syndrome, and are merely manifestations of other associated deficiencies. There may even be some who would wish to define pellagra as "the clinical consequence of uncomplicated nicotinic acid deficiency." Armed with this definition, it might then be true to say that nicotinic acid will cure pellagra, but the fact still remains that it will not cure pellagrins. Moreover, it would be impossible to give a clinical description of pellagra as so defined, since a pure deficiency of nicotinic acid, unassociated with any lack of other essential dietary factors, has probably never yet been seen in man. Your editorial implies that the simple administration of nicotinic acid is sufficient and adequate treatment for a case of pellagra, whereas the fact is that nothing short of a radical readjustment of the diet will result in a complete and satisfactory cure.

Your editorial also states that "the incidence of pellagra appears to depend not so much upon the lack of nicotinic acid in the diet as on the failure of the intestinal mucosa to absorb it." It is true that pellagra occasionally arises in consequence of some gastro-intestinal disease affecting digestion and absorption, but, in the common endemic disorder, the obvious inadequacy of the diet is surely a sufficient explanation of the deficiency, without calling in the additional hypothetical factor of faulty absorption.

You also state that "pernicious anaemia is often accompanied by glossitis similar to that of sprue and pellagra, and this is also amenable to nicotinic acid therapy." I am most surprised by this statement, since I had thought that all authorities on pernicious anaemia are now agreed that nicotinic acid has no effect on any feature of the glossitis in this disease.—I am, etc.,

Oxford Nutrition Survey, Nov. 22. ARNOLD P. MEIKLEJOHN.

Unusual Outbreak of Haemolytic Streptococcal Infection

SIR,—The seasonal epidemic of haemolytic streptococcal infections of the nasopharynx is upon us, and I think that the following brief report of an unusual outbreak will be of interest. Details have been sent to the Medical Research Council by the county bacteriologist, Dr. J. S. Croll, who has been extremely helpful and interested. The late Dr. Griffith, immediately before his tragic death, typed some of the strains.

On January 12 last a woman went alone to the lonely farmhouse where lived her sister and brother-in-law with their large family of children. Three days later she was delivered normally of her thirteenth child. It was discovered eventually that a few months previously she had sent some of her other children away with scarlet fever. On January 16 she developed pyrexia and later sore throat and cervical adenitis. On January 18 the road became completely blocked by snow, and for several weeks no one could approach except on foot or horseback over the fields. The house was thus isolated from all except myself and the foreman's employer. Between January 22 and February 4 three persons in the house developed typical scarlet fever and three tonsillitis without rash. Two of the latter developed nephritis, as did the parturient woman, and all of these patients were extremely ill. The scarlet fever patients were not ill and had no complications. Repeated throat swabs of all, except, curiously, the original case, gave cultures of haemolytic streptococci, Type A, Group 14. I regret now that I did not obtain a culture from the lochia.

The source of the epidemic is not important and I am not concerned with case histories or treatment. My point is this. In view of the accumulating evidence, how much longer must we wait for reform of the existing rules of treatment and notification of scarlet fever?—I am, etc.,

Barton-on-Humber, Nov. 26. T. H. KIRK.

Sulphonamides and Catgut

SIR,—I have heard the suggestion from more than one source that catgut employed for suturing wounds may have its normal rate of absorption seriously accelerated by the presence of sulphonamide powder, such as one has been using, for instance, in the abdominal wound in cases of gangrenous appendicitis. I have personally not yet found any reason for anxiety through rupture of such wounds, but I thought it would be helpful if others readers could bring forward any first-hand evidence either for or against this impression.—I am, etc.,

Bournemouth, Nov. 27. NOEL F. ADENEY.

Hemiprostatectomy

SIR,—The respect due to a surgeon of the eminence of Mr. W. Sampson Handley is enhanced when one has had the privilege of serving as his dresser, and it is therefore with some misgiving that I venture to offer any criticism of his advocacy of hemiprostatectomy (November 15, p. 681). Whilst I am in agreement with much of what he says, I feel that the general adoption of this operation even for one case in five would be a retrograde step. The figures he quotes from Thomson-Walker to support this proportion as suitable cases refer only to the intravesical projection and not to the all-important intra-urethral enlargement; and the conclusions of the same author that "the apparently normal lobe shows changes on section and microscopical examination which correspond exactly to those of the large lobe" are confirmed by the routine examination of all prostates in which both lobes are removed.

I would agree that the maintenance of continuity of the vesical and urethral mucous membranes posteriorly is an advantage, and the restoration of this continuity is one of the important principles of the Harris operation; the intra-urethral method of digital enucleation recommended by Harris (*Brit. J. Surg.*, 1934, **21**, 437, 442) is designed to leave intact the verumontanum and the urethral mucosa below it.

The shock produced is due to a summation of all the traumatic stimuli set up in the whole operation, and it is difficult to believe that the shock from hemiprostatectomy is only one-half that of total prostatectomy. In any case the shock can be minimized by a suitable combination of anaesthetics and by gentle rather than rapid enucleation.

Mr. Sampson Handley states that he has no experience of later enlargement of the residual lobe after hemiprostatectomy; I have recently seen and operated upon such a case. Left hemiprostatectomy was performed by one of Mr. Handley's colleagues in June, 1933, for a man of 57 with acute retention (two-stage operation). In May, 1941, he returned with acute retention: there was gross urinary sepsis and his general condition was poor. The remaining right lobe was moderately enlarged on rectal examination, but was seen on urethroscopy to project to the left and to produce much distortion of the urethra; on removal it showed the usual changes of senile enlargement. This patient died six months later from hypertensive failure and auricular fibrillation.

To compare hemiprostatectomy with endoscopic resection seems to confuse the issue; endoscopic resection undoubtedly has an important place in prostatic surgery, and it may be mentioned as a personal experience that where an adequate amount of tissue is removed in the first place by resection from a benign enlargement there is little tendency to a return of obstructive symptoms later.

After this preliminary report I shall await with interest the after-histories of the two patients operated upon this year and of the others for whom the operation has been done, but on the present evidence I am unconvinced that it has anything to offer over the accepted methods of treatment.—I am, etc.,

London, W.1, Nov. 24. E. W. RICHES.

SIR,—I have read with interest Mr. W. Sampson Handley's article on hemiprostatectomy (November 15, p. 681). In it he states that transurethral resection accomplishes "at best a partial removal of the adenomatous mass, the rest of which may continue to grow with a return of obstructive symptoms." Surely this description is more readily applicable to the operation he describes than to the modern "punch" operation, perfected by Gershom Thompson and Emmet. I have had the privilege of seeing Mr. Wardill of Newcastle using the "cold" punch, and can assure Mr. Sampson Handley that the removal of adenomatous gland is very nearly complete: ". . . as much of the enlarged gland is removed as possible. This in many cases must amount to about four-fifths; in some cases as much as 64 grammes has been removed at one sitting" (Wardill, W. E. M., *Lancet*, 1941, **2**, 127).

The statement that "it seems likely that hemiprostatectomy will have a lower mortality and will offer more security against the recurrence of obstruction" (than punch prostatectomy) does not seem to be a fair conclusion to draw from the two cases quoted, and is indeed rather surprising, when the fact that in 1935 Gershom Thompson published a series of 451 punch operations without mortality was noted earlier on the same page.