made, it may be worth recording that I have cured cases confidently diagnosed as pulmonary tuberculosis by extracting septic teeth. Further, where the disease is truly tuberculous, septic teeth must be a powerful cause of secondary infection, and I have seen enough of sanatorium treatment to have formed the opinion that free extraction of septic teeth is a great benefit to consumptives. I suspect that thorough dental treatment on these lines would eliminate a large proportion of mistaken diagnoses and give the truly tuberculous settlers a much better chance.—I am, etc.,

London, W.1, April 20th. J. G. TURNER, F.R.C.S., L.D.S.

SAND-FLY FEVER IN MESOPOTAMIA.

SIR,—In the interesting paper by Dr. Willcox on heat hyperpyrexia, published in your issue of March 20th, 1920, he states: "In the great incidence of heat-stroke in July and August, 1917, sand-fly fever was entirely absent." I cannot understand this statement, for during this period a great epidemic of the disease was raging at Basra.

I am convinced from my own observations that some of the milder cases of hyperpyrexia, diagnosed "effects of heat B," were sand-fly fever, for during normal summer weather in Mesopotamia it was not very uncommon to find patients with temperatures of 105° F. and higher in sand-fly fever. I was in Baghdad when the heat wave commenced and there sand-flies caused me little inconvenience, but on returning to Basra a few days later I found the torment from these pests was so unbearable that few of us could sleep.

Sand-fly fever may have been absent at Baghdad, but it was certainly raging at Basra throughout the summer of 1917, including the heat-wave period. I quite agree with Dr. K. G. Hearne's theory (BRITISH MEDICAL JOURNAL, April 26th, 1919), endorsed by Dr. Willcox (BRITISH MEDICAL JOURNAL, March 20th, 1920), that sand-fly fever was entirely out of the question in the majority of cases which he describes as "hyperpyrexial heat-stroke."—I am, etc.,

Bridlington, April 20th. C. R. TAYLOR.

THE EARLY DIAGNOSIS OF SYPHILIS.

SIR,—The diagnosis of syphilis depends on the laboratory report, the clinical aspect of the case, and the period of incubation. In any case of untreated venereal sore the procedure I adopt is as follows: (1) The incubation period is noted, and a careful examination of the patient is made; (2) a warm saline dressing is applied to the sore, and no other dressing is used, unless, of course, the sore should be phagadaenic. Several dark-ground examinations are made, an interval of a few hours elapsing between each examination; if no *Sp. pallida* is found, an inguinal lymphatic gland (if present) is punctured, and some fluid removed and examined by dark-ground illumination (following Mr. C. W. Mills's procedure). Should no *Sp. pallida* be found, an injection of 0.45 gram of novarsenobenzol is given intravenously, and in seven days' time a blood test is made; if this is negative another test is done seven days after the first; if the result is again negative, the patient is told to have another injection of 0.45 gram novarsenobenzol in two weeks, and a blood test a week after the injection. A careful clinical examination is made at the time of each test.

In this way a diagnosis of syphilis is either eliminated or proved, and there is little time lost in treatment. To treat every sore as syphilitic is hardly in accordance with modern teaching. We have advanced tremendously in our methods of diagnosis of syphilis, but to condemn every man with a venereal sore to several years' treatment for syphilis is surely going backwards. The time lost in making a diagnosis is compensated by the loss of anxiety to the patient. I have seen several patients lately in whom no laboratory tests have been made, but have yet been started on a course of injections for syphilis. Three or four injections mask the clinical symptoms and upset the Wassermann reaction, and a definite diagnosis is difficult to make. In my last hundred cases I have had twelve undoubted cases of simple chancroid.—I am, etc.,

REGINALD JOHNSON, M.D.,
M.O. i/c V.D. Wards, Bermondsey Military Hospital, Ladywell, S.E.
April 5th.

SIR,—In commenting on Dr. Bryan's letter published in your issue of March 20th Mr. Marshall and Major Ffrench give their opinion in support of Dr. E. Harrison that "chancroid is a rare condition, and nearly always has syphilis at the back of it." I think this statement should be qualified by adding: "in this country at the present time."

In France there has recently been quite an epidemic of simple chancre, and it would be easy to see as many as fifty or more any day of the week at St. Louis. I need hardly add that the French physicians insist on keeping these patients under observation, and that, while many cases turn out to be mixed, a large number remain simple throughout.

The advice given that "all cases of apparent chancroid should be treated at once for syphilis" will hardly meet with universal acceptance.—I am, etc.,

London, W., April 5th. M. G. HANNAY, F.R.C.P.E.

SIR,—Might I suggest that, while appreciating the interest of Drs. C. F. Marshall and E. G. Ffrench in my criticism of Dr. E. Harrison's previous letter, I think that a more careful perusal of my letter would have prevented them from making the entirely erroneous assumption that I am only prepared to accept a diagnosis of syphilis when *Sp. pallida* is shown by dark-ground illumination? They would then see that I merely wish to emphasize the risk of condemning a person suffering only from chancroid to a diagnosis of syphilis, with the prolonged course of treatment involved, on the strength of a faulty microscopic diagnosis.

As to the alleged rarity of chancroids pure and simple, Drs. Marshall and Ffrench's own figures seem to me to support my contention, as I consider that even 1 in 10 is a very considerable number. My own cases at the Middlesbrough clinic during the last year give a proportion of 1 in 4. These cases have been under observation not less than three months; the number (12) is, of course, one much too small on which to generalize, but the results confirm the impression I formed while serving in a military venereal hospital, which treated 4,000 to 5,000 venereal cases annually.

Referring to the remarks of Drs. Marshall and Ffrench as to "the false teaching which places laboratory diagnosis before clinical experience," might I quote the following extract from the report of the Medical Research Committee, 1918:

> That too much emphasis cannot be laid upon the importance of the detection of the spironema as affording the earliest means of diagnosis of syphilis, and this at a period when, clinically, it is not possible to arrive otherwise at a definite decision, and undoubtedly the ideal method of demonstrating the *Sp. pallida* is by the dark-ground condenser.

Allusion is made also to the disadvantages of staining methods, namely:

> Lack of affinity the *Sp. pallida* has for most staining reagents, the distortion caused by drying, and the absence of the characteristic movements.

From the report of Dr. E. Harrison in the BRITISH MEDICAL JOURNAL I am unable to decide which microscopical method he adopts; perhaps he will kindly enlighten us.—I am, etc.,

Middlesbrough, April 5th. A. BRYANS.

CIRCUMCISION—A BARBAROUS AND UNNECESSARY MUTILATION.

SIR,—While I agree with Mr. G. S. Thompson, in his communication of March 27th, that circumcision is often performed unnecessarily, it is an error to lay the blame entirely on the Jews for this practice. This piece of religious ritual originated with the Heliolithic culture which arose in the Nile valley thousands of years before the Jews became a nation, spread at first all over the East by trade routes, and after 800 B.C. was carried by the daring Phoenician mariners to all parts of the world, including Great Britain, the Pacific Islands, and even the American littoral.

Professor Elliot Smith has conclusively proved that this worship of the sun and the serpent was thus disseminated, together with the practices such as circumcision, mummification of the dead, massage, and piercing of the ears, to mention but a few.

Br Med J: first published as 10.1136/bmj.1.3096.620-a on 1 May 1920. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.