

little velocity, that that makes a change on the conditions of the problem. Here it is not a question of the velocity of the vessels at all, but purely a question of the velocity of light, which for any finite distance may be regarded as infinite. So soon as ever a vessel appears on the horizon a hypermetropic man will see it equally well with an emmetrope; I myself, with a dioptré and a half of hypermetropic astigmatism against the rule, have no difficulty in the matter whatever. It is purely a question of the velocity of light, not of the velocity of the vessels. Moreover, a man with that amount of hypermetropia has not the least dubiety as to which vessel is to clear the other. There are definite rules laid down by the Board of Trade on the subject, and it is not a question of speed but a question of position which determines the matter. I have no doubt whatever that anybody with 2 or 3 dioptrés of hypermetropia is perfectly as safe as a man who is approximately emmetropic.

I think it also possible, although I am not certain of it, that a man with a weak myopia may be safe; certainly I know of one case where a man with 5 dioptrés of myopia did pilotage for many a year. The radical blunder has been in attempting to make navigational ability a function of visual acuteness. Again let me express my thanks alike to you and to the reviewer.—I am, etc.,

Glasgow, Oct. 9th.

FREELAND FERGUS.

P.S.—I have no doubt whatever that the Royal Navy is annually deprived of the services of many excellent officers by the fact that the Admiralty insists on emmetropia.

ACCIDENTS DUE TO DEFECTIVE SIGHT :  
A CORRECTION.

SIR,—In a small book that I have lately brought out, *On Cases of Accident to Shipping and on Railways due to Defects of Sight*, which was favourably noticed in the JOURNAL of September 13th, Case 41, the case of the Guisborough accident on the North-Eastern Railway on January 1st, 1908, was included with others in a miscellaneous group of suspicious, although unproved, cases in which a defect of sight in the engine driver if present would have afforded a satisfactory explanation of the disaster. I think the attitude I took was justified by the facts that the report of the Board of Trade inquiry contained not a word as to the driver's sight having been examined after the accident and that I had no access to other information. Your own annotation upon the case in the JOURNAL of April 4th, 1908, was no doubt based also on the Board of Trade report. I have now just heard from Dr. J. G. McBride, the medical inspector to the North-Eastern Railway Company, that the driver, then aged 46, was examined by himself a month after the accident and found to have visual acuity of  $\frac{5}{6}$  in each eye and normal colour vision to Holmgren's test. He was injured at the accident, and could not be examined sooner. He has since been tested with Edridge-Green's lamp, and found to be normal. Although the man might possibly have been suffering from slight tobacco amblyopia at the time of the accident, such an interpretation is so much less probable in the light of Dr. McBride's information than it was before, that had I known, when writing the book, what I know now I should not have considered the case sufficiently strong to justify its inclusion in my list. It would have been more satisfactory if the result of Dr. McBride's examination and the reason that prevented this from being made until some weeks after the accident had been incorporated in the report of the Board of Trade Inspector.—I am, etc.,

Hindhead, Surrey, Oct. 11th.

E. NETTLESHIP.

THE SURGICAL TREATMENT OF PULMONARY TUBERCULOSIS.

SIR,—In your annotation of October 11th you refer to the difficulties of obtaining suitable cases, and to the disadvantages of producing artificial pneumothorax. One observation certainly holds true—that any form of treatment ought to do better in early rather than in late (one-sided) cases of phthisis, whereas artificial pneumothorax seems reserved for the later cases only.

Having seen the process, may I suggest as an advance on artificial pneumothorax that the production of artificial

pleuritic effusion would offer greater advantages in both early and late one-sided cases?

If a splint be required to rest the affected lung, surely a liquid rather than a gaseous medium, following Nature's hint in pleurisy with effusion, should be employed. I would suggest saline infusion, or, perhaps better still, sterilized oil, with the addition of sulphur and creosote in small quantities. This mixture, in my experience in localized tubercle after scraping, is the best dressing for the condition. And if a splint of oil to compress the lung were first employed on dogs, I venture to think the same method, seasoned with sulphur to compress and disinfect the affected lung, might be usefully employed in human subjects.—I am, etc.,

Newcastle-on-Tyne, Oct. 14th.

T. M. ALLISON, M.D.

SIR,—May I contribute a commentary to the paper under this heading in the JOURNAL for October 11th, with its rather pessimistic beginning, "The possibility of affording temporary relief . . ." ?<sup>1</sup> Discussing the action of an artificial pneumothorax, Dr. L. Spengler<sup>2</sup> has recorded 15 cases in which it had been induced from nine months to four years earlier. All these patients could do a full day's work, they had neither fever nor cough, and tubercle bacilli were no longer demonstrable.

With regard to the statement, "Statistical evidence as to the proportion of success achieved is not as yet forthcoming," I would point out that, at the International Medical Congress in London this summer, Professor Saugman read a paper in which he analysed 100 cases of advanced pulmonary tuberculosis, in which artificial pneumothorax was prescribed. In 36 cases pleural adhesions prevented the realization of this treatment. These cases were in other respects similar to the 64 cases in which a pneumothorax was induced. The following comparison, therefore, gives a fair estimate of the benefit to be derived in advanced pulmonary tuberculosis (1) from sanatorium treatment alone, and (2) from sanatorium plus pneumothorax treatment. No patient is included in this table for whom a pneumothorax was prescribed less than nineteen months earlier.

Fit for Pneumothorax Treatment (100).	Pneumothorax Effected (64).	Not Effected (36).
1. Able to do ordinary or light work	32	8
2. Unable to work on account of tuberculosis	18	12
3. Dead from tuberculosis ... ..	12	14
4. Unknown ... ..	0	1
5. Dead from acute complications...	2	1
Not considering the last three, the percentage is as follows:	Percentage.	Percentage.
1. Able to work ... ..	51.7	22.9
2. Unable to work ... ..	29.0	34.3
3. Dead from tuberculosis ... ..	19.3	40.0
4. Freed from tubercle bacilli ...	50	8.6

Striking though this comparison is, it does not yet do full justice to the treatment as confined to practically unilateral cases; for Professor Saugman has prescribed it in cases with the healthier of the two lungs considerably diseased. Even in such cases wonderfully good results may sometimes be obtained; but the practically unilateral cases are those in which, as a rule, the improvement is most dramatic and permanent. I do not suppose one lung is ever perfectly healthy when its fellow is extensively diseased. Cases of severe but unilateral disease, instead of being "counted in units," should be discreetly tucked away with "the Emperor's new clothes."—I am, etc.,

Gorleston-on-Sea, Oct. 13th.

CLAUDE LILLINGSTON.

TURBINECTOMY.

SIR,—I am pleased to hear that Sir Robert Woods repudiates the report of his remarks, but think he does not quite meet my criticism. My contentions are that:

<sup>1</sup> The italics are mine.

<sup>2</sup> *Münchener Medizinische Wochenschrift*, February 28th, 1911.