have ever experienced and the pain usually precedes the development of neurological signs by a definite interval. Although operation was performed within a few hours of the development of the paraplegia, the degree of neurological recovery is often, as in this case, very slight.

My thanks are due to Mr. R. C. Connolly for permission to publish these notes.—I am, etc.,

Cheltenham. I. P. ROWLANDS.

Periodic Syndrome

SIR,—The correspondence on the periodic syndrome provides an open invitation to anyone concerned with the medical treatment of children to fly kites, trail coats, and generally let off steam. What we do about these cases depends on our outlook on disease, our skill, and our judgment. On the one hand, the laboratory doctor has a high time with his tests (a better time than his young patient) in a baffled search for scientific certainty of diagnosis. On the other hand, the clinician, wearied with past negative results, may miss the special features which should lead him to full investigation. In practice the doctor (whatever his category) is called upon to deal with three or four human beings in a particular recurring situation. Attention has to be focused yet again on the child who keeps reproducing the same pattern of symptoms. The symptoms themselves are rarely dangerous, but they disturb the life of the child, his family, and his doctor, and they cause much alarm because of the diagnostic possibilities which their nature suggests, such as appendicitis, cerebral tumour, tuberculosis, or epilepsy. The doctor's first duty is to determine whether there is a recognizable or treatable local cause for the syndrome. His success in this and in the selection of the right cases for the right investigations is a measure of his clinical skill.

Drs. John A. Davis and Thomas Stapleton refer (*Journal*, January 28, p. 233) to the dangers of mistakes, which can easily be made even by skilful and experienced doctors, be they physicians, surgeons, or any of the organ or disease specialists who may be consulted. The fact remains that in the majority of the cases to which Dr. J. J. Kempton refers (*Journal*, January 14, p. 83) investigation and the passage of time show that the symptoms are not serious and do pass, suggesting an origin in the child's temporary failure to adjust to the needs or the demands of growth and of life. The usefulness of the careful acceptance of this concept is great, with due respect to Drs. Davis and Stapleton. First, it relieves all those concerned with the case from the tension and the anxiety which, when present, add so much to the child's difficulties, for reassurance is really the first important step in treatment. Secondly, it shows the need to search widely, in the family and in school, for points of excessive strain.

Unfortunately the most famous of the periodic syndromes is cyclical vomiting. My belief is that this, at least in its severe forms when associated with dehydration and chemical acidosis, is most likely to have an underlying pathology that will one day be recognized. Dr. Hugh R. E. Wallis (*Journal*, January 28, p. 233), like Dr. Millichap and others whom he quotes, have shown that cyclical vomiting sometimes shares the nature of epilepsy, which is not the same as saying that all children with cyclical vomiting are epileptics. But even if cyclical vomiting be excluded altogether, there remain enough cases to give a real value to the concept of the periodic syndrome in children formulated anew by Dr. Kempton.—I am, etc.,

London, W.1. ALFRED WHITE FRANKLIN.

SIR,—Drs. John A. Davis and Thomas Stapleton (*Journal*, January 28, p. 233) object, a little incoherently, to the periodic syndrome, a term which certainly has some disadvantages, though my submission is that it is better than others commonly used and a useful heading under which to discuss these interesting children. The suggestion that it is a new christening is, of course, quite wrong; the periodic syndrome had a perfectly respectable introduction into paediatrics 23 years ago.[1] True, it is only relatively recently that, under the editorship of their director, it has achieved a textbook chapter heading.[2]

I did not at any point state or imply (*Journal*, January 14, p. 233) that "psychological disturbances, as manifested by pallor, headache, abdominal pain, and vomiting, even fever," are cured by labelling them (though in fact they sometimes are). The suggestion was that such cases should be watched. Sometimes they have appendicitis.

In Bath they have epilepsy, and perhaps it is better to leave it so, though I would just like to suggest that before publishing his monograph Dr. H. R. E. Wallis (p. 233) might read the Skinner lecture on "The Nature, Methods, and Purpose of Diagnosis," to which the author, Sir Henry Cohen, drew attention in your columns (*Journal*, January 21, p. 173). Drs. John A. Davis and Thomas Stapleton might read it too.—I am, etc.,

Reading. J. J. KEMPTON.

REFERENCES

1 Wyllie, W. G., and Schlesinger, B., *Brit. J. Child. Dis.*, 1933, **30**, 1.
2 Gaisford, W., and Lightwood, R., *Paediatrics*, 1954. Butterworth, London.

Virus Epidemic in Recurrent Waves

SIR,—I was very interested to read Dr. A. Stafford Steen's letter on virus epidemic in recurrent waves (*Journal*, January 28, p. 235). For the past 16 months, excluding the very hot summer months, we have been experiencing in this area what might be termed a chronic epidemic of a symptomatologically identical disease.

Practically all the symptoms listed by Dr. Steen have been observed, the most striking being those caused by tracheitis—i.e., a very chronic and persistent cough, frequently accompanied by vomiting. Injected pharynx is invariably present, and occasionally oedema of the nasopharynx gives rise to a particularly painful sore throat during the first two or three days of the initial attack. Loss of weight is frequently observed, particularly in children, and anorexia is very pronounced in all cases. Like Dr. Steen, I have myself suffered many attacks—five last winter and four since last September—but I do not think that these are separate recurrent attacks so much as acute exacerbations of a chronic infection which never really resolves except possibly during the summer months. The vast majority of the local population have been infected, and I have reason to believe that the disease is widespread throughout the country.

I have never known a single disease to cause so much loss of work in a community. This is due to its chronicity, to the lassitude which persists for many weeks afterwards, and to the extremely infectious and recurrent nature of the disease. The illness, as in Perth, Australia, appears to have escaped serious attention, not so much due to the mildness of the symptoms (which are not really mild at all) as to the absence of serious complications. All antibiotics appear to be useless, as would be expected. I have no doubt that Dr. Steen's letter will produce others such as this from many parts of the country.—I am, etc.,

Gilfach Goch, Glam. T. D. JONES.

Erythema ab Igne

SIR,—As I have enjoyed the letters from Drs. M. Dales, J. Martin Beare, and Ian Sneddon (*Journal*, January 21, p. 170), I feel impelled to reply to them. Dr. Dales states that I invoked endocrine factors to account for the absence of erythema ab igne in males—to be exact, I was far less dogmatic and timidly remarked that "it may be that endocrine factors play some unknown part in the production of the lesions" (*Journal*, December 31, 1955, p. 1599). However, I was glad to receive support for this tentative idea in all three letters—in Dr. Dales's, the mention of his elderly male with advanced myxoedema and erythema ab igne; in Dr. Beare's, the fact that the latter dermatosis is almost universal in Ulster country districts in postmenopausal women; in Dr. Sneddon's, his suggestion that "another possible factor is the increased incidence of reti-

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