

Fractures of the Mandible

SIR,—Referring to your report of the meeting of the Medical Society of London, at which fractures of the mandible were discussed, it would be interesting to know what is the best method of procedure in these cases, tabulated thus:

1. Immediate treatment of the tooth-bearing area and behind it—(a) with teeth, (b) without teeth.
2. Later treatment.

Fortunately I have only had to deal with fractures of the tooth-bearing area in patients with teeth, and I have (following Sir Frank Colyer's teaching) extracted the tooth at each side of the line of fracture. This I have always considered a *sine qua non*. Then has followed the reduction of the displacement, and keeping this in position by means of wire or salmon-gut sutures round the occluded teeth. I admit that cap splints are better, but they take time to make, and are not always forthcoming, and in any case they come under "Later treatment."

Is it always advisable or essential to give an anaesthetic? Surely, in this enlightened age, skiagraphs should never be omitted? It is a subject that has received scant attention, for quite recently I saw a patient—a young man with complete teeth, his mouth open, dribbling saliva, and who was in acute pain and discomfort—who had been sent home from a general hospital, where the only treatment he had received was a bandage to support his chin. I told him to report at the end of a week.—I am, etc.,

WRIGHT LAMBERT, M.R.C.S., L.D.S.

Brentwood, Essex, Oct. 30th.

Rheumatic Fever and the Tropics

SIR,—In the *Journal* of October 22nd Professor T. A. Hughes writes that rheumatic fever occurs in the subtropical part of India; but the important part of his letter is at the end, where he points out that the majority of his patients "come from villages where there are no sewers of any description, sanitation being of the most primitive type."

Professor Hughes's letter does not affect the facts that I have set forth. I observed as far back as 1896 that rheumatic fever was so seldom met with or diagnosed in the Tropics that it is doubtful if the true disease ever occurred in those regions. I found later that the common rat flea of temperate climates, *Ceratophyllus fasciatus*, was not to be found in the Tropics. From this flea I was led to the brown rat, *Rattus norvegicus*, which also is not a natural denizen of the Tropics, and from the rat to the broken drain. This flea, this rat, and a broken drain are commonly found in association with the environments of rheumatic fever in temperate climates, though in some places, such as Northern India, the flea, *Ceratophyllus fasciatus*, may be replaced by a *Ceratophyllus* such as *punjabensis*—a species of a closely allied group. In this connexion it must be remembered that more than one species of anopheline can carry malaria.

The broken drain is not an essential part of my hypothesis, as cases of rheumatic fever occur in agricultural districts of England where there are cess-pits only and no drains. I have been trying, however, to connect up the disease with a certain kind of insanitary condition, and in this the statements in Professor Hughes's letter give me support. But what I have tried to uphold more than anything is that the one important environment of rheumatic fever is that of temperate climate, and that this, with the great difference in the geographical distribution of the disease, which cannot be due solely to temperature or humidity, should give a clue the following up of which ought to show the cause of the disease.—I am, etc.,

Harrow, Oct. 29th.

J. TERTIUS CLARKE.

Erythromelalgia

A Request

SIR,—I desire for purposes of investigation a few patients displaying severe burning pain in the feet, accompanied by redness of the skin and aggravated by warmth and the dependent position; and should be grateful for the name and address of any such patient who would be willing to attend my out-patient department at University College Hospital.—I am, etc.,

Department of Clinical Research, THOMAS LEWIS.
University Hospital Medical School, W.C.1.
October 26th.

Obituary

A. FREELAND FERGUS, M.D., LL.D.

F.R.F.P.S.GLAS., F.R.S.ED.

Consulting Surgeon, Glasgow Eye Infirmary

There passed away on October 24th, rather suddenly at his home in Rothesay, Andrew Freeland Fergus, formerly President of the Royal Faculty of Physicians and Surgeons of Glasgow, and of the Royal Philosophical Society of Glasgow, with which he had a long and honoured connexion. Early in his career he chose ophthalmology as his life-work, studied at Utrecht and Paris, and finally settled in Glasgow, where he was appointed surgeon on the staff of the Glasgow Eye Infirmary. During his time he wrote many papers on various subjects, connected with ophthalmology and unconnected with it, published a book on elementary ophthalmic optics, and devised several original operations.

He was born in Glasgow in 1858, where his father, Andrew Fergus, M.D., was in practice. He graduated M.B., C.M. in 1881, and proceeded M.D. ten years later. In 1884 he was elected F.R.F.P.S., and in 1921 his university conferred on him the honorary degree of LL.D. For some years he was professor of ophthalmology in Anderson's College, and consulting ophthalmic surgeon for the Corporation of Glasgow. During the European war he was a member of the staff of the Fourth Scottish General Hospital, with the rank of major R.A.M.C.(T.), and was mentioned for services rendered. When the British Medical Association met at Glasgow in 1888 he was honorary secretary of the Section of Ophthalmology, and at the Annual Meeting at Swansea in 1903 he was vice-president of the same Section. He represented the Glasgow and West of Scotland Branch on the Council of the Association from 1898 to 1903, and he served on the Arrangements Committee for the Annual Meeting at Glasgow in 1922.

Fergus introduced the use of the refraction ophthalmoscope and Snellen's metrical distance test types in the Glasgow Eye Infirmary, where previously types arranged for feet measurement had been in use, the sterilizing of instruments and dressings, the culture of conjunctival and lachrymal sac secretions prior to operation for cataract, and other operations for general investigation. His operations for ptosis and hypertrophic conjunctivitis are original, and he was probably the first in Scotland to remove the lachrymal sac. His advocacy of advancement *versus* tenotomy as a primary operation for squint came early in his career, and this he learnt from Landolt, and was strong in his opinions in the matter. Two other operations were original—one that of making a groove in cases of contracted socket, and the other a trephine modification of the Lagrange operation for glaucoma.

A colleague writes: Fergus was a born teacher, both in the classroom and in the clinic. He had large classes, great enthusiasm in his work, and patience with students,