

I wish to emphasize again the point I have made from the beginning, and which Dr. M'Gonigle supports, that lack of first-class protein is a vital point. I have indicated what I consider the immediate remedy. Just before the war, owing to the fact that I am a practical cook, I had arranged to cook in public against all the mothers in my area in two competitions, for which I had prizes promised: (1) the best dinner on a gas ring; (2) the best dinner for four for a shilling. In order to draw attention to this matter I have challenged our lady councillor to cook a five-course dinner in public.

My chief trouble is, I cannot make people understand: (a) how to buy cheap protein, and (b) how to cook it. It can be bought, but is not.

None of the cookery books, nor even Mrs. Arthur Webb's excellent broadcasts, tell the consumption of fuel necessary in the preparation of economical dishes. Among the poorer folk there is a perpetual terror of the hungry maw of the gas meter that swallows up the shillings they can so ill afford. I have been searching for a cookery book that will do what I want, but I find I shall have to compile it myself. Edinburgh has published one, but it, like all the others, is not cheap enough. Dr. M'Gonigle's figure of 4s. 6d. per man unit sounds too attractive. Dr. Crowden's figure of 7s., I am certain, is too high, as, I believe, is the Scottish figure of 6s.

To my mind the problem is urgent. The reports of the school medical officers are too euphemistic, largely because the examining officers have not had the requisite experience with regard to "malnutrition." Like Dr. M'Gonigle, I have been getting budgets from some of these humble homes, and, as Dr. M'Gonigle also finds, protein is the main item that money is saved on. I believe, and have said so often enough, that at the present time one of the most important functions a medical officer of health can perform is to ensure by instruction that money available is spent to proper nutritional advantage. If at long last something tangible will result, I for one shall be grateful indeed.—I am, etc.,

ELWIN H. NASH,

Medical Officer of Health and School Medical
Officer, Heston and Isleworth.

Hounslow, March 20th.

"Acetone and Diacetic Acid"

SIR,—Dr. R. D. Lawrence has drawn attention, in your issue of March 18th, to the error of speaking of acetone being present in the urine when aceto-acetic acid is absent. The error partly arose through the observation of Rothera that his modification of the nitroprusside test was given by acetone, but not by aceto-acetic acid, whereas the ferric chloride test was given by aceto-acetic acid and not by acetone. Hurtley showed that Rothera (as he himself discovered a little later) had been misled by not having a pure preparation of aceto-acetic acid. The presence of a small amount of the ester of aceto-acetic acid is sufficient to prevent aceto-acetic acid giving the nitroprusside test. Actually, Hurtley showed that it was possible to detect aceto-acetic acid by means of the nitroprusside test in a dilution of 1 in 400,000, while acetone could only be detected in a dilution of 1 in 20,000. The matter has been further simplified by Folin, who showed that acetone was either not present or only present in a very small amount in freshly passed urine, although the latter contained a great deal of aceto-acetic acid. When the urine was allowed to stand some of the aceto-acetic acid decomposed into acetone.

The term "acetonuria" is, therefore, really a misnomer, and it would be a great advantage if it could be replaced by the term "ketonuria." It is correct to speak

of the patient's breath smelling of acetone, because acetone is excreted by the lungs.—I am, etc.,

London, W.1, March 21st.

GEORGE GRAHAM.

BIBLIOGRAPHY

- Folin, O.: *Journ. Biol. Chem.*, 1907, iii, 117.
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Antimony Poisoning from Enamel

SIR,—Your most interesting annotation on antimony poisoning from lemonade made in enamel containers prompts me to put on record some similar cases, as I am sure the danger of cooking acid fruits in cheap enamel pie-dishes is not yet fully realized, either by the profession or by the public.

I have recently seen three families in which all the members were suddenly stricken down with sickness and diarrhoea; investigation in each case showed that the symptoms came on shortly after eating rhubarb pie, baked in a cheap new pie-dish. In most people the symptoms passed off rapidly, and were only serious in one case, as follows:

Mrs. X gave a party on Saturday night, for which she brewed a large quantity of lemonade in an enamelled basin. Nineteen out of the twenty-five present were taken ill, but the cause was not suspected. Next day, while clearing up, Mrs. X drank the remains of the lemonade (two glasses); half an hour later she was taken violently ill, with cramps in the stomach and acute diarrhoea. On the Sunday evening the five members of the X family sat down to a supper, which included a cold rhubarb pie which had been baked the day before in an enamelled dish. Within an hour they had all been taken ill with acute abdominal pains and sickness, and Mrs. X (whose third dose of antimony it evidently was) was so collapsed and ill that her condition caused considerable anxiety. Had she been a child instead of an adult I think there is reason to believe that the result might even have been fatal.

I cannot help feeling that the medical profession as a whole should take active steps to warn people of this danger, which, as far as I can see, applies to all acid fruits cooked in such dishes.—I am, etc.,

New Malden, March 24th.

HELEN LUKIS, M.D.

Chronic Pulmonary Tuberculosis

SIR,—Dr. R. C. Wingfield in his recent article (February 4th) referred to the diathesis of the patient as a factor influencing the evolution of the tuberculous lesion. What does he mean by this term "diathesis"? Is it an inherited or an acquired state? If inherited, the physician will be unable to influence it. In the *Journal* of January 28th there was an article on the significance of the residuum. This diathesis may be one of the residual phenomena of medicine.

During the past two or three years I have been investigating cases of tuberculosis of the lung among school children and young adults. The evidence gathered is pointing to the following conclusions. The treatment of pulmonary tuberculosis is unsatisfactory because our conception of the aetiology is not clear. Our conception will not be clear until we have devoted more research into the meaning of the diathesis—that is, have studied the whole individual, the soil in which the seed of disease grows. Diathesis from the point of view of biology means maladaptation, and this appears to be of twofold character, partly biochemical or nutritional and partly psychological; the first is probably wholly acquired, and the second mainly acquired but partly inherited.

Diagnosis which limits itself to the determination of the presence of the tubercle bacillus and to the character and extent of the lesion and resultant toxæmia is not