elastic adhesive bandage is one of the most important and valuable weapons in the treatment of varicose ulceration.—I am, etc.,

London, W.1. R. ROWDEN FOOTE.

SIR,—Mr. Harold Dodd's satisfaction (November 5, p. 1046) with the end-results of his method of inducing thrombophlebitis in the saphena trunk at ligation operation for varicose veins can hardly be shared by all readers. For, with proper surgical candour, he reports in his series of over 1,000 patients so treated in three years two cases of deep thrombophlebitis and one of pulmonary embolus, all happily recovered.

It is therefore apparent that even when the most favourable conditions obtain—viz., Mr. Dodd using his own method, with his operative skill, finely tempered by wide experience in operating on these cases over many years, and his exacting supervision—the dangerous sequelae, deep thrombophlebitis and pulmonary embolism, cannot be wholly avoided. I must add my commentary that in an unselected run of over a thousand patients whose varicose veins are left unabraded and uninjected neither deep thrombophlebitis nor pulmonary embolism is to be expected.—I am, etc.,

London, W.1. H. M. HANSCHELL.

Visual Defects in Young Children

SIR,—While the pilot survey carried out by Dr. P. A. Tyser and Mr. T. W. Letchworth (November 5, p. 1022) proves the value of the early ophthalmic examination of young children, it is not possible at present to cover the whole of the pre-school child population by such means. But it is possible for school nurses to discover among school entrants of 4 and 5 years of age, by means of picture-type test cards like those devised by Dr. Beale Collins, most of the children with defective vision. Children with squints are sent as a matter of course for ophthalmic investigation.

In York last year 6.9% of school entrants were found to need treatment or supervision at an ophthalmic clinic, 4% having squints. More than half the children with squints had already been seen by an ophthalmologist. Eighty per cent of the 4-year-olds and 97% of the 5-year-olds are able to co-operate in the testing of their vision by means of picture-type test cards. To leave school-children until the age of 7 or 8 years before testing their vision is a mistake, as irreparable damage may have been done by then.—I am, etc.,

York. F. B. SHEVLIN.

SIR,—May I suggest two additions to the visual survey of young children suggested by Dr. P. A. Tyser and Mr. T. W. Letchworth (November 5, p. 1022)? The first is the cover test, which can be used as soon as a child will fix its vision on a torch attentively for even a few seconds. Very little experience is necessary to enable an examiner to notice a phoria which is likely to develop into a squint.

The second is a subjective test to which most children of 3 will respond. Each eye is tested separately with the ordinary twelve-sided threepenny bit. With very little encouragement they will name heads and tails as "the man" or "the bunch of flowers." They always guess when they cannot see, but it takes only seconds to find the distance at which you cannot catch them out. This gives a direct comparison of the visual acuities of the two eyes. In good light recognition at 2 metres is about equivalent to 6/7.5.—I am, etc.,

London, S.W.1. CHARNWOOD.

Treatment of Cutaneous Anthrax

SIR,—There are three points in Dr. L. Hoyle's letter (October 15, p. 875) with reference to the treatment of cutaneous anthrax which should not be allowed to slip by uncriticized.

1. To deprecate the use of penicillin after trying it therapeutically in two cases only and without quoting the dosage is unwarranted, particularly as the recent literature indicates that penicillin is the most effective readily obtainable antibiotic against *B. anthracis*. Incidentally, in our series of cases there was no great increase in the inflammatory reaction around the lesions, nor any marked elevation of the patient's temperature. All that was noticed was a mild increase in local irritation which did not arouse anyone's concern.

2. We should be interested to have experimental evidence or otherwise of the assumption that penicillin used therapeutically is bactericidal for *B. anthracis*.

3. We do not think that patients relish receiving 100 to 200 ml. of anthrax antiserum subcutaneously. They are far more comfortable and develop no ill-effects (apart from slight generalized pruritus on or about the eighth day) following intravenous administration.

In spite of the production of more effective modern remedies for this infection, we still agree with our forebears that cutaneous anthrax constitutes a severe disease, and do not for a moment think of altering that opinion.—We are, etc.,

J. A. HOLGATE.
Leeds. R. A. HOLMAN.

Vaccination During Measles

SIR,—Due to a misunderstanding a baby of 7 months was inadvertently vaccinated during what later transpired to be the acute catarrhal stage of morbilli. The history of this case was as follows.

The baby was vaccinated on May 30, 1949. His mother had stated he was free from infection and had no skin rash. During the insertion of the lymph the child made a sudden movement, producing a linear scratch 1 in. (2.5 cm.) in length. Blood was drawn. He was seen urgently on June 4 at 11.30 p.m. He had developed a rash on the body the day before. He appeared ill and lay apathetic in his cot; there was distressed respiration, anxious look, and dry irritating cough. The temperature was 102.5° F. (39.1° C.), and the pulse rate was rapid; the tongue was furred. There was evidence of Koplick's spots. Slight nasal catarrh was present, but no definite conjunctivitis. There was a generalized morbilliform rash, more pronounced in the groins. Chest: no definite areas of dullness, rales scattered throughout both lungs, and poor air entry over two circumscribed areas of the left lower lobe. The site of vaccination was already in the marked vesicular stage, with cloudy contents, and was about the size of a halfpenny. Penicillin injections and sulphadiazine were started. The next day showed no improvement, but the rash had coalesced in the groins and had spread to the face, where six days later it had faded to brownish mottling. After ten days the child's condition had improved markedly and convalescence was uneventful.

On June 5 his sister was unwell for 24 hours, and in exactly 14 days this girl and her sister developed measles, thus establishing the diagnosis in the first case.

One would have hesitated to make a diagnosis of measles owing to the possibility of transient scarlatiniform and morbilliform rashes during vaccination, but the development by the child's sisters of typical measles within 14 days, with a definite indication of the exact date of infection, established the diagnosis.—I am, etc.,

Wigmore, Kent. GORDON STRONG.

Revaccination of a Case of Post-vaccinal Myelitis

SIR,—I am reporting the following case history, though the combination of events makes it a very rare occurrence. While searching through the literature on vaccination I was unable to find a record of a similar incident.

The patient, a male aged 34 years, was vaccinated against smallpox when a member of the Army in 1941. Twelve days later he developed fever, backache, paralysis of the lower limbs, and retention of urine. He was diagnosed as suffering from post-vaccinal myelitis and treated at an Army infectious diseases hospital for three months. During this time he steadily improved. When discharged, he had a weakness of the lower limbs and lack of bladder control to a mild degree. Subsequently he was invalided from the Army and accepted by the Repatriation Commission as suffering from transverse myelitis (post-vaccinal) due to war service.

I saw this man approximately two months ago when he had just been appointed to a position overseas. His duties entailed a lot of travelling from one country to another, so that a valid vaccination certificate was essential. At this time he walked with a slight limp and both knee-jerks were exaggerated. In searching through the literature and discussing this with my colleagues, conflicting opinions were obtained. It seemed that revaccination with the minimum of