you ?" I reply with feeling, "I do, I do." Life is certainly becoming more difficult. Even the hypochondriac can have little pleasure in his illness, for with the enormous increase in remedies there is the constant anxiety lest a cure be found for his particular complaint.

My opinion is that this problem is not psychological but philosophical. I have found, in this country practice, that my patients have required my help at a regularly increasing rate during the last 17 years, and the war years and the Health Service did not alter this regular yearly increase with approximately the same number of patients. Moreover, it seems to take me longer and longer to do less and less. The attitude to life which appears to be almost universal is increasingly based on the attitude, "Why should I have to do this ?" or, "Why shouldn't I have that ?" and we are so busy asking these questions, to which we do not wish to have the answers, that it leaves us with little time for anything else. As Sir Robert would say, it is a mentally constipating and physically exhausting process.

Patients, for instance, are wondering if they are receiving all that they have paid for, and this provokes the attitude, "Am I being paid for all that I am giving them ?" As one of my patients so truly remarked on the advent of the shilling charge for prescriptions, "We was better off as we was before this scheme." He was quite right, for I had sent him numerous accounts in the good old days and he never paid any one of them. But in those days he did repay me with gratitude.

"Frustration" and "overwork" are banished by happiness, and I believe happiness is a result of giving and receiving rather than buying and selling. I would therefore suggest that these factors are philosophical and are incorrectly referred to as psychological problems. I should be grateful to learn whether philosophers undertake therapeutic measures, or do they merely utter aphorisms. For my own part, with my limited experience, I have yet to find a patient who has been cured by psychological methods unless the treatment included electric shocks.

That famous philosopher of the old music halls, Marie Lloyd, gave some useful advice, but more recently Mae West was on a more solid foundation when she said, "Take it easy, big boy, you'll last longer."—I am, etc.,

Boston, Lincolnshire. N. J. BEE.

A Gastric Gossip

SIR,—Your issue of Saturday, July 19, has just reached me, and I read with great interest Sir Arthur Porritt's gastric gossip (p. 107). It would be important to substantiate the statement that peptic ulcer is a rare condition in the black races. First, one must take into account the considerable variations in disease among the races within the race—due to epidemiological, climatic, sociological, and tribal differences—even within the single political entity of an enormous country like Nigeria. Secondly, what we see in our hospitals may or may not be typical of the world outside in village and bush. In our tropical institutions we touch only the fringe of the problem of health and disease. Some people like coming to us like those of the western region; others, like the tradition-bound Hausas, avoid us, as we are reminded in passing their village streets filled with bodies of the crippled and diseased. What can be said, however, is that in our hospital at Ibadan the peptic ulcer problem is very much with us and that for the past year numerous and severe cases have come for operation. In fact, peptic ulcer is the outstanding abdominal complaint—acute abdominal cases apart—and rivals in frequency the cases of complications of parasitic infection.

As for a "hectic environment," tropical man's struggle for existence may be as hectic as anybody's; the idea, however, that the "speed around him" has anything to do with our problem does not apply in Africa, and seems to me to have become just a phrase in our books and dissertations. Maladjustment to the struggle—yes, perhaps, but speed—in equatorial Africa ? One final word on the advice to transfer the dyspeptic from "ulcer-prone countries" to tropical regions. A journey to Africa will benefit everyone, but it would hardly be specific treatment. In nine months I have dealt professionally with six Europeans (out of a small community) in various phases of the ulcer trend. A long-standing member of our College who had a gastrectomy, and the tragic death of an "old coaster" in Government service who refused to have himself pensioned off in order to stay the course prescribed for a full pension and who eventually perforated, come especially to mind.

It should be borne in mind that only very slowly does the unemancipated African find his way into our care and statistics; any generalization on what does and what does not occur, and occur frequently or otherwise, in the "black races" must await the results of patient, thorough, and prolonged collection and analysis of data so far utterly lacking. —I am, etc.,

University College, Ibadan, Nigeria. PETER KONSTAM.

Resuscitation with Hand-bellows

SIR,—The article by Dr. E. J. Gordon Wallace on resuscitation (August 2, p. 278), and the Ministry of Supply notice on the treatment of nerve gas casualties (August 9, p. 334), will surely be of great practical interest to all first-aid and Civil Defence workers. Could not the small hand-bellows illustrated in the M.O.S. circular also be used for the resuscitation of drowned persons and patients with asphyxia due to fire, coal-gas, and electrocution ? A case was recently reported in a daily newspaper of a nurse who used mouth-to-mouth breathing and resuscitated an apparently moribund infant—surely the same principle is involved in the use of the bellows. I believe that on some anaesthetic machines the bellows can be utilized to give atmospheric air in an emergency. There may be reasons why the bellows could not be used by first-aid workers in this way—for example, fear of over-ventilation—but it would be interesting to have the views of experts on this seemingly simple method of resuscitation.—I am, etc.,

London, E.7. J. A. COPPING.

Aetiology of Rheumatic Diseases

SIR,—Dr. T. W. Lees (August 16, p. 363) reports experiments on rabbits in which a decreased skin reaction to an injected foreign protein was found in animals rendered myxoedematous by thyroidectomy. From this observation and selected observations of others he argues that the endocrine theory of the aetiology of rheumatic diseases is not plausible and that the effects produced by A.C.T.H. and cortisone acetate are those of non-specific toxic substances.

The arguments that he brings forward are so full of fallacies and the observations that he quotes susceptible of so many interpretations that it would require more than a letter to deal with them. The subjects into which he plunges may perhaps be somewhat clarified by stating these three facts. (1) The effects produced by A.C.T.H. and cortisone, like those produced by other physiological substances, depend upon the amounts administered and the state of the body receiving them. The effects of excess are deleterious, as are those of deficiency. This applies equally to such substances as common salt and insulin. (2) There is so much that remains unknown about the metabolism of hormones that it is unwise to argue that there is or is not a defect in their metabolism in this or that form of rheumatism or cancer. (3) For more than one and a half years now, at certain centres in this country and in the United States, cortisone acetate has been given continuously in the treatment of rheumatoid arthritis in daily doses averaging 62½ mg. (for adults). So far we have no proof that such dosage has interfered with normal body function or resistance to infection.—I am, etc.,

Sheffield, 3. H. F. WEST.

Trials of Antihistaminics

SIR,—Dr. O. A. N. Husain's interesting report (August 9, p. 337) prompts me briefly to mention some of our observations of the effect of a potent antihistaminic—namely, "phenergan" (promethazine-hydrochloride)—on micro-organisms *in vitro* and in experimental animals. The antibacterial properties of phenergan were presumably first