

population so long as their pneumoconiosis does not become complicated by tuberculosis, when the prognosis is much worse. The more rapid the onset of pneumoconiosis, and usually, therefore, the younger the man, the greater the liability of conversion at some time to silico-tuberculosis and the worse the prognosis. Cases with "massive fibrosis" have a worse prognosis, and cases with open tuberculosis seldom live more than two years. The liability to develop open tuberculosis appears to be much greater in cases of pure silicosis than in the various forms of mixed dust pneumoconiosis such as those of coal-workers and foundry workers. This is shown by the much higher tuberculosis death rates that have prevailed in the pure silica risk industries than in coal-mining and foundries. Other forms of pneumoconiosis than silicosis—for example, asbestosis, aluminosis, berylliosis—do not appear to predispose to tuberculosis.

The frequency with which tuberculosis is found to complicate pneumoconiosis depends upon the diagnostic criteria and upon the material used for the study. For instance, in post-mortem examinations of coal-miners Rogers⁸ found tuberculosis in 75.8% of cases with massive fibrosis, Gooding⁹ found it in 26% of all cases. Theodos and Gordon¹⁰ found a positive sputum in 13% of coal-miners admitted to hospital, whereas in a community survey in a coal-mining district Cochrane (unpublished) found that only 1% of all cases of massive fibrosis had a positive sputum. The diagnosis of tuberculosis on the grounds of a positive sputum is the only way of making the diagnosis certain. When clinical and radiological criteria are also admitted, the proportion of cases of pneumoconiosis with tuberculosis will be found to range from about 5% to 75%, depending upon the selection of cases and the diagnostic whim of the observer.

REFERENCES

- 1 MacDonal, G., Piggot, A. P., and Gilder, F. W., *Lancet*, 1930, 2, 846.
- 2 Hardy, H. L., and Trabershaw, I. R., *J. industr. Hyg.*, 1946, 28, 197.
- 3 Baader, E. W., *Z. Unfallmed. Berufskr.*, 1949, 2, 79.
- 4 *British Medical Journal*, 1949, 2, 1148.
- 5 *Brit. J. industr. Med.*, 1948, 5, 120.
- 6 *Sem. Hôp. Paris*, 1949, 25, 507.
- 7 *Med. d. Lavoro*, 1952, 43, 147.
- 8 *Lancet*, 1946, 1, 462.
- 9 *Ibid.*, 1946, 2, 891.
- 10 *Amer. Rev. Tuberc.*, 1952, 65, 24.

Shortening the List of Notifiable Diseases

Q.—Can a local authority shorten the list of diseases notifiable in its area as well as lengthen it?

A.—"Notifiable disease" is defined by section 343 of the Public Health Act, 1936, as any one of nine named diseases, plus any infectious disease which the local authority (with the approval of the Minister) may declare to be a notifiable disease within its area.

A local authority has no power to shorten the list of named diseases, but only those which became notifiable by a resolution of its own council. To remove such a disease from its list a further resolution of the council is required and also the approval of the Minister.

In addition, the Minister has power to make regulations under section 143 of the Public Health Act, 1936, for the treatment of persons affected with any epidemic, endemic, or infectious diseases, and for preventing the spread of such diseases. These regulations include provisions requiring notification of the diseases to which they apply, and may extend to the whole of England and Wales or any part thereof. Regulations made by the Minister may of course be amended or revoked by him.

Eosinophils in C.S.F.

Q.—What are the causes of eosinophilia in the C.S.F.?

A.—Very little is known about the incidence of eosinophils in the cerebrospinal fluid, and less still about their significance. Only rarely are these cells seen, and then mainly in cerebral syphilis and in some cases of acute meningitis, always provided there has been no blood admixture. Eosinophils might also be found in the C.S.F. in allergic conditions.

NOTES AND COMMENTS

Implantation of Hormone Pellets.—Dr. R. P. EDKINS, Ph.D. (Pharmaceutical Research Department, Organon Laboratories, Motherwell, Lanarks), writes: With regard to the previous notes on this matter (February 28, p. 519, and March 14, p. 632) it must, as Mr. A. R. G. Chamings states, be regarded as dangerous to boil these pellets, as most of the hormone substances used soften or actually melt under this treatment, and at the best the pellets will become deformed. A simple and invariably successful method by which either fused or compressed pellets which have been accidentally contaminated may be re-sterilized without fear of melting or distortion consists in keeping the pellets in a solution of phenol (0.5%) or phenylmercuric nitrate (0.002%) or other substance having similar bactericidal activity, at a temperature not below 37° C. or above 80° C. for 24 hours; the addition of a small percentage of a surface active agent such as cetrimide (0.025%) to the phenol solution (or other bactericide, provided there is no reaction between them) is an added advantage, as it promotes efficient wetting of the surface of the pellet. After this treatment, the pellet may then be implanted directly, after preliminary drying, if desired, on a sterile towel. It must be realized that this treatment will sterilize only the external surface of the pellet; but, since it is internally sterile by the process of manufacture, it is only the outer surface which will require re-sterilization if the pellet is accidentally contaminated. It is emphasized that it is undesirable to apply this process to pellets which have already been implanted and which have either been removed intentionally or extruded.

Poisonous Snakes.—Sir HAROLD SCOTT (Braintree) writes: Your expert in his reply on the treatment of bites by poisonous snakes ("Any Questions?" April 4, p. 793) rightly stresses the specificity of antivenins. As the use of such is generally urgent and they may not be immediately obtainable, a first-aid treatment which will delay the action of the poison deserves to be more widely known. Almost 30 years ago (in 1924) the fact was observed that soaps could detoxify snake venoms, and in 1945 Ahuja and Brooks in India showed that local injections, at four or five points surrounding the site of the bite, each of 0.5-1 ml. of 5% emulsion of "lifebuoy" carbolic soap (say to a total of 5 ml.) might delay the action of the poison for some hours, at least two and often more. Carbolic soap is to be found in many houses, and it might be kept made up in a 5% strength at local dispensaries in countries where snake-bites are likely to occur. Bleeding should be encouraged by crucial incisions.

OUR EXPERT writes: I agree that local injection of soap emulsion in the region of the bite might be worth trying in an emergency, but it should be stressed that it is only a first-aid treatment, and should never be regarded as a substitute for antivenin. The idea of using soap suspension in this way arose from some work on the effect of surface-tension suppressants on tissue poisons, including bacterial toxins and certain snake venoms. It has since been shown that soaps, particularly those of the unsaturated fatty acids, have some retarding effect on the venoms of rattlesnake, asp, cobra, krait, and ringhals. This effect has been shown both *in vitro* and *in vivo* in laboratory animals, including pigeons. I believe that the injection of carbolic soap emulsion has recently been used by Ahuja and Brooks as first-aid treatment of snake-bite in man. I am grateful to Sir Harold Scott for raising this point, which perhaps should have been included in my reply to the original question.

Corrections.—The figure for Foundation Membership of the College of General Practitioners given in the legend to the map in the *Journal* of May 2 (p. 990) should have read 1,807.

In the article entitled "Controlled Hypotension in Neurosurgery with Hexamethonium and Procaine Amide" (May 2, p. 961) by Dr. David Aserman, acknowledgment was inadvertently omitted to the fact that the procaine amide used in the investigation was generously supplied by Messrs. E. R. Squibb and Sons.

All communications with regard to editorial business should be addressed to THE EDITOR, BRITISH MEDICAL JOURNAL, B.M.A. HOUSE, TAVISTOCK SQUARE, LONDON, W.C.1. TELEPHONE: EUSTON 4499. TELEGRAMS: *Aitiology, Westcent, London*. ORIGINAL ARTICLES AND LETTERS forwarded for publication are understood to be offered to the *British Medical Journal* alone unless the contrary be stated. Authors desiring REPRINTS should communicate with the Publishing Manager, B.M.A. House, Tavistock Square, W.C.1, on receipt of proofs. ADVERTISEMENTS should be addressed to the Advertisement Manager, B.M.A. House, Tavistock Square, London, W.C.1 (hours 9 a.m. to 5 p.m.). TELEPHONE: EUSTON 4499. TELEGRAMS: *Britmedads, Westcent, London*. MEMBERS' SUBSCRIPTIONS should be sent to the SECRETARY of the Association, TELEPHONE: EUSTON 4499. TELEGRAMS: *Medisecra, Westcent, London*. B.M.A. SCOTTISH OFFICE: 7, Drumsheugh Gardens, Edinburgh.