

weakness when the pressure fell below 100 mm., and at 90 mm., with a pulse pressure of 20 mm., he felt weak and giddy, experienced some difficulty in breathing, and could hardly stand. He was given pituitary whole gland, two grains night and morning, but this proved too much, as it caused a feeling of fullness and throbbing in the head. The amount was therefore reduced to one grain night and morning, and later on to one grain daily. While he is taking pituitary the blood pressure keeps between 110 and 122 mm. systolic with a diastolic of 78 mm. He has found, however, that if he takes it for a few days the pressure will hold up at about 108 mm. for some months without any more pituitary. Recently he suffered from influenza, his blood pressure being so affected as to be just perceptible and no more, at the radial artery. The pulse rate fell to 58. He felt so weak that he could hardly raise his head. He took one grain of pituitary whole gland and within two hours his pulse rate was 72, the artery was full and almost bounding, and he felt fit to walk.

Reviewing the above cases leaves me convinced that pituitary whole gland does act by the mouth. Not very large doses are required. Further, in certain people in whom the pituitary gland apparently needs stimulation from time to time, re-activation would appear to occur from the rest given to it by pituitary administration for a short period. In one case in which it was tried the posterior pituitary body was evidently the agent of importance. In two of the above cases Dr. Mackenzie Wallis kindly did the glucose tolerance test, which showed pituitary deficiency in both.

I bring this matter before the readers of the *Journal* believing that it will be of interest to many, and it is my intention later on, in collaboration with another, to give detailed information of the effect of orally administered pituitary whole gland on a case of low blood pressure.—I am, etc.,

London, W.1, Feb. 12th.

BERNARD MYERS.

TREATMENT OF ACTINOMYCOSIS.

SIR,—The article by Dr. Hubert Chitty in the *British Medical Journal* for February 23rd (p. 347) on the treatment of actinomycosis by tincture of iodine administered in milk leads me to state briefly that during the last twenty years I have used the proprietary article called tiodine in five cases of actinomycosis, with rapid and complete success.

It is probable that iodine in any form is of great value in clearing up the lesions of this disease, but my experience, and that of many of my medical friends and colleagues, leads me to believe that the compound mentioned acts more rapidly and more effectively than ordinary iodides. Tiodine is stated by Martindale to be a chemical combination of thiosinamin and ethyl iodide, and is administered either hypodermically or in the form of pills. My attention was first called to its value some twenty years ago by the late Sir Charles Ball, who related to me the details of a case in which potassium iodide had failed to produce any effect, and in which injections of tiodine had been followed by rapid improvement. I have always employed tiodine hypodermically, and have recommended it to others in this form. In addition to my own series of five cases, I have had reports on various occasions from old students testifying to its efficacy.—I am, etc.,

T. GILLMAN MOORHEAD, M.D., F.R.C.P.I.

Dublin, Feb. 23rd.

PROGNOSIS IN ECLAMPSIA AND ALBUMINURIA OF PREGNANCY.

SIR,—Dr. Arthur Crook, in his valuable letter (February 16th, p. 320), raises some difficult points which must be cleared up before we can even begin to understand the nature of the problem we are studying. Criticizing a statement in my paper (January 19th, p. 91) he asks, "What positive evidence as yet is there available to us that kidneys were previously healthy" in the case of the initial attack of eclampsia or albuminuria in a woman with recurring toxæmia? The evidence is twofold: (1) there is ample *post-mortem* evidence in eclampsia and not inconsiderable evidence of the same kind in albuminuria that the kidney lesion is typically entirely recent and that there has been no pre-existing disease—that is, that the nephritis is secondary to the toxæmia; (2) within a few weeks of the termination of the pregnancy in a woman who recovers there is often no manifestation even to

the most delicate test of any renal lesion or deficiency. In the face of such evidence dare we assume that pre-existing kidney disease has anything to do with the cause of eclampsia, etc? And why should the relationship between toxæmia and kidney be different in any subsequent attack? It would, indeed, be a strange phenomenon if in one pregnancy eclampsia or pre-eclampsia should cause nephritis whilst in the next pregnancy nephritis should cause eclampsia or pre-eclampsia! Can this mean anything save that in searching for the cause of the 50 per cent. risk of recurrence in these conditions we must address ourselves to something more fundamental than a defect in the kidney?

In the second paragraph of his letter Dr. Crook seems to urge in favour of his views the "extreme difficulty in deciding whether an albuminuria of pregnancy is a 'simple toxic' or a 'nephritic' one." The difficulty, of course, arises from the fact that, owing to a confusion of the issues, we have in the past been attempting to distinguish between things which are identical. Most of the so-called "nephritic" cases, as I showed in my paper, have really been cases of eclampsia or pre-eclampsia recurring in successive pregnancies, which are common, and not cases of primary nephritis complicating pregnancy but arising independently of pregnancy—for example, from scarlet fever—which are rare. So rare are such cases that, although we have been carefully looking for them, we have seen only two in several years. During that time we have seen many obvious cases of recurrent toxæmia. We are anxious to get records of primary nephritis in pregnancy, and I take this opportunity of saying that we would be grateful if any of your readers would kindly send to me at the Edinburgh Royal Maternity Hospital notes of any such cases under their care, stating (1) the evidence showing that the nephritis had arisen independently of a pregnancy, and (2) its effect on the pregnancies and foetus, if any.—I am, etc.,

Edinburgh, Feb. 23rd.

JAMES YOUNG.

TREATMENT OF EMPYEMA.

SIR,—With regard to the treatment of empyema there is a very simple and very effective method of ensuring the expansion of the lung after operation which is not so much recognized as it ought to be, and the hopelessness of the last sentence in Dr. W. Thomas's letter on February 16th (p. 322) prompts me to draw attention to it.

The method is as follows. The patient closes the lower false cords, and by their valve-like action prevents the escape of air up the trachea. He then makes an expiratory effort, and with the outlet through the trachea closed and no counter-pressure on the one side possible (owing to the opening in the chest wall), all the force of this expiratory effort will be spent upon the collapsed lung, which will be blown up just like a football bladder.

If there is much collapse or consolidation, care must be taken not to use too much force, for fear of overstretching the more healthy parts of the lung; frequent gentle efforts are therefore desirable.

When, as not infrequently happens, the patient has no voluntary power of closing the lower false cords, it is sometimes very difficult to teach him. In such a case one can often do so by drawing his attention to the fact that the closure of this valve is an essential part of the act of straining during defaecation.—I am, etc.,

Birmingham, Feb. 18th.

T. STACEY WILSON.

VITAMIN D AND THE CALCIFICATION OF BONE IN TUBERCULOSIS.

SIR,—In 1925 certain patients with bone or joint tuberculosis were given milk irradiated by ultra-violet rays, and the results then obtained appeared to justify further investigation in this direction.¹ The facts given below seem to show that this method of treatment is not as valuable as it was hoped to be.

Half a pint of milk previously exposed to ultra-violet radiations was given daily to 17 patients whose bones were partially decalcified by tuberculosis. In 7 of these patients

¹ Pattison: The Effect on Tuberculosis of Bones and Joints of Food Exposed to Ultra-violet Radiations, *British Journal of Radiology*, February, 1926.