In the case of the man who was infected six months ago by the woman he proposes to marry, it is fairly obvious that he is liable to be reinfected by her unless she is treated. Certainly it would be wise to examine her, because if she infected the man, obviously she herself was infected.

There is no doubt that a mild urethritis, difficult to cure and liable to relapse, has become much more common during the last three or four years than it was previously. A good deal of work has been done on it, but the cause has not yet been definitely identified and treatment is largely empirical in consequence. (See also *Brit. J. vener. Dis.*, 1942, **18**, 106.)

INCOME TAX

Payment to Wife

W. B. asks what is "the highest sum one can pay one's wife (for clerical assistance, etc.) free of income tax from the practice account."

*** The only possible answer to this question is that the wife can be paid as much as her services to the practice are worth—and no more. The effect on taxation depends on the extent to which the wife's earnings as an employee would be taxable. At present the wife is entitled to a maximum allowance of £80 against her earnings, and to the 10% earned income allowance, if the husband is not already receiving the maximum amount (£150) of that allowance.

Eire Resident: English Building Society Interest

M. M. asks: "Is an Eire resident liable to the Eire Government for income tax on dividends received from an English building society?"

*** The only reason why such dividends are not assessed on British residents is that under a special arrangement the building societies make payment to the British Government of sums estimated to be a reasonable composition for the tax which would otherwise be due from depositors, etc. So far as we are aware no such payment is made to the Eire Government and the answer to this question is apparently "Yes."

LETTERS, NOTES, ETC.

Names of Drugs

Dr. DONALD V. BATEMAN (Woodford Green, Essex) writes: In "Any Questions?" (Oct. 13, 1945, p. 519) there is a question on "Generalized Sweats," in the course of which the questioner refers to phenobarbitone. In the answer mention is made of the same drug but as represented by the word "luminal" with neither capital initial letter nor inverted commas. It is disappointing to find your correspondent falling into the habit of referring to a proprietary product as though the name were an official pharmacopoeial word. Not so very long ago many candidates in a final examination, asked about nikethamide, were nonplussed by what seemed a mysterious word, when they could have written about "coramine" with familiarity. Our authority for a drug's correct name is the *British Pharmacopoeia*; *not* one particular commercial firm's trade mark for its own preparation of the drug.

*** At the same time we should remember that the discovery of the drug is often made by the commercial firm in the first instance, or rather by its chemists.—ED., *B.M.J.*

Bell's Palsy

Dr. EDGAR CYRIAX (London, W.1) writes: I have read with great interest the article by Drs. H. P. and Cecily M. Pickerill on the early treatment of Bell's palsy (Oct. 6, p. 457). But I feel I must draw attention to a method of treatment of peripheral facial paralysis which is very little known. Briefly speaking, it consists of manual vibrations applied over the mastoid process to promote absorption of the exudation so often present, and of manual mechanical stimulation of the facial nerve by means of "nerve friction" according to the methods of Henrik Kellgren. This treatment, especially as regards the vibrations, can be started immediately, and the combined manipulations give very good results indeed. A complete technique has been described by me in *International Clinics* (1912, 22s, **1**, 40) and *Brit. J. phys. Med.* (1943, **6**, 37).

Liver Extracts

Dr. H. M. WALKER (London) writes: In "Any Questions?" (Oct. 6, p. 482) an inquiry is made regarding the treatment of aplastic anaemia or essential thrombocytopenia with liver extract. The reply contains some statements which seem to be contrary to all established fact, and in many ways misleading. The statement that "it is a good rule that no patient with a blood disorder should be denied the opportunity of responding to liver therapy" is completely at variance with experience and practice. What effect would liver extract have on myelogenous leukaemia or haemolytic anaemia? Liver extract is specific in macrocytic anaemias, and, although it may have some value in combination with iron in iron-deficiency anaemia, its use in the latter condition is by no means generally accepted. The statement that purified extracts are more reliable than crude, and the conclusion that this is due to greater care in clinical testing, is incorrect. Both purified and crude extracts are reliable, and they are submitted to exactly the same type of test. Finally, the statement that the use of proteolysed liver therapy by mouth is superior to any form of intramuscular therapy is just incorrect. Injection treatment is the method of choice, and is supported by all the authoritative writers on the subject.

Infection from Dead Teeth

Dr. SYDNEY PERN (Ballarat, Victoria) writes: In your issue for May 26 (p. 749) Dr. J. B. Parfitt discusses infection from dead teeth. I cannot say that from twenty-five years' experience I am in agreement with him. I have long ago given up the idea that *x*-ray examination was of any value in deciding infection or otherwise, as on so many occasions where the film proved negative extraction showed gross infection and the patient recovered. I would like to quote from a paper by Dr. Russell Hayden, published in the *Dental Cosmos*, read before the Radiological Society of North America on Dec. 10, 1924. The experiments were carried out in the Department of Medical Research, Deaner Institute, Kansas City. Cultures were made in deep tubes of glucose brain-broth agar. He states: "The changes which from the *x*-ray standpoint are usually considered as indicative of infection are all, in fact, evidence of resistance of the host to the infection. In cases of systemic disease arising from chronic foci the very existence of the systemic lesion is in itself evidence of lack of resistance to the focal lesion. It is logical also to assume that the infected pulpless tooth which shows no evidence of infection is a far greater source of danger than one which does show definite radiographic evidence. . . . Cultures have been made of the apical tissues of 1,307 vital and pulpless teeth and the findings compared with the radiograms. Of 490 pulpless teeth negative in the radiogram 10% showed from 1 to 10 colonies, 44% showed 10 or more, and 24% showed over 100 colonies. Of 425 pulpless teeth with positive radiograms 10% showed from 1 to 10 colonies, 60% had 10 or more colonies, and 44% showed over 100 colonies. The incidence of infection is almost as high in the radiographic negative group as in the radiographic positive group. The absence of radiographic evidence of infection at the apex of a pulpless tooth never excludes the presence of active infection. In many cases the radiographic negative tooth is a far greater source of systemic infection that the radio-positive tooth, since in the former there may be little resistance to the infection." With root infection of dead teeth the general belief is that the infection comes from the tooth itself. In many cases this is not so, as Rosenow has shown that intravenous injections of organisms can and do lodge in the pulp of live teeth and set up foci of infection; thus, however carefully teeth are prepared there is always a possibility of their becoming infected at some future time from food-borne micro-organisms, and so it comes about that any dead tooth is always a source of potential danger. Another fallacy is that because a person is not feeling ill he is therefore not receiving any injury from an infected tooth. Organisms can be poured into the blood stream for years before any particular organ or tissue becomes sensitized to that organism, but that does not say their bodies are receiving no injury; bacterial toxins may be circulating in the blood, causing deterioration of blood vessels and cartilages which eventually results in hyperpiesis and chronic arthritis long before any symptoms are manifest to the individual. One finds that a large proportion of the diseases we are called upon to treat are the result of dental infection from either gingival or root infection. An eye specialist not long ago made the remark that a third of his work resulted from dental infection. If we take the fact that *x*-ray examination is of no value in assessing apical infection and that an individual can be receiving gross pathological damage from bacterial toxins without showing any definite symptoms, we have to ask ourselves the question: Is it worth while carrying a dead tooth when the penalties are so great? Surely the time has come for the dental profession to give us some conclusive evidence as to the usefulness or otherwise of any form of treatment in gingival or apical infections. Personally I cannot say that I have seen any permanent results, which means that the individual is left with a virulent streptococcus entering his blood stream.

Herpes Zoster and Varicella

Dr. B. H. SYMON (London, S.W.8) writes: On Oct. 16 a middle-aged woman consulted me with regard to a definite patch of herpes zoster round the left side of her waist. The symptoms were characteristic. Two days later she sent for me, having developed an attack of varicella, also with characteristic symptoms and hard palate affected. This would surely imply that the virus of the two diseases is the same.

Correction

In Dr. W. W. Shrubshall's letter (Nov. 10, p. 668) there is a small typing error which, though obvious, needs correction. In the last line "overheating" should of course be "overeating."