or skin lotions. Mycosis fungoides has been excluded in every instance. As a reticulosis usually has a subclinical onset several months before palpable lymphadenopathy, it may be assumed that the two pathological processes have had a concurrent onset in seven patients. Further evidence of the association of allergy with reticulosis is afforded by one patient aged 48 years who developed lymphosarcoma in 1947 and in each succeeding summer has had severe hay-fever. She had been well before 1947. This does not apply to the three cases of asthma in my series, one of whom lost his asthma five months before the onset of the reticulosis, while in two an existing asthma became less severe with the onset of reticulosis. These 12 cases would appear to offer evidence of a powerful antigenic factor in the early stages of the malignancy. An initial attack of eczema, hay-fever, or asthma may precede the appearance of a carcinoma.[2]

May I conclude with a plea to radiotherapists to investigate the incidence of allergic disorders in their patients with malignant lymphomas as a possible key to the riddle of cancer ?—I am, etc.,

Wellington, New Zealand. J. LOGAN.

REFERENCES

1 Custer, R. P., and Bernhard, W. G. (1948). *Amer. J. med. Sci.*, **216**, 625.
2 Logan, J., and Saker, —. (1953). *N.Z. med. J.*, **52**, 210.

Genetics and Clinical Research

SIR,—It was interesting to see your leading article on this subject (*Journal*, August 8, p. 326). I was sorry, however, to miss in it the name of one of the pioneers in this field, Professor Julius Bauer. This omission appears the more regrettable as he is well known to you, and you devoted a first leading article to his work in the past (*Journal*, April 24, 1943, p. 510).

Several of the problems mentioned in your present article have been studied intensively by J. Bauer and reported in original papers. I would like to mention—among many others—his studies on genetic factors in cancer and ulceration of the stomach ; but, of course, in 1943 you yourself referred to the importance of his book *Constitution and Disease*.[1]—I am, etc.,

London, S.W.3. V. C. MEDVEI.

REFERENCE

1 *Constitution and Disease : Applied Constitutional Pathology*, 1942, Grune and Stratton, New York.

Dr. Samuel Gee

SIR,—May I point out that, being misled by Sir Philip Manson-Bahr (*Journal*, August 1, p. 284), you have given Dr. Samuel Gee a title in your leading article (p. 266) ? The story which was current in St. Bartholomew's Hospital 50 years ago was that one of his colleagues saw Dr. Samuel Gee in the Square, wearing a fine fur coat, and expressed the hope that he might receive some recognition for looking after a royal personage. Gee replied: "They asked me if I would like to be made a baronet, but I said I would much rather have a fur coat, and this," fingering the lapel, "is it." —I am, etc.,

London, W.1. GEORGE GRAHAM.

Upside Down

SIR,—Dr. Wilfred Harris (*Journal*, August 8, p. 297) provokes us by saying : "We know from the optics of the eye that the image of any object seen is inverted on the retina. Why then do we see objects in their correct position and not upside down ?" To see everything, including ourselves, as "upside down" would merely mean "upside down" in relation to perceptions derived from the other sense organs, and the position in space of the representation on the retina or visual cortex will have nothing to do with this relationship.

The young children he reports as seeing "all test letters upside down" are perhaps more mysterious than he makes out. If they simply saw everything upside down then they would be expected to draw the right way up, so that when they looked at their drawing and saw it inverted it would match the object they were attempting to portray. Perhaps they are drawing from memory.—I am, etc.,

H. ASHER.

Physiology Dept., Birmingham University.

Myocardial Infarction

SIR,—The article by Dr. H. E. S. Pearson (*Journal*, July 4, p. 4) once again demonstrates the reduction in mortality and complications achieved by the use of anticoagulant therapy. Cardiac failure and its effects are important early complications which might be included when considering this subject. I have recently had under my care a man doing well under anticoagulant therapy with complicating congestive failure. Although the latter was treated, at the end of the third week he developed a sudden passive pleural effusion which proved fatal before medical aid could reach him.

Dr. R. A. Murray Scott (*Journal*, July 18, p. 151) quotes three references in support of his claim that prothrombin depression need not be taken below 60% of normal. I think these deserve some comment. Wright *et al.* achieved a 6% incidence of thrombo-embolism, with prothrombin levels of 20% and less. However, they went on to analyse their failures, and found that out of 38 such cases only four were actually in their desired therapeutic range of prothrombin depression, the others having escaped from control. Furthermore, they concluded that a considerable proportion of these failures were in fact due to inadequate prolongation of the prothrombin time. Burt *et al.*[2] described a series of cases of thrombo-embolism occurring in peripheral blood vessels, and did not describe any cases of coronary thrombosis. Their results are not therefore really comparable to the subject under discussion. Peters *et al.*[3] record the surprisingly optimistic figure of only 2% of thrombo-embolic complications in their series of 50 cases, rather than the 6% credited to them by Dr. Murray Scott. Their mortality rate of only 4% is also well below that of other writers, who usually put it at about 13.8%.[4] However, their patients were selected ones in whom they claimed to have demonstrated an increased coagulability of the blood. They do not give details of the proportion of severe cases, or many clinical details. In view of these circumstances I feel that their results should be interpreted with reserve.

Finally, I would like to quote Gilchrist's opinion[5] that adequate anticoagulant therapy has a favourable influence on shock in support of my plea for the prompt use of this treatment by the general practitioner.—I am, etc.,

Twickenham. DAVID WHEATLEY.

REFERENCES

1 *Amer. Heart J.*, 1948, **36**, 801.
2 *British Medical Journal*, 1949, **2**, 1250.
3 *J. Amer. med. Ass.*, 1946, **130**, 398.
4 Tulloch, J. A., and Gilchrist, A. R. (1950). *British Medical Journal*, **2**, 965.
5 Ibid., 1952, **2**, 351.

The Egg Maligned

SIR,—My morning bacon and egg is being impugned by Dr. H. W. Fullerton *et al.* (*Journal*, August 1, p. 250). It is literally blood-curdling, and, despite the cautious wording of the authors, already many a casual reader of the daily press may be switching to a Continental breakfast. It is hard to relate our restricted consumption of fats during the last years to the rising incidence of coronary thrombosis. For my own part I shall continue to take an English breakfast, and shall comfort myself with the reflection that coagulation has its virtues and that not every clot is clumsy.

As a surgeon I see arteriosclerosis and secondary thrombosis mainly in the lower limbs of patients complaining of intermittent claudication. In the last few years I have advised over 300 such patients, and, though I know nothing of their breakfast habits, I cannot recall a single one who was not an inveterate cigarette smoker. The link between cigarettes and arteriosclerosis in the lower limbs appears to me to be almost invariable and quite inescapable. I can recall only one patient who was able to give up smoking for even a few weeks, and he, poor fellow, died of coronary

thrombosis shortly after an operation. About coronary thrombosis itself I must write with more caution, because this is a disease which, in general, I have not studied. In claudication, however, the coronary accident is so common, and so frequent a cause of death, that the two do appear to be related—at least to each other if not to tobacco.

Your authors say that "the pathogenesis of arteriosclerosis remains obscure." Without any reference to tobacco, they indict, albeit tentatively, the egg. This seems so unfair that it has stung me into writing this letter and saying something I have been wanting to say for a long time.—I am, etc.,

Liverpool, 7. CHARLES WELLS.

The Role of the Pathologist

SIR,—Drs. M. Goldman and D. H. Miller (*Journal*, July 25, p. 227) accuse pathologists of being "self-appointed judge and juries of their clinical colleagues." May I remind them that they appear in court as witnesses on oath and answer the interrogation of judge, counsel, or coroner to the best of their ability? They are not permitted to give a spontaneous expression of their views. They are in fact already "confined to a statement of facts and, at the most, an expression of opinion as to the cause of death."—I am, etc.,

Keighley. IAN STEWART.

Malaria in Ex-Servicemen

SIR,—I was very interested to read the letter by Drs. A. F. Knyvett and F. D. Schofield (*Journal*, August 8, p. 339) on malaria in ex-Servicemen. I thought the following two cases might be of interest.

Case 1.—A Territorial soldier, aged 22, admitted with pyrexia and generalized muscular aches of 24 hours' duration. No diagnosis was made at this time because of the bizarre and seemingly unrelated nature of the symptoms, which included vague abdominal pains and headaches. A peripheral blood smear taken during a rigor 96 hours after admission revealed the schizonts of *Plasmodium vivax*.

Case 2.—A regular soldier, aged 24, also admitted with a very similar history of malaise and pyrexia, but he had carried on for six days without reporting sick. This case also had many of the features of an "influenzal" illness, but here again a peripheral blood smear examined at 24 hours demonstrated the schizonts of *Plasmodium vivax*.

Both these patients were seen within six weeks of each other and had served in Korea last summer. One had returned eight months ago and the other six months ago. No previous history of malaria was obtained, although the first patient had had a mild pyrexial illness with one rigor shortly after returning to this country. Both men had taken the issue of proguanil whilst overseas.

First impressions in both—namely, that they were cases of influenza—tended to obscure the diagnosis, which in the first was not made until the periodicity of the rigors was recognized after 96 hours. There were no other signs in either case, such as splenomegaly, to assist in arriving at the diagnosis.—I am, etc.,

Holt, Norfolk. W. A. CRABBE.

Polyarthritis in Rubella

SIR,—I was most interested to see that Dr. K. H. Pickworth (*Journal*, August 8, p. 339) and Dr. G. W. Lewis (*Journal*, July 18, p. 149) found, as I did (*Journal*, June 20, p. 1388), that the complication of polyarthritis in rubella seemed to be confined to adult women. I can think of no other infectious illness affecting both children and adults which behaves so differently in the group of adult women only, and in this curious fact there may be hidden some clue to the aetiology of the arthritis. Dr. Pickworth suggests that the polyarthritis of rubella is allied to the aches and pains that occur at the beginning of the majority of infections, and he goes further and suggests that all these phenomena are allergic and allied to serum sickness.

I cannot agree, for the following reasons: (1) The polyarthritis continued in my experience long after any slight fever associated with the rash, and in 5 out of my 16 cases first appeared on or after the second day of the illness. (2) The severity of the pains in the joints was out of all proportion to the mildness of the illness itself. (3) If the polyarthritis were in the nature of an allergic response it would be reasonable to suppose that there might be an accompanying eosinophilia and that the joint symptoms would subside if antihistamine drugs were given.

In two of my cases blood films were examined for eosinophilia and there was none. Four of my cases received diphenhydramine, 50 mg. three times a day, without any alteration of joint symptoms.

Four cases is, admittedly, a small number, but soon after plans were laid for investigating the possibility of the allergic nature of the arthritis the epidemic died out.—I am, etc.,

Wantage. I. S. L. LOUDON.

Intravenous Picrotoxin for Barbiturate Poisoning

SIR,—Intravenous picrotoxin, as advocated by Dr. R. S. Saxton (*Journal*, July 25, p. 227), is not without hazard. I have seen a patient on more than one occasion in coma from barbiturate poisoning having convulsions as a result of picrotoxin therapy, while in no way coming out of the coma. In serious cases, which nowadays occur not infrequently in the course of a routine "take in," gastric lavage is always indicated, and hospital treatment should not be denied to these patients. One sees cases surviving after three or more days in coma, and psychiatric aftercare may be instituted speedily under in-patient conditions.

All cases recently reviewed in a Scandinavian paper[1] were treated with amphetamine, as picrotoxin was considered too toxic for routine use.—I am, etc.,

Collingbourne Ducis, Wilts. B. H. BASS.

REFERENCE

[1] Nilsson, E. (1951). *Acta med. scand.*, suppl. 253.

Please Wash Your Hands

SIR,—All G.P.s, not to mention the general public, must by now be heartily tired of the gastro-enteritis which has become endemic in this country in the last few years. Public health activities seem confined to looking for carriers after major outbreaks, but the number of carriers must be legion and this seems a hopeless task. There seems to be some agreement that nine-tenths of the trouble would stop if the public were educated to wash their hands after visiting the lavatory, but no one educates them.

I should like to suggest a simple solution. If every public lavatory abolished the charge for a wash, and exhibited a notice saying, "Please wash your hands before leaving. No charge," the result would probably be as effective as in the two precedents of "Please do not spit" and "Please adjust your dress before leaving." Once it became a habit in public lavatories it would soon become a habit elsewhere.

If the Ministry of Health offered to pay local authorities the cost, it would soon make a profit from the reduced number of prescriptions for sulphonamides and antibiotics. Is it possible for our public health colleagues to use their influence in bringing about this reform?—I am, etc.,

Ashtead, Surrey. W. EDWARDS.

Brain of Kernicteric Infants: An Appeal

SIR,—I would be very grateful for specimens of the brain of kernicteric infants. I am investigating the pigments occurring in the blood and tissues of infants affected with haemolytic disease of the newborn, and there is at present an extreme shortage of post-mortem material from infants dying of kernicterus. The specimens should preferably be unfixed, as formalin and alcohol seem to affect the pigments.

If any specimens occur I can arrange for them to be collected within a radius of 100 miles of Manchester if a telegram or 'phone call is made to URMston 4022 or SALe 3111.—I am, etc.,

Park Hospital, Davyhulme, Urmston, nr. Manchester. D. C. A. BEVIS.