LETTERS, NOTES, AND ANSWERS TO CORRESPONDENTS.

☞ *Queries, answers, and communications relating to subjects to which special departments of the* BRITISH MEDICAL JOURNAL *are devoted will be found under their respective headings.*

QUERIES.

THE HISTORY OF TEETOTALISM.

DR. S. G. SLOMAN (Farnham) asks for references to books or writings giving information as to any action taken in the matter of partial or total abstinence from alcoholic or intoxicating drinks in any age preceding the eighteenth century, to be used for the purpose of temperance addresses or instruction on the subject of temperance.

TINNITUS AURIUM.

HIMALAYA writes: I have suffered for twenty years from tinnitus aurium in one ear in a mild form, increased by late hours and fatigue, such as a dance, temporarily; but since November last, when there was a sudden marked fall in the temperature, it has got very loud and troublesome, with intervals of relief when the hissing noise dies down considerably. The noise is a continuous hiss, accompanied by a hum when severe. Would the noise of a gun when shooting influence it, or is it digestive?

ANSWERS.

VRILYA.—Many a good practice has been built up on quite as modest a beginning.

THE VITALITY OF THE TYPHOID BACILLUS.

MEDICO.—The typhoid bacillus could not live and develop in so powerful a disinfectant as 1 in 20 carbolic.

THE COLOUR OF THE HAIR IN OVARIAN DERMOIDS.

MR. G. H. MAPLETON writes: It may, perhaps, interest Mr. Bond to know that the colour of the hair in a dermoid cyst of the peritoneum which I removed some years ago from a negress was a light tow.

ST. JOHN AMBULANCE CLASSES.

S. H. H.—The scope of the instruction for a St. John Ambulance Class in First Aid is shown in the syllabus, which can be obtained from the Chief Secretary at St. John's Gate, Clerkenwell, from whom also all other information is obtainable. The best books to show the nature of the instruction to be given are: The official *First Aid* textbook of the St. John Ambulance Association (1s. 6d.); *First Aid in Accidents*, by Collie and Wightman, published by G. Gill and Sons, 13, Warwick Lane, E.C. (9d.); and *First Aid to the Injured and Sick*, by Warwick and Tunstall, published by John Wright and Co., Bristol (2s. 6d.). The last-named is especially valuable to lecturers, as it is fuller and more advanced than either of the others.

LETTERS, NOTES, etc.

THE *X*-RAY TREATMENT OF RINGWORM.

DR. S. ERNEST DORE (London, W.) writes: After a considerable experience of the *x*-ray treatment of ringworm, both in private practice and at the Middlesex Hospital, I venture to think that Mr. Sichel's views are unnecessarily pessimistic. There can be no doubt that the difficulties are great, but they are not, in my experience, insurmountable. I take it for granted that an experienced operator who watches the condition of his tubes during the exposure is not likely to subject his patient to serious risk. Sabouraud's pastilles no doubt afford a certain indication of the dose required for epilation in the majority of cases of scalp ringworm; but, pending the introduction—which I believe is not far distant—of a reliable milliampèremeter or instrument that will measure the direct output of the rays, I am inclined to agree with those who prefer to rely upon the appearance of the tube, length of spark-gap, and other conditions, according to the particular form of apparatus employed. It seems to me that the precautions necessary to ensure trustworthy results with the pastilles, as enumerated by Dr. Adamson, seriously detract from their usefulness.

There is no doubt that an idiosyncrasy to the action of the rays exists, although there is probably a wider margin of safety in the case of the scalp than of the non-hairy skin. I agree with Mr. Sichel in attributing somewhat greater susceptibility to fair-haired children, and if this be so, allowance must be made for it when pastilles are used. Epilation of a localized patch of tinea is usually successful, but fresh patches of the disease will often be found subsequently, due either to foci which had not been detected in spite of the most careful and repeated search, or to reinfection from loose fungus-containing hairs, or to minute stumps left in the hair follicles. Another obvious and common cause of reinfection is that children often continue to wear the same dirty caps as they did before treatment. In view of these contingencies I now epilate a much larger area than is apparently affected, or remove all the hair of the scalp if the patches are extensive and multiple. The difficulties associated with "overlapping" when several areas are exposed at a sitting are not easily overcome. In using a specially constructed shield or cap there is either the danger of exposing the borders of the areas twice over, or of leaving infected patches between them. In extensive cases I have found it more satisfactory to use an unscreened tube, and to leave an interval of some days between the treatment of different parts of the scalp.

Another difficulty is the provocation of a pustular eczematous condition probably due to increased activity of cocci in the skin or to lowering of the tissue-resistance so as to favour their multiplication. Pus infection, or seborrhoea capitis, when present at the time of treatment, is apt to become troublesome, and may even spread over the body. In one of my cases a severe and persistent erythema developed on the denuded scalp, which was certainly not entirely due to reaction from the rays, and which speedily cleared up after the use of a weak sulphur-resorcin ointment. I have also seen circinate seborrhoea of the scalp develop during *x*-ray treatment. A moderately severe dermatitis, even when accompanied by follicular pus infection, is not necessarily prejudicial to the subsequent renewal of hair, which in several of my cases has grown well, and indeed often more vigorously and of a darker colour than before.

In most of the cases treated by the single exposure method the hair falls or becomes quite loose by the fourteenth day, but this period is variable, and may extend to three or more weeks. Regrowth of the hair may also be considerably delayed, but extremely rarely fails to occur. In about one hundred and twenty cases treated by multiple exposures under the care of Dr. Pringle and Mr. Lyster at the Middlesex Hospital I have only seen one permanent alopecic patch, and that in one of the earliest cases submitted to the treatment. In forty cases I have treated for Mr. Malcolm Morris the first fifteen had exposures to a single area, varying from four to eight in number, and on the whole the epilation was more complete and less apt to be complicated than in the single-exposure cases. Some allowance must, however, be made for the fact that the former were mostly private cases and the latter inmates of charitable institutions.

Finally, I would emphasize the difficulty of locating patches of ringworm in children under *x*-ray treatment; my own belief is that this cannot be entirely accounted for by washing and the application of ointments, etc., to the head.

SOME UNUSUAL MANIFESTATIONS OF SYPHILIS IN THE UPPER AIR PASSAGES.

QUAESTOR writes: Though belated, I would yet beg the favour of a small space in your excellent JOURNAL for a few observations touching Sir Felix Semon's masterly lecture to the London Polyclinic on Some Unusual Manifestations of Syphilis in the Upper Air Passages, in the BRITISH MEDICAL JOURNAL of January 13th, p. 61. I had the unhappy experience of being in ordinary attendance upon Sir Felix's "Case I," and, from other causes than native obstinacy, still believe, as Sir Felix has said, that Case I was mercurial ulceration of an unusually violent sort. I saw the commencement of the first ulcers on the two tonsils, and they certainly were not any form of syphilis. There were no other signs of any form of syphilis anywhere. As for the two relapses ("spontaneous") quoted in the lecture—the first was before the first ulceration was quite healed—the patient went to the sea coast against my advice, and the irritating air at once inflamed the yet tender throat. The second was when the throat was quite healed; the patient contracted an influenza, and slight ulceration reappeared. On both occasions consultants could see nothing but syphilis. Mercury was poured in, and away went throat ulcerating and sloughing its hardest. The present condition of the throat, disfigured by gaps and cicatrices, as Sir Felix describes it, would certainly be produced just the same in any throat where there had been from any cause such fearful loss of tissue. Certainly as soon as sarsaparilla was administered the throat began to heal. Twice before I completely healed it with other remedies. Now sarsaparilla is stated to be of value in the cases of individuals whose systems have been "rotted," like Case I, with mercury, the drug had a grand chance here, but whether the good result was from sarsa root or from the atmosphere of Aix, and the entire absence of the antispecifics, is quite fairly an open question. Sarsa enjoyed a doubtful reputation as a cure for syphilis in the far past, and it *may* be useful in persons whose constitutions have been reduced by over-mercurialization, and in Case I this last condition was a perfect type, and sarsa had everything it could want if it was any good at all.

TRYPSIN IN CANCER.

DR. GEORGE E. KEITH (London, W.) writes: Dr. Ligertwood's memorandum on the use of trypsin in cancer is of special interest to me, as I have experimented somewhat largely with this drug since reading Dr. Beard's account of his experiments. After taking a great amount of trouble, Mr. Caines, of Messrs. Squire and Sons, has made for me a solution containing trypsin which does not cause pain, and

which can be given with no more precautions than are necessary for an ordinary hypodermic injection. To purify the skin, and then apply a piece of ice, possibly from a stagnant pool, seems to me approaching the ridiculous. I may add that I think it a great pity to bring forward trypsin, or anything else, as a possible cure for cancer, especially in the daily press, before the drug has cured, even temporarily, a single authentic case. For my own part, I doubt very much if the cure for this disease is to be found in trypsin, or, indeed, if any one drug will be found successful in all or the majority of cases.

DISPENSING ON THE METRIC SYSTEM.

DR. H. CRICHTON MILLER (San Remo) writes: I have from time to time noticed in your columns complaints from members of the difficulty or impossibility of procuring in this country dispensing bottles of the sizes required for use with the metric system. It may interest your readers to know the contrivance whereby I have met the difficulty. I use ordinary ungraduated 4 oz. and 8 oz. dispensing bottles. On these I paste a graduated slip, dividing the bottle into ten or twenty equal doses, as the case may be. Supposing my prescription in divided doses run thus:

℞ Tr. ferri perchlor. 0.5 c.cm.
Tr. nucis vom. 0.3 c.cm.
Infus. quassiae ad 10.0 c.cm.

My extended prescription would naturally be:

℞ Tr. ferri perchlor. 5.0 c.cm.
Tr. nucis vom. 3.0 c.cm.
Infus. quassiae ad 100.0 c.cm.

Instead of this I make it out as follows:

℞ Tr. ferri perchlor. 5.0 c.cm.
Tr. nucis vom. 3.0 c.cm.
Infus. quassiae ad 4 oz.

I then apply the slip and a label, "one division to be taken." In this way the metric system can be used almost as conveniently as with bottles of 100 c.cm. and 200 c.cm. The slips are made by Mr. H. Silverlock of Blackfriars Street.

NOT WELL ENOUGH TO STAY IN HOSPITAL.

HOUSE-PHYSICIANS, says the *London Hospital Gazette*, when they wish to empty a bed of a chronic case, will welcome the new and original excuse contained in the following letter: "Dear Sister,—When next the doctor attends Mother, will you please ask him to dismiss Mother, as she does not feel well, and oblige, Yours truly, ——."

CORYZA FOLLOWING INGESTION OF QUININE.

DR. SIDNEY H. CARR, M.D. (China Inland Mission, Kaifeng Fu, China) writes: There has lately been a correspondence in your columns about acute oedema of the uvula, which has interested me on account of the following facts in connexion with the taking of quinine. For the last year or more I have on several occasions been suddenly seized with a very severe coryza accompanied by considerable oedema of the uvula, and causing in one or two instances extreme discomfort. I knew of no reason for these attacks, until I found that they supervened on the days on which I had taken a small dose of quinine. To confirm this I took the other day quinine sulphate 3 gr. dissolved in water, with acid. sulph. aromat. ♏ 5, at about noon. An hour later, during dinner, the symptoms came on—sneezing, running at the nose, injection of conjunctiva, and oedema of uvula. I am not aware that these symptoms commonly follow the administration of quinine, but it would be interesting to know if the cases quoted by your correspondents could have had any connexion with it.

THE PALLIATION OF CLEFT PALATE.

MR. J. G. TURNER, Lecturer on Dental Surgery and Pathology, Royal Dental Hospital of London, writes: The following case may throw some light on the function of the soft palate, on which some of your correspondents so strongly insist. A lady, aged 26, had complete cleft of hard and soft palate. No operation had been attempted. Two years ago, when I first saw her, her speech was bad, in the same way and to the same degree as in these cases it usually is. I made for her a rigid obturator with an immovable "velum." This reaches within perhaps ⅛ in. of the posterior pharyngeal wall, but nowhere touches. Then I taught her to speak; and to-day she hardly betrays herself with her obturator in, and without it is not much worse.

FOOD FEVER IN CHILDREN.

DR. FRANCIS HARE (Upper Norwood) writes: In his article on "Food Fever in Children" (BRITISH MEDICAL JOURNAL, February 10th, 1906), Dr. Eustace Smith makes kindly reference to the view recently brought forward by me that many cases of recurrent gastric catarrh depend upon recurrent distension of the liver by glycogen (*The Food Factor in Disease*, 1905, vol. i, p. 66). He says, however, "Dr. Hare, as I understand him, not only excludes chill from any share in the production of the disturbance of function, but goes so far as to declare that external cold actually tends to retard glycogenic distension of the cells, and should therefore be a protection against attacks." Dr. Eustace Smith has overlooked my reference to the factor of chill in glycogenic distension of the liver, doubtless because it appears in a different connexion, namely, in the section on "Vasomotor action and the liver" (*The Food Factor in Disease*, vol. i, pp. 358, 359). There is no question that in all warm-blooded animals, exposure to cold, within certain limits, tends to raise the rate of combustion by the tissues, and so to unload the liver of glycogen. Conformably, in the subtropics at any rate, a certain class of patients suffers from recurrent gastric catarrh during the summer months, ceases to suffer during the winter, and remains altogether well after removal to a cool climate. But external cold has a complex action. It tends also to cause vaso-constriction of the cutaneous area, especially of the extremities. And I have argued that such widespread vaso-constriction is peculiarly prone to set in action the vasomotor mechanism of glycogenic distension of the liver. Conformably, it is found that a second class of patients suffer from recurrent gastric catarrh during the winter months, cease to suffer during the summer, and remain altogether well after removal to a warm climate. The same two classes of patients are equally well represented amongst those who suffer from ordinary biliousness, bilious attacks, migraine, etc. And the differentiating factor in both classes seems to me to be the degree of responsiveness of the vasomotor mechanism to thermal stimuli. The preventive treatment advocated by Dr. Eustace Smith and myself is identical in all details. It may be thus summarized: Restriction of the intake of glycogen-forming material, especially carbohydrates: increase in the expenditure of glycogen, especially by physical exercise; and the avoidance of sudden cutaneous vaso-constriction by protection of the surface from chill. We differ only in the fundamental pathology of the affection and in the *rationale* of the treatment. Dr. Eustace Smith regards the gastric catarrh as primary and due, among other causes, to gastro-intestinal fermentation. This view, however, fails to explain what seems to me the most characteristic feature of the disorder, namely, its marked tendency to be periodic, even regularly periodic. For it is difficult to see why food which is normally digested in the intervals of the attacks should give rise to fermentation with regular periodicity unless it be from some cumulative influence. On the other hand, a cumulative factor is readily supplied by a gradually-increasing accumulation of liver glycogen, leading, at more or less regular intervals, to pathological distension. Further, such distension would explain all the phenomena of the attacks as well as the *rationale* of the treatment.

MARMOREK'S SERUM FOR TUBERCULOSIS.

DR. FRANK GODFREY (Nettlestone, I.W.) writes: Three years ago I was called in consultation to a patient suffering acute pain in the testicle. After prolonged treatment, which was unsuccessful, it was decided to amputate the organ, which proved it to be in a condition of suppurative tuberculous degeneration. Shortly afterwards the other testicle took on the same condition, with excessive sciatic pain which was ascribed to the same cause. About this time some one had recommended him to consult a medical man who was curing tuberculous disease by injections. I assented to this experiment. As the medical man resided in a distant town I wrote to Dr. Marmorek to ask him to supply me with the serum, and promising to carry out his suggestions in the treatment. This he decidedly refused to do, stating it was to be supplied only to his own *clientèle*. The injections were given at intervals for eight months, during which time a little abscess in the sternum healed and his general health improved. The remaining testicle continued at times to suppurate a little, the pain in the hip was better, the patient got fatter, but there the improvement ended. At the present time he is again at Ventnor, but will not continue the injections at least for some time. I have merely given this case for what it is worth.

ETIOLOGY OF HEPATIC ABSCESS.

SURGEON-CAPTAIN G. C. HALL, I.M.S. (ret.), Islip, Oxford, writes: It is nearly twelve years since Colonel Maitland operated on me in Madras for abscess of liver. No cause whatever for the same could be discovered. There was no history whatever of dysentery or alcoholism. The resisting power having been weakened by countless attacks of ague and remittent fever, it now occurs to me that the microbic invasion may have taken place through the slight anal fissure from which I suffered for about ten years previously to the hepatitis.