"Not always at first." The microbic invasion of the peribronchial tissues and the influx of leucocytes that follows (giving rise to mottling) is, I am convinced, nearly always micrococcal. Whether, and how soon, tubercle bacilli arrive there and begin to multiply depends on individual susceptibility to tuberculosis, and this may be inborn or acquired, or both—a fatal combination! Acquired susceptibility to tuberculosis, again, may be local or general. By "local" I mean that a chronic micrococcal infection of some portion of the lung impairs the resistance of that portion and renders it unnaturally susceptible to tuberculosis. By "general" I mean that a general toxaemia renders *all* tissues of the body prone to attack, since the toxaemia depreciates their natural resisting powers, and wherever tubercle bacilli lodge they are able to multiply and gain a firm foothold.—I am, etc.,

ALFRED C. JORDAN, M.D.,
M.R.C.P., D.M.R.E.

London, W.1, Sept. 10th.

Pineapple Juice in Oedema

SIR,—I was much interested in the letter on the above subject in the *Journal* of September 8th (p. 492). During an outbreak of beri-beri in the gaol at Kuala Lumpur, Federated Malay States, in the years 1896 to 1898, the Chinese patients with dropsy invariably asked for pine-apple. They said it was good for reducing the swelling. Their request was granted as a placebo, although I thought at the time it might act as a diuretic. The dropsy subsided, but, as they were given other diuretics, I could not attribute its disappearance entirely to the pineapple. I may state that Chinese patients suffering from dropsical beri-beri in other State hospitals also always asked for pineapple.—I am, etc.,

A. J. MCCLOSKY, M.D.
Retired Senior Medical Officer, Selangor, Federated Malay States.

London, W.13, Sept. 17th.

"Port Sanitation and Common Sense"

SIR,—"Port Medical Officer" (September 8th, p. 491) has not perceived that my criticism of port authorities is almost entirely directed against *foreign* ones. He cannot have had much experience of these individuals, especially the Mediterranean and South American varieties, each of whom sees himself as a petty Cerberus in charge of the national safety, and to whom the mention of *any* kind of illness (even accidents!) arouses visions of dread epidemics, the ship being regarded as a sort of dung-heap which must forthwith be "disinfected" at a heavy charge to the owners.

In British ports a standard health questionary now at long last prevails in which the question, "Have you had any cases of illness on board whether of an infectious nature or not?" does not occur. "Port Medical Officer" does not see that I was referring here to cases which have occurred during the early part of a voyage *and have since completely recovered*. Why should the ship surgeon almost always be regarded as ignorant or inexperienced in regard to such cases of minor illness? Or, if he must be so regarded, why is no supervision exercised over the general practitioner ashore? Surely he is just as likely to miss ambulatory cases of small-pox, gonorrhoeal sequelae, and typhoid fever as the ship surgeon. What of the port medical officer himself? Is *he* entitled to claim medical omniscience?

Speaking from over ten years' sea-going experience in all parts of the world, I would say that the vast majority of these minor maladies are found to be mares' nests in regard to their danger to the community. In regard to the remainder, it is sad to relate that British law, being the ass that it is, is sometimes woefully lacking. Witness the *Tuscania* affair. This ship landed a case of small-pox at Marseilles homewards. On arrival at Liverpool, though obviously contacts were on board, the ship could not be quarantined in the absence of actual cases. The result was a small epidemic ashore. Surely this requires amendment.

I trust that "Port Medical Officer" will not consider my remarks as directed against himself or other officers in British ports, whom I have almost invariably found sensible and friendly. It is the crass futilities and absurdities of foreign port sanitation procedures that I am up against. Surely the time has come when all such procedures should be made internationally uniform, and some system of checking a ship from point to point of its voyage be established in place of the present one of treating it as an "unknown quantity" at every port.—I am, etc.,

SHIP SURGEON.

September 9th.

Injuries of the Knee-Joint

SIR,—I have just read Dr. Stewart's letter (July 7th, (p. 40). I am as unwilling as he is to perpetuate old heresies, but I am equally unwilling to subscribe to new ones. I hasten to assure him that I have never seen a joint "locked" in extension, but I read his letter to mean that he had. Absence of full extension presupposes some degree of flexion, and I suggest to him that in his cases the injury occurred during an attempt to re-extend the joint after a temporary flexion—that is, a rebracing under strain.

I welcome his suggestion of a slow-motion picture—if he is fortunate enough to obtain one I feel he will change his views. In the meantime perhaps he will describe the mechanism by which injury to a cartilage occurs in a fully extended knee-joint without severe damage to other joint structures.

I regret it was not clear that the last paragraph of my letter (June 23rd, p. 1142) referred to another part of Mr. McMurray's paper—that on crucial ligament injuries.—I am, etc.,

G. STEWART WOODMAN.

Newcastle-on-Tyne, Sept. 11th.

The Swab in Diphtheria Diagnosis

SIR,—I have read with considerable interest correspondence on this subject. As a medical officer of health and superintendent of a fever hospital I have seen a considerable number of cases of this disease during the past fifteen years, and I would like to make the following observations:

1. The diagnosis of diphtheria is by no means as simple as some of your correspondents would maintain; in the early stages of the disease I would defy any expert to diagnose many of the cases.

2. If a practitioner is in any doubt that a case is clinically diphtheria he should not only take a swab, planting the swab exactly upon the suspected area on the tonsil or elsewhere, but should also remember that in quite a number of cases a nasal swab will give a positive result where a throat swab will not. But if there is clinical evidence which renders the practitioner doubtful as to the case being diphtheria it should at once be given at least 8,000 units of concentrated antitoxin, and if the history is longer than twenty-four hours such a dose should be doubled or trebled. Many a child's life would be saved if only this procedure were adopted.

3. It is my sad experience that in all cases of faucial diphtheria, if no antitoxin has been given prior to the fourth day of the disease, if they are true clinical