Untoward and common sequelae were acute otitis media; less often but not infrequent were acute mastoiditis. More remote and rarer effects were rheumatic fever, arthritis (septic), pleurisy, and even malignant endocarditis. The latter were encountered in the poorer and more crowded districts.

Since the advent of the sulphonamide era the clinical picture has changed. One to three days initiates the period of convalescence, and untoward effects are extremely rare. This is not to argue *post hoc propter hoc*, as during the same period one has noted that scarlet fever has become a benign disease. In scarlet fever one must also conclude that sulphonamides have not been standard or universal, but again one cannot seriously argue that the therapy has not removed the sting from puerperal fever (prior to the use of penicillin, etc.).

In perusing the account of cases in the *Journal* one finds no mention of the state of the pulse, blood pressure, peripheral circulation, and other criteria of toxaemia. Now these data are of much more importance in assessing the condition of the patient than the presence of temperature or haemolytic streptococci in tonsils and local signs.

In puerperal fever grave toxaemia may be present in the absence of raised temperature, or temperature may be raised only once in 24 hours, but other signs of toxaemia are present, rapid pulse and peripheral circulatory weakness, while clinical recovery has often taken place, even if the cervical swab is positive for haemolytic streptococci.

It is possible, even likely, that tonsillitis is now a less virulent infection than in the old days (of scarlet fever), but there are other criteria to be assessed.

In the presulphonamide era I encountered on the average a peritonsillar abscess once weekly, say, while otitis media was not infrequent and acute mastoiditis not very rare. During the sulphonamide era I encountered peritonsillar abscess once and acute mastoiditis once. The peritonsillar case had acute tonsillitis for four days before sulphonamide treatment could be given, and the mastoid had no treatment for the tonsillar infection.

Until more observation is done and more data are available I cannot believe that sulphonamide therapy is superfluous in acute tonsillitis.—I am, etc.,

Fraserburgh. J. MACLEOD.

Treatment of Naevi

SIR,—I agree with Dr. Cyril M. Ross (February 17, p. 356) and Dr. R. E. Bowers (January 20, p. 121) on the importance of Lister's observation that the majority of the most common type of cavernous angiomata disappear spontanously, leaving usually little scarring, by about the age of 5 or 6 (I would have said 7). Lister cites certain exceptions, and I would have added a very important one: that when a mucous membrane is involved disappearance spontaneously must be extremely rare. Dr. Ross's observation of his failed case falls into line with this.

I have found that the γ rays of radium leave absolutely no scar and considerably reduce the time of disappearance, much to the parents' satisfaction. Consequently I used to employ this for all cases on the face and neck, and when the angiomata were multiple used those on the body as controls. In the rare cases in which repetition of the treatment is necessary it should not be done until a year or at least six months have elapsed. In order to prevent an overzealous assistant breaking this rule, after seeing the patient at three weeks to determine the amount of reaction I used to give a definite appointment for six months later. Some untreated cases ulcerate spontaneously, especially if very extensive, and these will leave scarring. The best way to stop the ulceration is by very small doses of radium γ rays once a week, with the possible addition of penicillin cream. In some cases this may be sufficient to start rapid regression, otherwise adequate treatment is given in a month or six weeks. *X* rays seem to cause more pigmentation in the early stages, but I have seen few of the late results. I have seen it recommended that the *x*-ray dose should be repeated in six weeks or two months, but this is much too soon and often the original dose suffices.—I am, etc.,

Cobham, Surrey. N. S. FINZI.

Environment and Intelligence

SIR,—I would like to suggest to some graduate in search of a suitable subject for an M.D. thesis that he should make an assessment of the intelligence of children adopted into good middle-class homes. The majority of these children come from working-class households, and it would be interesting to see how they compare with their class-mates in intelligence. My casual and limited observations appear to indicate that they compare very favourably. Additional light upon the subject might be got from the results of the scholarship examinations held by education committees, which most children take at 11 years of age and which have one section devoted to intelligence testing.

The effect of environment upon children has been studied extensively in the United States by comparing identical twins living under different conditions. One of the fallacies of this comparison is that identical twins have often substantial differences in height, weight, liability to illness, temperament, and so on. The number of identical twins available for investigation is also very limited. It should be a simple matter to carry out the testing of adopted children in school without causing them any embarrassment, by spacing them out between controls. The listing of adopted children can readily be done by their class teachers.—I am, etc.,

Rotherham. J. M. WATT.

The South African Meeting

SIR,—Your leading article (February 17, p. 342) interested me very much, and I should not like the occasion to pass without comment. As you pointed out, the B.M.A., as a medical organization, would not even attempt to interfere with or criticize the policy of the South African Government, but at the same time it has not sacrificed principle for expediency.

An attitude such as this is what one expects from an organization of men and women who subscribe to the rules of professional conduct summarized in the Hippocratic code, and I think it is not unfair to expect such an attitude from most self-respecting people—professional or otherwise. It is from the ranks of such people that a country's Government is largely chosen, and thus the policy of a Government will surely be influenced to a large extent by the attitude of these people.

All this may seem somewhat irrelevant, but I intend it to be the preamble to an attempt to show that, if the Medical Association of South Africa—and incidentally other organizations of educated and responsible men in South Africa—had not in the past so readily sacrificed principle on the altar of expediency, the extreme form of racial discrimination practised in South Africa to-day would never have found such a rich medium for its dissemination and growth.

In May, 1944, a non-European medical student at the University of Capetown was suspended from the University pending an inquiry by the disciplinary committee of that institution. His "crime" was that he had attended an orthopaedic clinic at which white patients were being examined. The objection to his presence was not from the patients but from his white colleagues.

He was found "not guilty" and acquitted. At the time the incident evoked considerable comment from all parts of the country. A former dean and archdeacon of Bloemfontein wrote to the *South African Medical Journal* deploring the failure of an enlightened and scientific body such as a university to brush aside the prejudice of the less enlightened. One would have expected the medical profession to have taken a strong stand to maintain its principles on this occasion. However, the editorial comment of the *S.A.M.J.* (July 8, 1944) adopted an extremely non-committal attitude and gave no clear lead such as appears in your

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columns last week. I have given the reference for those who wish to read the complete editorial, but to make my point here I shall quote some of the relevant passages.

Paragraph 2 commences: "Correspondents have urged us to 'state the principles at stake clearly in this *Journal,*' but we do not think that such a course is either necessary or desirable." The article goes on to say that it "presumes" that the members of the South African Medical Association "subscribe to the principles universally accepted by our profession—namely, that medicine knows no distinction of colour, or creed, or kind, or kin." Therefore, "We do not think any useful purpose will be served by discussing . . . in this *Journal* the points that Dean Hulme raises." In its concluding stages it says, "In this matter of the Colour Bar in Medicine our Association has not, as yet, taken up an attitude that supports, or conflicts with what may be called the liberal and conservative schools of thought in the Union."

Not long after this incident, non-European medical students at Capetown were asked to sign a document which officially prohibited them from attending any "class, clinic, lecture, operation, or post-mortem examination, on a white patient."

If to-day the Medical Association of South Africa feels that the colour policy of the South African Government will lead to the country's isolation from scientific and cultural intercourse with the rest of the world, it would be interesting to contrast their present-day attitude with that of the editorial I have quoted.

In the last world war we saw how medicine and science were prostituted to serve the inhuman plans of the Nazis, and I think we should bear this in mind when dealing with ideologies which discriminate on grounds of colour, creed, or race. The medical profession should be ever to the fore in upholding all that is righteous, and the B.M.A. should be proud of the stand it has taken in deciding not to take part in the proposed joint meeting at Johannesburg because of South Africa's racial discrimination.—I am, etc.,

Derby. RALPH A. A. R. LAWRENCE.

** Dr. Lawrence informs us that he was himself the student who was suspended from the University in 1944.—ED., *B.M.J.*

POINTS FROM LETTERS

Allergy with Procaine Penicillin

Dr. F. E. LOEWY (London, W.1) writes: Dr. T. V. Humphrey's experience of an alarming allergic reaction after injection of this preparation (February 10, p. 299) deserves special attention. The cause in his case was most likely sensitivity to procaine, not infrequently met with also after local anaesthesia for dentistry, etc. Patients complain of palpitation, nausea, and faintness for some hours, and it is customary but unjustified to put the blame on a minute trace of adrenaline usually injected at the same time. . . . It is certainly advisable before giving procaine penicillin to inquire for unpleasant reactions after injections for tooth extractions, for fibrositis, or for local anaesthesia.

Research by General Practitioners

Dr. C. E. S. FLEMMING (Limpley Stoke) writes: In the *Journal* of February 24 (p. 415) there is a letter by Dr. G. G. Dawson regretting that the general practitioner's claim to research is not acknowledged. In the *Journal* of June 3, 1944 (p. 759), there is an article on this subject by me setting out this claim in some detail.

Corrections

The author of the paper "Side-effects of Chloramphenicol and Aureomycin" in our issue of February 24 (p. 388) is W. Tomaszewski, not T. Tomaszewski.

In the leading article "Occupation and Peptic Ulcer" (March 3, p. 463) line 18 of column 1, p. 464 should read ". . . from 0.03% at ages 20–25 . . ." and *not* 0.3% as printed.

Professor A. D. M. Greenfield (Belfast) writes: The post referred to by Professors Frazer and Huggett in their letter "Spens Awards for Professors" (March 3, p. 477) at the Queen's University of Belfast is a lectureship in physiology and not a lectureship in dental physiology as they stated.

Obituary

P. J. MACLEOD, O.B.E., M.B.

Dr. P. J. Macleod, medical superintendent of Bridge of Earn Hospital, Perthshire, died on February 15 in Dundee Royal Infirmary at the age of 54. During his tenure of office he had established and developed in Bridge of Earn a rehabilitation centre which, under his lively and enterprising guidance, is now of national and even international reputation.

Peter John Macleod, who was the son of an outstanding Lewis seaman, meant to be an engineer. He went straight from school into the Royal Artillery in 1914 and did not take up his medical studies until after the war. He graduated M.B., Ch.B. at Glasgow University in 1924 and then served as an assistant in Stornoway before joining the Highlands and Islands Service, first in Applecross, then in Carloway. He returned as an independent practitioner to Stornoway, where he was prominent in forming the Outer Isles Division of the B.M.A. Early in the second world war the Department of Health for Scotland decided to establish a rehabilitation unit for miners at the E.M.S. hospital in Gleneagles Hotel, and Macleod was put in charge. Shortly afterwards he joined the R.A.M.C., but was later released to resume his work at Gleneagles. The scope of the unit was extended to surgical and medical cases generally, and with the closure of the hospital at Gleneagles it was transferred to the emergency hospital at Bridge of Earn. There after extensive alterations some 120 beds were devoted to this purpose. The adaptation, equipment, and organization of this centre were entirely according to Macleod's planning, and the success he achieved is ample proof of his efficient administration.

Sir Andrew Davidson writes: Macleod's approach to the subject of rehabilitation was warmly humanistic, based on an intense desire to do the very best for each and every patient. He believed that the work of the hospital was not complete till the patient had derived the maximum degree of restoration to fitness. The rehabilitation centre was called the "fitness centre" because he felt that rehabilitation began long before the patient reached the stage of going to a special part of the hospital. Rehabilitation began in the earliest stages of the illness and continued throughout treatment and if necessary after active treatment was discontinued. The fitness centre was thus only a part of the rehabilitation process. To visit Bridge of Earn was to see how the inspiration of a leader uplifted and gladdened the disabled patient and infused him with zeal in his task of working himself back to fitness.

One of the secrets of Macleod's success was that first and foremost he was a general practitioner of medicine. He had experienced the loneliness and the responsibility of single-handed practice in a remote area and was able thereby to enrich his natural interest in people by getting down to the very roots of human life. In the town of Stornoway he has left his mark; his house there was a centre of warm-hearted hospitality to the stranger.

In 1949 Macleod, who had been awarded the O.B.E. four years before, visited the United States and Canada with a Rockefeller travelling scholarship for the study of his subject, and during his sojourn there he was in great demand for discussion groups, lectures, and even broadcasting on one of the networks. His interests

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