it is given in an early stage of the disease. And, further, that if given in a doubtful case, which proves not to be diphtheria, the antitoxin is at any rate harmless. With such a potent remedy in your hands, how comes it that preventive inoculation is required?

2. An antitoxin has been in use for some thirty years ; how comes it that, according to the Registrar-General's returns, the death rate from diphtheria has declined no more rapidly than has been the case with measles, scarlet fever, and whooping-cough, for which no specific remedy has been employed? Has antitoxin proved a less efficient remedy than was expected?

I shall be grateful for any suggestions as to how these questions ought to be answered.—I am, etc.,

Leamington Spa, Sept. 16th. R. T. BOWDEN.

*** These questions are dealt with in an annotation on page 673.—ED., *B.M.J.*

Puerperal Streptococcal Septicaemia

SIR,—Much publicity has been given this subject in both the medical and the public press. It has been to the disadvantage of both the practitioner and the patient. To the former, because authorities who ought to know better have been pleased to apportion the main share of the blame to him ; and to the latter, because young women have developed a fear of motherhood, which is most detrimental to their general health during pregnancy. Statistics on this subject do not, in my opinion, bear out the conclusions their creators seem to draw from them. Perhaps, however, the culprit was discovered before the statistics were completed ; and so the general practitioner is blamed by the public and by some of his own brethren.

Most of us in general practice have attended a great number of confinements and, being human, make mistakes. We know in most cases, however, when to apply forceps. Most of us also find that it is not our forceps cases which as a rule become septic, but often the normal easy case, while a difficult forceps delivery under unsuitable and most unhygienic surroundings will have an uneventful puerperium. This leads one to the conclusion that the most probable cause of puerperal septicaemia is " inherent infection " plus " lowered general resistance " of the patient. When a person receives a slight hurt and develops acute osteomyelitis, a slight cold and develops pneumonia, or for some still more obscure reason develops appendicitis, we recognize that the infection is inherent, and that hurt or cold has simply lowered the general resistance, and so brought about the acute illness. Why not recognize these factors more openly in the case of puerperal sepsis? It would be a gracious act if some of our specialists, whom we know and recognize as being much more efficient than we are, would do a little in public to uphold the prestige of the much-maligned practitioner.

I am most grateful to Dr. A. G. C. ffolliott for his most interesting and helpful letter in the *Journal* of August 24th, on the possible use of anti-scarlatinal serum as a prophylactic measure against puerperal streptococcal septicaemia. It seems an excellent idea, as every pregnant woman, no matter how easy her confinement may be, or how well she may have been during her pregnancy, is liable to become septicaemic. Some infection may be lying ready for the turmoil of labour to liberate it, and so precipitate the onset of puerperal sepsis. Would the routine administration of anti-streptococcal serum at the onset of labour not save a great many cases? I would be grateful for advice on this matter, as it seems to at least offer us some hope, and we have already had too much wrong and unhelpful criticism.—I am, etc.,

Clydebank, Oct. 1st. W. D. ALLAN.

Sensational Publicity for Medical Matters

SIR,—The B.M.A. would surely be rendering a valuable service to the community if, as Dr. W. J. McCardie suggests in your issue of September 28th, it would bring to the notice of the Press Dr. Dain's important resolution regarding the danger of sensational publicity. Probably the editors of lay newspapers have no idea of what damage such emotional notices may cause, otherwise they would surely refrain from publishing them. All anaesthetists, especially those who practised before the days of premedication, must occasionally have come across a patient about to be anaesthetized who, owing to fear, is in a " blue funk," with lips blue, the extremities blue and cold, and the pulse and respiration feeble—a perilous condition which may persist until anaesthesia has been well established and one which calls for especial caution during induction. It is of interest to note that these patients almost invariably give a history of having been frightened by reports of deaths due to anaesthesia.—I am, etc.,

Bristol, Sept. 30th. ARTHUR L. FLEMMING.

Complications of Tracheal Intubation

SIR,—I am very grateful to Dr. R. J. Clausen (*Journal*, September 28th, p. 601) for drawing my attention to his case of laryngeal granuloma following intubation. I must beg his pardon for having overlooked it. The fact that this complication has occurred in the hands of one so much more experienced than myself affords me some consolation, however slight it may be.

I was very interested to read Dr. I. W. Magill's comments. Dr. Magill is, of course, a master in all that appertains to anaesthesia, and especially of the technique of intubation, and to have drawn his fire, however devastating, I take as a compliment. On the other hand, I hope I shall not be accused of *lèse-majesté* if I join issue with him on certain particulars. Thus, with reference to the size of tube used, Dr. Magill states that " size 4 is inadequate for the respiratory requirements of an adult woman." This may be so theoretically, but I have never found it to be so in practice. I do not use the method of insufflation, but I have never found respiratory or circulatory distress from the use of a tube of this size. I have breathed through such a tube myself with the nose clipped for some time without any difficulty. Personally, I feel that with the use of a larger tube—even if it be a soft one, and I agree that soft tubes are preferable—the pressure on the delicate mucous membrane of the nose and larynx is greater, and, with it, the liability to trauma. The risk of subsequent sore throat is therefore increased with a larger tube, and I feel that, in spite of the theoretical objections, the use of a smaller tube is justifiable and in most cases adequate.

I note that Dr. Magill prefers the " blind " method, and considers that its use " has proved to be a definite advance in the prevention of trauma." I know that Dr. Magill is an expert at " blind " intubation, and in his hands this may well be so. But is this necessarily true? A blind intubation, neatly carried out, often earns the approbation of one's surgeon ; from this point of view it is an effective and spectacular procedure. But I cannot believe that a surgical manipulation carried out blindly is to be recommended for its own sake in preference to visual methods. What would we think of a surgeon who ordered the theatre lights to be extinguished during his operating session? Perhaps this is not a fair comparison, but I do feel that the very spectacular nature of the blind technique often blinds us to its disadvantages. On the other hand, with the aid of the laryngoscope, every movement of the tube can be controlled under