

Correspondence

Aerial Convection from Smallpox Hospitals

SIR,—The article by Dr. Killick Millard (May 6, p. 628) is a useful reminder of a problem which has not yet been solved. More recent events than those he recounts cause one to suspect that smallpox may possibly be transmitted at long range through the air. The question was dealt with by Sir A. S. M. Macgregor in connexion with the 1920-1 epidemic in Glasgow,¹ with the conclusion that, while there was some ground for suspicion that a hospital had disseminated smallpox in its vicinity, the evidence was not definitive. According to my recollection (admittedly not too reliable after twenty-four years), when cases began to be admitted to a different hospital the disease began to occur in its vicinity, but here again it was impossible at a late stage of the epidemic to exclude other possible sources. More definitely, and in this case I can speak from personal knowledge, a confluent case was admitted to the smallpox compound of a hospital from a distant part of the city at a time when no other cases were occurring, and this was the only case of smallpox in that hospital. Death occurred within a day or two. After the lapse of the usual incubation period, patients in a scarlet-fever ward, who had been there too long to have been infected with smallpox before admission, sickened of the disease. The wards in question were among those overlooking the smallpox compound. Of course, it was not possible to exclude carriage by members of the medical staff, who were naturally keen to see this then unusual disease, but they were accustomed to take reasonable precautions, and the juxtaposition of the wards in question seemed to be significant.

Much more striking were the events at Gravesend in 1938, when disembarkation of a case of smallpox of foreign origin was followed by six non-contact cases, four of whom lived at distances ranging from a quarter of a mile to one and three-quarters of a mile from a hospital containing at least one case in the acute stage.^{2,3,4,5} Apparently no other source of infection was traced in these instances, but other circumstances of this little outbreak indicate that the infection may have been of an unusually dispersive type.—I am, etc.,

Welsh National School of Medicine, Cardiff. RALPH M. F. PICKEN.

REFERENCES

- ¹ Annual Report of the Medical Officer of Health, Glasgow, 1920.
- ² *Lancet*, 1939, 1, 813.
- ³ *Ibid.*, p. 1125.
- ⁴ Annual Report, Ministry of Health, 1938-9, 25.
- ⁵ *St. Bart's Hosp. J.*, 1938, 45, 155.

SIR,—Dr. Killick Millard believes that the case for aerial convection of the virus of smallpox is "very strong"; but he cannot have it both ways. If the virus may be aerielly transmitted in *effective dosage* over distances of the order of half a mile, how can he—a staunch opponent, moreover, of compulsory vaccination—seriously suggest the reception of patients suffering from variola major by "general isolation hospitals" in which the approved distance between ward blocks is 40 feet?—I am, etc.,

London, N.15.

E. H. R. HARRIES.

SIR,—An incident that happened at Salonika in 1917 bears out the air-convection theory so well described by Dr. Killick Millard (May 6, p. 628). A seaman was admitted to a general hospital in the town of Salonika and was subsequently diagnosed as smallpox. He was isolated in a tented camp half a mile from any habitation except the tents of the isolation hospital to which his camp was attached. Yet there was an outbreak of smallpox among the personnel of an ordnance depot which was just half a mile away across a sandy desert. Over twenty cases (British and Greek) were admitted, and there were several deaths among the unprotected. There were no cases in the general hospital where the original case had been admitted.—I am, etc.,

Sutton Green, nr. Guildford.

P. G. EASTON,
Licut.-Col., R.A.M.C. (ret.).

Penicillin for Skin Diseases

SIR,—We have studied carefully and with considerable interest the report on the therapeutic properties of penicillin, with special reference to the section on the treatment of skin diseases (Roxburgh, Christie, and Roxburgh, *B.M.J.*, April 15, p. 524). We note that certain cases were treated with an aqueous solution of penicillin (1,000 units per c.cm.) used as a spray. This method of application was adopted by us at the end of January, 1944. It was tried out extensively in the skin department of a large military hospital, and satisfactory results were obtained using a strength of only 200 units per c.cm. So far as we have ascertained, the spray technique had not previously been used.

We have been experimenting with various applications of penicillin for the treatment of certain skin diseases since September, 1943, and in our opinion the spray technique has given the best results, and in the strength used we have found it the most economical preparation of penicillin. A full report will shortly be published.

We would be interested to hear whether the cases which appeared to be irritated by the penicillin ointment or spray were growing penicillin-insensitive organisms at the time penicillin treatment was stopped. Our own observations suggest that in these cases penicillin-insensitive organisms have appeared, and have been the cause of the condition getting worse. The purity of the petroleum jelly used in the base might also be a factor in the causation of irritation. In the first series of cases treated by us, one particular batch of petroleum jelly caused definite eczematization.—We are, etc.,

P. H. TAYLOR.
K. E. A. HUGHES.

Status Lymphaticus

SIR,—In reply to Major G. R. Peberdy's inquiry (April 29, p. 600) I can say that in the course of some five years' work in the coroner's districts of South London, East Surrey, and the county borough of Croydon, also in hospital practice as a pathologist in and around the London area since 1929, during which time I have carried out an average of not less than three hundred necropsies a year, I have not seen a single case of status lymphaticus. I personally do not believe in the existence of such an entity. With the volume of sudden deaths that I am called upon to examine I feel sure that had the condition a real existence I should have seen at least one case.—I am, etc.,

London, W.1.

DAVID HALER.

Nutritional Oedema in a Vegetarian

SIR,—The case of nutritional oedema in a vegetarian reported by Dr. Holmes (May 6, p. 620) is of great interest in view of the reports of the widespread incidence of this condition in occupied Europe. While the findings are highly suggestive that the oedema was produced solely by the hypoproteinaemia, it is not possible from the evidence adduced to exclude the influence of myocardial weakness. It is known that oedema of cardiac origin may occur in the absence of enlargement of the heart. Presumably in this case signs of a general increase of venous blood pressure were absent and the blood circulation rate gave a reading within normal limits; otherwise the effect of improvement in the nutritional state of the myocardium cannot be overlooked. In raising this point I have had in mind that reports indicate that sudden death, presumably of cardiac origin, is a not uncommon means of termination in cases of hunger oedema.—I am, etc.,

Dundee.

D. G. MCINTOSH.

The Effects of Cold

SIR,—Will you allow me to trespass upon your valuable space to comment upon Mr. Norman Lake's reply (April 22) to Dr. Raymond Greene's letter of April 1. I think it is important to our conception of the pathology of the cryopathies to point out that the lesion is one associated with the tissue as a whole rather than with a collection of cells intertwined with blood vessels. The pathology is thus best considered on a tissue rather than a cellular basis.