

not suffering from any of these complaints, and to pronounce a verdict on them is very difficult. It is easy to say they should be enucleated, but to do so in every case must eventually bring discredit on the operation and the operator. I entirely agree with Mr. Tilley's statement that "it is impossible by mere inspection to say whether a tonsil is healthy or diseased." I hope the time will come when this assertion will be inaccurate. From certain passages in Dr. Poynton's lecture, I rather assumed that he considered it was possible, and it was more particularly to elicit this information that I raised the question.

The presence of enlarged lymphatic glands at the angle of the jaw is a very valuable sign, but there are many cases of obviously diseased tonsils where they are not palpable.

Dr. Cavenagh asks, "If 'pus' is not a sign of disease [in the tonsil] why should it be considered so in tooth sockets or accessory sinuses?" Surely there is no analogy. The more I study this subject, especially the transatlantic and Continental literature, the more convinced I become that the tonsils have a definite function to perform in resisting systemic invasion and in building up immunity. Professor Digby, whose researches, perhaps, are not so well known as they should be, describes in his letter in the JOURNAL of June 23rd (p. 1075) how he considers they do this. In his own words: "The lymphocytes in the tonsil are continually migrating through the epithelium, phagocytosing the bacteria in the crypts, and returning into the lymph nodules." In his book *Immunity in Health* he says: "Lymphocytes found astray in the lumen . . . are the few which have failed to wander back into the lymphoid tissue." We have therefore a fluid normally in the crypts which consists of micro-organisms, lymphocytes, shed epithelial cells, and mucus—clinically very like pus, but as it is formed by the tonsil in the exercise of its function, surely it is more physiological than pathological (a very different thing from pus in a tooth socket or accessory sinus, neither of which are lymphoid structures). The real practical difficulty is to distinguish between this physiological fluid (which has been mistaken for pus) and pus. If these findings are accepted the question of what is a diseased tonsil becomes very difficult to answer. In the present state of our knowledge, I think, only a physician can answer it if, after a thorough examination of all the systems of the patient, he finds evidence of systemic invasion, which is likely to have occurred through the tonsil.

The correspondence, to my mind, clearly shows that the problem has never been really tackled and that we have still much to learn.—I am, etc.,

Norwich, June 25th.

N. STUART CARRUTHERS.

THE EDUCATION OF MYOPES.

SIR,—The statement by Dr. Edridge-Green (June 30th, p. 1115) that "myopia is caused by distension of the eye due to back pressure through the veins, such as is caused by lifting a heavy weight," probably contains an element of truth, as my experience as oculist attached to medical boards during the war coincides with his in finding many cases of high myopia in farm servants, who are far from literary in their tastes.

That it does not state the whole truth is demonstrated by the case of a schoolgirl, aged 12, examined by me at Alford this year for the Aberdeenshire Education Authority. Under atropine her refraction was: Right eye $-20 D.=6/18$; left eye $+1 D.=6/6$. The fundus of the myopic eye was practically normal, with a very small crescent and no other lesion. Cases of anisometropia frequently repeat themselves in various members of a family; the same sort of astigmatism with the same axis may occasionally behave in a similar fashion. There is no doubt that heredity plays a very important part in the production of refractive errors. Nevertheless, careful correction and supervision of the education of a young myope is essential.—I am, etc.,

Aberdeen, June 30th.

A. RUDOLF GALLOWAY.

PROPOSED RONALD ROSS CLINIC.

SIR,—Your leading article and the recent letter in the *Times* concerning the proposal to establish in honour of Sir Ronald Ross a "Ronald Ross Clinic" leads me to write to you.

Sir Ronald Ross, whom I have had the great pleasure of knowing for many years, is deserving of the highest honour and recognition for the work so patiently pursued under difficulties, disappointments, and discouragements, to such a successful end. But may I venture to ask professional and informed opinion whether a clinic in a temperate climate is the proper place for research in tropical diseases, and whether the fund now proposed to be raised would not be much more advantageously expended in establishing one in a tropical country—India, for instance, where Sir Ronald Ross laid the foundations of his great work—or, perhaps, in endowing periodical expeditions to the tropics for the investigation on the spot of particular diseases or local forms of disease.

I make these suggestions with some hesitation, being only a layman who has been keenly interested for many years in the work of schools of tropical disease, and particularly in the establishment of the Sir Alfred Jones Laboratories at Sierra Leone.—I am, etc.,

Liverpool, June 29th.

J. PICKERING JONES.

FREEDOM OF NEGRO RACES FROM CANCER.

SIR,—Will you allow me to add the results of my own inquiries to Dr. F. P. Fouché's statement of the freedom of the South African native races from malignant disease (June 30th, p. 1116)?

Thirty years ago I was interested in the causation of cancer, when my friend, the late Sir Henry Morton Stanley, the African explorer, drew my attention to the fact he had observed, that the native races in the regions through which he had travelled were free from it. To make sure, he furnished me with a list of hospitals and got me to write to the physicians in charge of them. The replies I received confirmed his observation and revealed that only in coast towns, where natives mingled with Europeans, did cancer occur, and then only (at that time) one case in about ten or twelve years.

This information led me to further inquiries, and I ascertained that native races of other continents were similarly immune when not brought in contact with civilization. I also noted the belief of several of my correspondents that it was the vegetarian diet of the natives which accounted for the exemption.—I am, etc.,

London, W.1, June 29th.

BERNARD HOLLANDER.

HERPES ZOSTER WITH LOCALIZED MUSCULAR PARALYSIS.

SIR,—I am indebted to Dr. Parkes Weber (June 23rd, p. 1075), whose knowledge of the literature of the rarer manifestations of disease is unrivalled, for drawing attention to further references dealing with herpes zoster complicated by localized paralysis. In my paper, however, I commented upon the extreme rarity of cases of muscular paralysis in the affected zone accompanying or following herpes zoster of the trunk, and stated that I had found very few recorded cases.

By "herpes zoster of the trunk" I implied herpes due to involvement of any of the spinal ganglia between and including the second thoracic and twelfth thoracic segments, and used the term "trunk" as distinct from "limbs." I gave the few references to cases of paralysis of thoracic and abdominal muscles following herpes in the affected zone that I had been able to find, and also mentioned Epstein's series of twenty cases of paralysis complicating herpes zoster, which included no case of paralysis of thoracic or abdominal muscles, merely to emphasize the rarity of the latter distribution. I made no attempt whatever to deal with the literature of paralysis of the limbs or shoulder-girdle muscles complicating herpes zoster, which I mentioned as being relatively more frequent owing to the closer association of the anterior and posterior spinal nerve roots in the lower cervical region than in the thoracic region.

The case which Dr. Parkes Weber recorded in 1915 was a brachial paralysis, and the nine references he gives all concern paralysis of muscles supplied from the spinal roots concerned in the formation of the brachial plexus—namely, paralysis of muscles of the upper extremity and shoulder girdle. I myself have met with two such examples, and it was my intention to deal with this form of paralysis in a subsequent communication.—I am, etc.,
London, W., June 24th. C. WORSTER-DROUGHT.

HOUSE DISINFECTION.

SIR,—A recent decision in the King's Bench Division by Mr. Justice McCardie on the need for house disinfection as an important factor in the control of tuberculosis raises issues regarding infectious disease and disinfection alike important to the practitioner of curative and of preventive medicine.

In their relation to disinfection, infectious diseases may be regarded as constituting three groups. The first group would include the majority of common infections—scarlet fever, measles, whooping cough, cerebro-spinal fever, and typhoid, from all of which infection is spread either from actual cases of the disease or from carriers, the infectivity of contacts being in all probability due to whether or not they happen to be carriers of the infection. The liability for fomites in this group to play the important part attributed to them in the past has less significance in the light of the carrier problem, and as a result the practice of home disinfection by chemical means after scarlet fever or diphtheria has now been largely given up as redundant by many medical officers of health. Chemical disinfection of an inhabited house fails therefore to control the spread of the above series of infections for two reasons: first, because no effect is produced upon carriers, who are mainly responsible for dissemination of the infection; and, secondly, because satisfactory disinfection of an inhabited house is in many cases wellnigh impossible without resorting to almost impracticable measures to ensure chemical cleanliness. Equal benefit has in these infections been found to result from disinfection of the fomites of the actual case, together with house cleansing, apart from any further attempts at disinfection by chemical means of the premises during occupancy.

In the next group the carrier is an invertebrate, actual cases of the disease apart from the carrier being non-infectious, as for example in typhus fever. Other examples might be quoted, such as trench fever and relapsing fever, both of which, like typhus, are due to infection spread through the common louse. Disinfestation and delousing are, therefore, of importance in controlling the dissemination of such diseases, destruction of the carrier being the most important part of the task of prevention.

A third group would be represented by tuberculosis disseminated in the pulmonary type, through infected sputum, whether recently exhaled or in dry dust months after its extrusion. In the case of tuberculosis, with its absence of carriers, home disinfection can, with proper precautions, be carried out either after the removal of an infective case from his former surroundings, or, with greater satisfaction, should be enforced as a valuable public health measure, compulsorily, if necessary, when the premises are vacated. The ideal time to disinfect a house is on vacation, a fact that might well be considered by owners a matter of self-protection, before re-letting, in any case where a previous tenant is known to have had infectious disease in his household.

Apart from personal fomites care need only therefore be directed to the acquisition of ordinary domestic cleanliness and supervision of contacts in the first group, delousing of contacts and disinfestation of premises in the second, whilst in the third domestic and chemical cleanliness should be carried out as effectively as possible, the absence of a carrier in tuberculosis being obviously an additional asset in the more effective control of this disease, by disinfection.—I am, etc.,

Croydon, June 26th.

K. SIMPSON, M.D., D.P.H.

Obituary.

SIR JAMES REID, Bt., G.C.V.O., K.C.B., LL.D.,
F.R.C.P.,

Physician-in-Ordinary to the King.

WE regret to record the death, on June 28th, at the age of 73, of Sir James Reid, Bt., G.C.V.O., K.C.B., Physician-in-Ordinary successively to Queen Victoria, King Edward VII, and King George.

James Reid, son of Dr. James Reid of Ellon, Aberdeenshire, was born in 1849, and was educated at the Grammar School of Aberdeen and then at the University of that city, where he graduated M.A. in 1869 with honours in natural science and a gold medal. He took the degrees of M.B. and C.M. three years later with highest honours, and the M.D. in 1875. He practised in London for two years, and then was in Vienna in 1876 and 1877 for post-graduate study. Returning home, he settled down in general practice at Ellon, and in 1881 he was introduced into Court circles by being given temporary charge of the Royal household at Balmoral during the illness of Dr. William Marshall, who had been resident physician to Queen Victoria for several years. When it was seen that Dr. Marshall would be unable to take up his duties again, Dr. Reid was appointed in his stead and moved with the Court to London.

At first he acted under the supervision of Sir William Jenner, who for years paid a weekly visit to Queen Victoria except when the Court was in Scotland or abroad. Reid was undoubtedly an able and tactful man, and he soon gained the full confidence and respect of Sir William Jenner as well as of his patients. He proved very successful in what must have been a difficult position, and in 1887 was appointed Physician Extraordinary to the Queen. Sir William Jenner's health broke down about this time, and in 1889 Dr. Reid became in title, as well as in fact, Physician-in-Ordinary to Her Majesty. His duties at the Court occupied him fully, and as he was constantly in residence there he engaged in no other practice. The Queen thought very highly of Reid, and was accustomed to seek his advice in many matters not connected with medicine. She made him a C.B. in 1889, K.C.B. in 1895, and a baronet in 1897; in 1901 he was made G.C.V.O. A few years before her death the Queen bestowed on him a house within the precincts of Windsor Castle. After her death Reid continued as a Court physician, but the late Sir Francis Laking was rather the personal medical attendant of King Edward VII, and Reid took a house in London. He relieved Laking at times, attending often on Continental visits, and also taking part charge when the King was ill at home. In 1901 he was appointed Physician-in-Ordinary to the Prince of Wales, and on King George V's accession (1910) he was continued in that office.

While Sir James Reid was physician to Queen Victoria he resided always with the Court and was but little known to the medical profession, but after her death he lived in London and mixed more with his professional brethren, who were able to judge of his personal character and medical capacity, and formed high opinions of both. Reid became a Member of the Royal College of Physicians in 1887, and a Fellow in 1892. He was consulting physician to the King Edward VII Sanatorium, Midhurst. He received many decorations from the various Courts which he visited with Royal patients.

He married in 1899 the Hon. Susan Baring, daughter of Baron Revelstoke, one of the Maids of Honour to Queen Victoria, and leaves two sons and two daughters. His eldest son and successor was a Page of Honour to King George, and distinguished himself at Cambridge, obtaining a first class in the classical tripos, Part II, last year.

A memorial service was held on July 3rd at the Chapel Royal, St. James's Palace, when the Archbishop of Canterbury officiated. A large congregation was present, including representatives of the King and Queen and other members of the Royal Family.