upon any upper respiratory infection provided the necessary physical activity is maintained.

Upper respiratory catarrh is extremely common in this country, yet the syndrome of primary atypical pneumonia remains in general rare. When it does occur, in my experience it tends to be epidemic and characteristically is *not* preceded by upper respiratory infection. To me it is quite as clear an entity as measles or chicken-pox, and in these the organism or virus has not yet been isolated. It is almost invariably ushered in with an intense headache and with an oppressive pain behind the upper sternum. Neither of these symptoms was mentioned by Drs. Robertson and Morle.

The incubation period in the epidemics I have seen has been 12–18 days—i.e., the cases occurred in groups at this interval. Most occurred in schools. Response to "aureomycin" and "chloromycetin" has been dramatic; penicillin and sulphonamides have shown no therapeutic effect.

If we are to accept the authors' suggestion that the syndrome is due to the aspiration of catarrhal secretion it is curious that although the organisms of such secretions are almost all penicillin-sensitive, yet penicillin fails to lower the temperature or influence the condition, whereas aureomycin does. While perfectly prepared to accept their theory of the pathology of that condition I still adhere to the opinion that there is a specific disease or group of diseases which is characterized by (*a*) fever, slow pulse, severe headache, sternal pain, and a patchy pneumonic consolidation with a characteristic radiological appearance; (*b*) failure to respond to penicillin and sulphonamides; (*c*) rapid response to aureomycin and chloromycetin; (*d*) a high titre of cold agglutinins and in many cases agglutination of the M.G. streptococcus.

It may well be that cold agglutinins occur in other conditions—e.g., infective mononucleosis—but I have yet to hear of any condition in which the cold agglutinins have so high a titre. Reimann (*Medicine*, 1947, **26**, 177) would not accept a titre lower than 1:32. In my small series it varied from 1:256 to 1:1,280. All throat swabs taken showed non-specific results and all sera showed insignificant reactions to the known viruses.

In my opinion any further evidence in the elucidation of this syndrome must largely come from workers in the field, the general practitioners, who alone are in a position to study the epidemiology of such a condition, since few cases are admitted to hospital.—I am, etc.,

Northwood, Middlesex. DUDLEY M. BAKER.

Erysipeloid of Baker-Rosenbach

SIR,—I was interested in Drs. J. E. L. Price and W. E. J. Bennett's article (November 3, p. 1060) on the erysipeloid of Rosenbach (or, more accurately, Baker–Rosenbach, as suggested by Roederer and Lanzenberg[1]). It is, of course, far from a rarity. It is a common mistake for our more academic colleagues to assume that because they seldom see or read about a disease it must therefore be rare; McNeill Love[2] even suggests that this is due to frequent misdiagnosis. The fact is that erysipeloid is well known to many practitioners who treat and cure their patients without reference to hospital.

The clinical features are pathognomonic, and the disease ranks with mongolism, pink disease, etc., for, having once been seen they are never forgotten. Unfortunately Price and Bennett have omitted to mention the single most important clinical feature, dismissing the colour of the lesion as "dusky," which just means dark coloured. The lesion is a dusky reddish purple plum colour which is unmistakable. The patient confirms this subacute appearance with the evidence that it has been present for one or more weeks, the long stage of invasion excluding a pyogenic infection. The satisfaction that Price and Bennett get from "subjecting the patients to biopsy" is derived more simply from discovering an occupational hazard in most cases. Whilst severe pain may be present and such cases are more likely to reach hospital, it is misleading to suggest that this is a feature. The patient more often says, "I'm sorry to waste your time with this, but . . ." "It's been so long, my husband told me to come," etc., statements not indicative of severe pain. Several times I have noticed erysipeloid in the fingers of friends or patients seen for something else. The discomfort may be trivial. Itching may be prominent.

The widespread saprophytic nature of the erysipelothrix is further suggested by the fact that, although erysipeloid is commoner in those handling meat and fish, it also occurs in greengrocers. I have seen two such cases, and Iselin[3] makes this point. An inquiry in Covent Garden would be interesting. The shops euphemistically self-styled, and referred to by Price and Bennett, as "Continental butchers" were known as "Bonzo's butchers" the day before the ban on horse-meat for human consumption was lifted. As long as a horse is worth more to the knackerman than as a horse, erysipeloid is the least one can wish on these vandals. If I am correct in supposing that the "Continental butchers" handle horsemeat, it is surprising that Sneath, Abbott, and Cunliffe could find only one reference to "isolated infections" in the horse in the veterinary literature.

In my experience seven daily injections of 600,000 units of procaine penicillin are curative and enough to prevent a relapse. Sulphonamides are unnecessary, and it is distressing to read that Price and Bennett still use sulphadiazine, especially dangerous when entrusted to an out-patient. The risk of anuria is too great to permit any other choice than sulphamezathine (which is so innocuous that it is becoming more of a food than a medicine). Efficient and early treatment is desirable, as articular stiffness is sometimes a troublesome sequel of erysipeloid (Buzello[4]). The patient may be simply reassured that two to three weeks will usually see the end of his symptoms. Price and Bennett's statement, "Thus, of the 15 patients of whom we have full details, 7 (47%) were symptom-free within six days, and 11 (73%) within 12 days," must have brought an extra loud blast from Mr. Grant Waugh's trumpet.

Price and Bennett have done a service in again drawing attention to erysipeloid, but the implication that it is either uncommon or widely misdiagnosed cannot be allowed to pass unchallenged.—I am, etc.,

Worcester. C. ROMER.

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2 Love, R. J. McNeill (1949). *British Medical Journal*, **2**, 1411.
3 Iselin, M. (1940). *Surgery of the Hand*, p. 154. London.
4 Buzello, A. (1935). *Report to the 7th International Congress of Industrial Accidents*, Brussels, p. 517.

Plain Words

SIR,—The neglect of the linguistic evolutionary point of view occasions Dr. B. Isaacs (October 27, p. 1032) unnecessary heartache. Language cannot be regarded as a museum piece like the stone axe, the bronze hatchet, and the bow and arrow. It is something very much alive, growing and expanding and constantly escaping from those semantic, syntactical, and accidencial constraints in which the linguistic anatomist of the grammarian would contain it. Such a person is inclined to look to what words *are* rather than what they *do*.

The purist or would-be purist in language is invariably vulnerable on the very ground he so stoutly champions. Thus to one like myself, who is not a purist and who zealously and habitually eschews the sesquipedalian utterance in favour of those cogent and pungent brevities which approximate to basic English, such an opening sentence in Gowers's *Plain English* as, "This book was written at the invitation of the Treasury," or Isaacs's, "But I should like to conclude with an example . . ." would have been written, "The Treasury asked me to write this book," and, "I want to end with an example. . . ." It is a pity that Dr. Isaacs chose Gowers's *The A B C of Words* as a model, for, apart from its being a very poor imitation of Fowler, a worse example of a book which falls into many of the errors it exhorts others to avoid could scarcely be found—and that right from the first paragraph, which is uneven in style, alternating between mandarin English and the colloquial, which begins with the passive and then swings over into the active, which is verbose to the extent of being

easily condensed into half, at least, of its present size, and whose meaning could be more easily grasped by the judicious employment of inverted commas. Dr. Isaacs's letter shows similar peculiarities: apart from its unevenness and colloquialisms foreign to the august columns of the *British Medical Journal*, he, for instance, uses "penchant," a word which has never become naturalized in the English language, attacks "obstetric colleague," which satisfies the linguistic canons of the schoolmarm, and the employment of "follow-up" as a verb, adjective, and noun as if that were either something new or reprehensible in English, whereas in the hands of Shakespeare and the lesser lights it was one of the advantages, even glories, of English, a tradition which doubtless Dr. Isaacs carries on in a humbler way on those occasions he *parks* his car in a car-*park* and gets a chit from the car-*park* attendant.

Dr. Isaacs (and Sir Ernest Gowers), ignoring the evolutionary linguistic point of view, does not seem to see that many of what he considers the garish and discordant linguistic practices and innovations of to-day will become the staid philological respectabilities of to-morrow, just as "Good-bye" must have at one time sounded a very slangy rendering of "God be wi' you" and "narrate" stigmatized as a Scotticism by Johnson.

Let Dr. Isaacs take heart from a sentence from the magnificent peroration which ends Bradley's *The Making of English*—"In the daily increasing multitude of new forms of expression, even though it may be largely due to the unwholesome appetite for novelty, there must be not a little that will be found to answer to real needs, and will survive and be developed, while what is valueless will perish as it deserves."—I am, etc.,

Shotts, Lanarkshire. R. GOOD.

More Blasts on the Trumpet

SIR,—Mr. W. Grant Waugh's trumpet blast (November 3, p. 1088) is indeed timely. But he needs a surgical, not a musical, instrument—a lithotrite—in order to eradicate the calculus which many of us find so painful. An example of the cerebral exaltation—I prefer the word conceit—to which he refers occurred at a recent medical meeting when, after three short papers had been read by mature and much-respected clinicians, the fourth speaker, a young medical statistician, opened with the remark, "You have heard the previous speakers with great interest; I will now give you the facts."

I think it would be fair to say, Mr. Editor, that most of your readers have little interest in higher mathematics. We open our journals in a mood of quiet enjoyment and relaxation, hoping to find something to help us in our pursuit of humanism, of the *art* of medicine. If the mathematically minded must burst into print, then let their jargon be published elsewhere, and not in our clinical journals.—I am, etc.,

Maidstone. F. TEMPLE CLIVE.

Educating the Public about Cancer

SIR,—I read with great interest the letter from Dr. James F. Brailsford (November 10, p. 1154), the main object of which, I gather, is to criticize in general education of the public concerning cancer, and in particular my article in *Family Doctor*. His first criticism is of my use of the word "cure." I agree it is very difficult to define a cure, but this applies to other diseases besides cancer. For example, when I was 14 years of age, before *x* rays were discovered, I suffered from a prolonged and obscure illness, the cause of which was accidentally discovered to be tuberculosis when my heart was *x*-rayed at the age of 60. I consider that I am cured, but the scientific proof of that belief must wait until I am dead and serial sections of my whole body are examined to exclude the presence of a single living tubercle bacillus.

The same is true of cancer, but even most intelligent patients consider that when there is no sign or symptom of a disease they are cured. The question of what yardstick of time should be used to denote a cure in the case of cancer is a debatable point, but five years without sign or symptom seems to me to be a very convenient one.

Dr. Brailsford's idea that women have an intuition about the presence of cancer of the breast is interesting, but surely he does not advocate mastectomy in such cases before there is any other evidence. If all these intuitions are correct some of the growths must develop very slowly, as there are patients whom I reassured more than 20 years ago, who so far have developed no further evidence of the disease.

The object of some of the paragraphs in the letter, such as the criminal omission to do a rectal examination, freedom of the Press, the tactlessness of some doctors, etc., is a little difficult to unravel, but I must take exception to one phrase —propaganda of fear. This suggests that my education campaign is based on producing fear. Fear is a justifiable weapon to use in the case of a preventable disease—e.g., diphtheria, venereal disease, etc.—but if used in cancer it would defeat the very object it has in view—namely, earlier diagnosis. The whole object of cancer education in this country is to diminish fear, which—and I gather Dr. Brailsford agrees—is the main stumbling-block to earlier diagnosis.

Everybody will agree that when a cure (Dr. Brailsford uses the word in this connexion) is found for all types of the disease, and in all its stages, cancer education will no longer be necessary. Meanwhile, what does Dr. Brailsford propose to do? Surely he is not satisfied with the *status quo*?—I am, etc.,

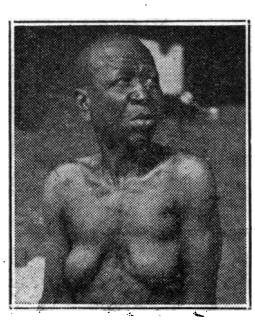
London, W.1. MALCOLM DONALDSON.

SIR,—The article in *Family Doctor* which Dr. James F. Brailsford criticizes (November 10, p. 1154) was written by a recognized authority in this field, who freely admits that treatment fails in 25% of early growths. As an expert his results are perhaps better than the general average; but if only 10% were cures the effort would be worth while. But what is "cure"? We cure all manner of disorders, but have never agreed upon a satisfactory definition of the term. Some maintain that we do no more than relieve. Yet surely a man or woman who is happy, interested, and in reasonable bodily comfort 5, 10, or 15 years after operative or other treatment of early cancer may be said to have achieved something remarkably like the popular notion of a cure.

There is much that can be done about cancer if its presence is detected early, and this presupposes some awareness among the public through carefully designed cancer education. Given a little more knowledge the failures might have sought help sooner and would perhaps be listed in the other column. The opposing view, which Dr. Brailsford seems to endorse, is that we should sit tight and do nothing since nothing's no good. Of these opposites but one can be right, and there can be no doubt about which is the more rewarding.—I am, etc.,

Bognor Regis. H. D. LIVINGSTONE-SPENCE.

Gynaecomastia in a Leper



Tamale, Gold Coast.

SIR,—The history of the patient in the photograph is as follows: He is about 40 years, married, and has one daughter aged 12. He developed leprosy nine years ago. Three years later he developed gynaecomastia. His genitals are normal. Dr. C. Bowesman has a similar photograph of a case seen in the Gambia. He remarks that it is fairly common in lepers.—We are, etc.,

J. C. V. MURPHY.
M. P. BROWNE.