consider if their beliefs are founded on any rational judgment, or merely on emotionally toned prejudice? Do a significantly higher proportion of Scotsmen than Englishmen or Argentinians, for example, make better assistants even to other Scotsmen: do more Catholics than Jews? I have no figures available so am unable to formulate any conclusions lest they be based on prejudice. I think it is true to say that many beliefs of racial superiority or inferiority have been shown not to be founded on fact, and it would be reasonable to suggest that this may be so in this present case.

In any case I feel that a liberal-minded profession should be capable of putting aside emotionally toned judgments and accepting a colleague on his merits as "a good man to work with," irrespective of his race, colour, or creed. It should set an example in this disturbed world, where polls are necessary to decide on the allowable quantity of skin pigment in bus conductors, and abhor the discriminatory techniques so prevalent to-day.—I am, etc.,

Bristol. C. P. SEAGER.