An interesting and important point is whether to give an injection of the pure "anti-infective" vitamin A, or to give vitamins A and D as combined in dekadexolin. Most of my work has been done with the latter. It is certainly very satisfactory, and though results can be obtained with vitamin A alone, I believe that the vitamin D helps considerably in giving the patients that feeling of well-being which is so marked—and can be so misleading and even dangerous—after it has been given. The case quoted above illustrates this effect perfectly. In an infection such as influenza, which is pre-eminent in its power to make the patient "feel rotten," I think the two vitamins are indicated. In a severe case I should now give 2 c.cm. at once, repeated as required. This type of chemotherapy presumably acts on the host and not on the invader. It seems to stop or even reverse some of the physico-chemical reactions which show themselves as disease, it has no contraindications, and is compatible with any other treatment which may be indicated. As such I am sure it is worthy of a more extended trial than I can give.—I am, etc.,

Winsford, Cheshire, Jan. 27. W. N. LEAK.

Post-operative Pneumonia

SIR,—I had no intention of suggesting that Mr. H. J. McCurrich was not familiar with the condition of post-operative collapse, and perhaps should apologize for having used his letter as a text for drawing attention to the not-well-recognized fact that such collapse is the cause of more than 50 per cent. of all post-operative pulmonary complications. Mr. McCurrich, I think, will agree that where it is possible—as, for example, in hospital—all such cases should be *x*-rayed as a routine in order to eliminate primary pneumonias from the secondary pneumonic complications of a primary collapse. The frequency of such post-operative pneumonic conditions would suggest that most of the cases are due to some factor less fortuitous than prevailing epidemics. One feels that recognition of this would result in some common-sense prophylactic measure—possibly mechanical—which might obviate, for example, hypoventilation of the bases. It is to the surgeons rather than the physicians one must look for such suggestions.

My failure to appreciate Mr. McCurrich's jest must be put down, as he says, to careless reading—in the light of his explanation it is perfectly obvious—or maybe it could be attributed to the proverbial delayed joke reaction of the Scot!—I am, etc.,

London, N.6, Jan. 20. W. LEES TEMPLETON.

Endotracheal Anaesthesia

SIR,—I do not presume to enter the arena beside protagonists such as Sir Robert Kelly and Sir Harold Gillies. Yet as a younger and humble member of that body of anaesthetists to whom the latter refers, perhaps I may be permitted to add a few remarks of a practical nature.

From the correspondence it might be inferred that the possible disadvantages of nasal intubation are inherent in the endotracheal method. That, of course, is not the case, as the tube can be passed through the mouth, although the nasal route is generally preferable. Two of the risks of nasal intubation claimed—namely, transport of infection and damage due to blind passage into the glottis—would seem to be avoidable. If infection is deemed to be a risk, that could easily be eliminated by enveloping the end of the tube with a thin rubber sheath, this to be rolled on after sterilization and removed after nasal passage of the tube into the mouth before its introduction into the glottis. That such a simple device is not actually employed may possibly be due to the fact (pointed out) that infection seldom occurs. However that may be, it is, of course, perfectly easy to remove gross contamination of the tube before passing it from the pharynx to the glottis.

Again, without commenting on the risk of blind passage into the glottis, one may observe that it is not difficult to guide a nasal tube into the glottis under direct vision down the laryngoscope. Finally, if there is any objection to very low or negative pressures, this too is not inherent in the endotracheal method. In most types of apparatus it is easy to raise pressure by increasing either the head of gas or the tension on the spring of the outlet valve, while in the McKesson type apparatus a bellows of adjustable tension replaces the rebreathing bag.—I am, etc.,

Eye, Suffolk, Jan. 21. J. SHACKLETON-BAILEY.

Friedreich's Ataxia

SIR,—I am at present attending a boy of 13 who was diagnosed at the age of 3, so the mother says, as suffering from the above condition. She has not taken him to hospital since. He is small for his age, shows considerable ataxia, wasting of the thighs, and a hypertrophy of his calf muscles, due possibly to the fact that he walks on tiptoe. He is of low-grade intelligence, his expression is somewhat vacant, and he has a tendency to smile or grimace. Knee-jerks could not be obtained. Tachycardia is present. A few months ago I attended, during his last illness, a cousin of this boy, though I was unaware of the relationship at the time. He was 14 years of age, well built, inclined to corpulence, and looked well in the face. Ataxia was marked, so also was pes cavus in both feet. Absent knee-jerks and nystagmus were noticeable. He had tachycardia and a severe attack of jaundice (which cleared up) a few weeks before his sudden death. To add to the tragedy of this family, two of his brothers also died at about the same age of the same condition.

I now learn that the mothers of these children, who were sisters (one now being dead), had two brothers who also suffered from Friedreich's ataxia, one dying at the age of 21 and the other at 28.

A history of this kind impresses upon one the importance of the "family history" in filling up a life assurance proposal form. It also stresses the need for a very careful selection of one's parents.—I am, etc.,

Hove, Jan. 20. G. L. DAVIES, M.R.C.S.

Fracture-Dislocation of Cervical Spine

SIR,—With regard to my case report of fracture-dislocation of the cervical spine in the *Journal* of December 30, 1939 (p. 1273), I thought it might be worth mentioning that I had the chance of visiting the patient in question at the beginning of this month—roughly eighteen months since proper treatment began. Unfortunately I still could not persuade her to come to hospital for another *x*-ray examination. However, on clinical examination I found her neck apparently quite normal except for a bony mass, palpable but not visible, in the upper end of the nuchal groove. Movements were free in all directions and, so far as I dared ascertain, union was quite firm. The patient was in excellent health and spirits.—I am, etc.,

Old Cairo, Egypt, Jan. 14. E. N. CALLUM, F.R.C.S.Ed.

Medical Library for the B.E.F.

SIR,—I am glad to be able to supplement the information contained in the annotation in your issue of January 27 (p. 135). The Council of the Royal College of Surgeons of England is already organizing a library for the Army Medical Services in France, and during the past three weeks a large number of periodicals and books have been dispatched, and it is hoped that the library will shortly be opened.—I am, etc.,

W. R. LE FANU,
Librarian, Royal College of Surgeons.

London, W.C.2, Jan. 29.

Hemiatrophy of Brain.—A case of hemiatrophy of the brain is described, and other cases recorded in the literature are reviewed. It is suggested that the cerebral hemiatrophies should be divided into two groups: a primary or congenital and a secondary or acquired group.—Hemiatrophy of Brain. B. J. Alpers and R. B. Dear.—*J. nerv. ment. Dis.*, May, 1939, **89**, 653.