

far. My job was to see all chest wounds on admission, decide whether operation was necessary or not, have the foreign body located by x rays, and send the report to the surgeon with the patient for removal of the foreign body. After operation I looked after the patient until he was able to be evacuated to the base.

Of course one got mixed cases of chest and abdomen, chest and spine, wounds of the heart, etc., but I am sure that, so far as possible, specialization in one particular line saves lives and prolonged convalescence.

I used to come across American doctors operating on our men at C.C. stations long before any American troops were in the line. In that way they learnt experience on our men, which always worried me at the time; some were quite good surgeons and some were not.—I am, etc.,

Swanage, Oct. 12.

W. A. REES.

### Organization of First-aid Posts

SIR,—I have read with keen interest Dr. C. Seely's article on this subject in the *Journal* of September 30 (p. 697), and also Dr. W. N. Leak's able comment (October 7, p. 744). I do not think it is fair either to the patient or to the members of first-aid parties to leave responsibility for disposal of cases in the hands of these men. My experience during the last war was that properly trained men were capable of rendering immediate first aid and bringing the patient to the doctor, from whom the patients were able to receive such further attention as was needed to prepare them for transport to the advanced dressing station, but that few were capable of "exercising discretion in the initial disposal of cases."

Surely the medical officer of the first-aid posts should have this responsibility? The aid post would then be able to discharge its proper function, as laid down in E.M.S./Gen/245, "to arrest haemorrhage, relieve pain, and so prepare those casualties who may be found to require institutional treatment that they can be transferred to the receiving hospital with the least possible harm—that is, by having taken steps to prevent any immediate deterioration." At the first-aid post the patients would receive the immediate and preventive treatment of shock recommended by Colonel E. M. Cowell (April 29, p. 883), and the minimum necessary wound treatment, morphine, serum, etc. Patients would be sent on to the receiving hospital when it was ready to deal with them. The first-aid post would then be fulfilling the important function of "acting as a buffer to the receiving hospital, and so preventing it being overcrowded by the less seriously wounded" and the moribund.—I am, etc.,

Stalybridge, Cheshire, Oct. 10.

ERIC M. MOLESWORTH.

### Manzullo's Tellurite Test for Diphtheria

SIR,—The Manzullo application of potassium tellurite to pharyngeal exudate attracted\* considerable attention. Your pages in June, 1939 (pp. 1273 and 1275) describe results given by the test which may be misleading.

With the encouragement of Dr. E. C. Benn, the superintendent of the Leeds City Hospital for Infectious Diseases, I have tested 200 successive patients admitted with membrane or exudate. The problem was, Would the Manzullo test help the clinician? Of 113 patients who appeared clinically to be suffering from diphtheria, 103 (91 per cent.) gave a positive swab, while only 96 (85 per cent.) gave a positive tellurite result. Of the 17 tellurite negative, 15 gave a positive swab and one proved fatal. Thirty-nine patients "clinically negative" gave 37 (95 per cent.) negative swabs, while only 21 (54 per cent.) gave a tellurite negative result. Put in another way—of 152 patients, 113 appeared positive clinically and 39 negative; this diagnosis was supported bacteriologically in 92 per cent. while the tellurite test agreed in only 77 per cent. In the "doubtful" clinical group (48 cases), 35 (73 per cent.) were bacteriologically positive, but of these only 18 (37 per cent.) were positive by the Manzullo method also. In this doubtful group the bacteriological evidence, essential for final diagnosis, was supported by the tellurite result in only 23 cases

(18 positive, 5 negative)—that is, 48 per cent. One must therefore conclude that the test is of no real help to the clinician, who must find his treatment in the first place on clinical signs.

Professor McLeod very kindly examined cultures from all the 200 cases. There were 75 gravis, 61 mitis, 1 atypical intermedium, and three untyped positive.—I am, etc.,

Leeds, Oct. 5. HESTER E. DE C. WOODCOCK, M.B., D.P.H.

### The Patellar Sign and Osteo-arthritis

SIR,—Dr. T. C. McCombie Young's letter on patellar crepitus and osteo-arthritis in your issue of September 30 (p. 702) is very welcome as it provides exactly that control group which it is impossible to obtain in a rheumatism clinic—a fact recognized by Dr. McCombie Young, who has indeed done us signal service by his observations. He is, however, mistaken in suggesting that a positive patellar sign is held at the Charterhouse Rheumatism Clinic to be an indication of the actual onset of osteo-arthritis.

It is a fact that every case of arthritis, without exception, whether the knees are affected or not, gives a positive patellar sign. Therefore patellar crepitus in a rheumatic patient obviously constitutes a threat that osteo-arthritis might later develop. Drs. Walker and Sandell have recently demonstrated in a series of sections that crepitus is due to fibrillation from destruction of cartilage. It is for this reason that patients suffering from muscular rheumatism, fibrositis, bursitis, or synovitis are grouped according to the patellar sign. If this is negative even those with quite severely swollen joints are labelled as synovitis or capsulitis, since these clear up and leave no trace. If positive, then even the mildest of rheumatic cases is placed in the group named "early osteo-arthritis" (although osteo-arthritis under proper treatment will seldom develop). The term "early osteo-arthritis" may not be strictly logical, but it must be remembered that it is applied only to rheumatic patients and not to healthy individuals.

Dr. McCombie Young finds that in 15 per cent. of his recruits cartilage was degenerating. The bearing on the aetiology of osteo-arthritis is obvious, and the percentage does not seem too high considering the prevalence of that disease in later decades. Can Dr. McCombie Young tell us whether the 15 per cent. of positives (a) gave a family history of cripples, and (b) had suffered from rheumatism (excluding fever) in childhood? If not, possibly in further examinations of recruits these questions might be resolved. No doubt the records will be available, so that in future we may find some of this group developing osteo-arthritis, thus confirming our view at the Charterhouse Rheumatism Clinic that osteo-arthritis is a disease which attacks people whose cartilage is constitutionally vulnerable and therefore easily damaged by friction.—I am, etc.,

London, W.1, Oct. 12.

H. WARREN CROWE.

### Vitamin C in Black-currant Juice

SIR,—I should like, through the medium of your columns, to bring to the notice of my colleagues in the medical profession the virtue of matured, freshly expressed, black-currant juice syrup. The vitamin C content (77 mg. per 100 c.cm.) is 50 per cent. higher than that of the common citrus fruits—as a matter of fact it is considerably higher than that of any of the fruits easily obtained in England. Oranges and lemons may possibly soon be difficult to obtain, by reason of either cost or scarcity. Black-currant juice syrup forms a very efficient, in my opinion a better, substitute. Being depectinized it is easily tolerated by all, and especially by children of all ages. It is prepared in England from English fruit. The following is an analysis of its content.

*Sugars.*—Fructose, 25.4 per cent.; glucose, 26.0 per cent.; sucrose, 1.7 per cent.

*Ash.*—0.36 per cent.

*Iron.*—11 parts per million.

*Vitamin C.*—77 milligrammes per 100 c.cm. by volume, or 61 milligrammes per 100 grammes by weight.

The added sugar is inverted to glucose in the process of maturing. There is also a small proportion of organic iron.