disseminated around the world after that great era of discovery and grows mainly in tropical areas, but rarely in the subtropics, in every section of that part of Africa south of the Sahara and north of the Zambezi and other areas within the tropical belt. It is consumed in these areas as either the chief staple or secondary staple diet or as supplementary food. By-products such as starch, adhesives, cosmetics, size for textiles, tapioca, confectionery, and beer and other alcoholic drinks are obtainable from this plant. No soil nutriment or fertilizer is needed for its growth. I have myself seen it flourishing in sandy soil. Except for a virus it is also reported to be free from attack by nearly all plant diseases and locusts. It is therefore of great national importance to the economy of developing tropical countries on account of its lowest cost of production when compared with other cereals and the uses already mentioned.

This report unfortunately did not take the following into consideration in drawing up its conclusions.

(1) The methods of preparation of the diet, which usually result in the reduction of the prussic acid content to safe levels.^{1,2} The methods used are cutting, soaking in several changes of water for some days, followed by shredding, fermenting, grating, and heating, etc. Any remaining unhydrolysed glucoside is further broken down in the gastrointestinal tract.

(2) That manioc (cassava) is not the only food plant that may contain cyanogenetic glucosides; they have also been found in lima beans (*Phaseolus lunatus*), corn (*Zea mays*), sorghum, field beans, kidney beans, sweet potatoes, lettuce, and seeds of various fruits.¹

(3) That the amount of prussic acid that can safely be consumed varies from person to person, and appears to be affected by the variety of other foods eaten.¹

(4) The hydrocyanic acid content is determined not only by the variety but also by age of the plant and local soil and climatic conditions.^{3,4}

In view of the foregoing the postulated relationship in this article has evidently not been fully established. Nevertheless, I feel this report has focused attention on, and again emphasized the possible harmful effects to man of, one of the most important food plants of developing countries in tropical areas. Further co-ordinated scientific and dietetic research would be extremely valuable.—I am, etc.,

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Mitcham, Surrey.

REFERENCES

- 1 Jones, W. O., *Manioc in Africa*, 1959. California, Stanford University Press.
- 2 Jacquot, R., and Nataf, B., *Le Manioc et son Utilisation Alimentaire*, 1936. Paris, Hermann.
- 3 Purseglove, J. W., *Tropical Crops, Dicotyledons*, vol. 1, p. 172, 1968. London, Longmans, Green.
- 4 Bolhuis, G. G., *Netherlands Journal of Agricultural Science*, 1954, 2, 176.

Jakob-Creutzfeldt Disease

SIR,—As Dr. S. Nevin points out (29 March, p. 847) there is at present a good deal of confusion in the use of this term. There is also an unsettled dispute among neurologists and neuropathologists as to whether the term as commonly used covers one disease, or two, or many. Dr. Nevin himself draws a sharp distinction between,

on the one hand, Jakob-Creutzfeldt disease as described by Jakob in 1921 and 1923, and, on the other hand, a condition which he calls subacute spongiform encephalopathy.¹ It is the latter, he believes, in which a transmissible "agent" has been demonstrated.

Until this dispute has been settled it would avoid a good deal of misunderstanding if the term "Jakob-Creutzfeldt disease" were dropped entirely. (For one thing, few modern neurologists would accept Creutzfeldt's (1920) case as an instance of the syndrome described by Jakob). The term "subacute presenile polioencephalopathy," though cumbersome, should satisfy those who believe in the unity of the group as well as those who regard the question as unsettled; and I would respectfully suggest to Dr. Nevin that he should use the term "Jakob's encephalopathy," rather than "Jakob-Creutzfeldt disease" for the restricted group originally described by Jakob.—I am, etc.,

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Oxford.

REFERENCE

- 1 Nevin, S., *Proceedings of the Royal Society of Medicine*, 1967, 60, 517.

Meralgia Paraesthetica

SIR,—Mr. K. Mukherjee and Dr. I. B. Bassett (5 April, p. 55) were unfortunate in that their case of meralgia paraesthetica had progressed to the stage of neuroma formation. In the three cases I have seen in general practice relief was obtained by correcting the mechanical factors causing pressure on the lateral cutaneous nerve of the thigh at the point where it emerged through the fascia lata. In the two ladies this was the edge of a tight "roll on," which happened to cross the nerve at this point on one side. In the man pressure was caused by prolonged writing in a contorted position at a small desk.

An analogous condition has been seen of severe pain with paraesthesia on the inner aspect of the heel due to the pressure of an unusually high and rigid shoe-upper on the medial calcaneal branch of the posterior tibial nerve at the point where it perforated the flexor retinaculum. The pain and paraesthesia were readily reproduced by pressure at this point and relieved by a change of footwear. This condition could pass under the name of calcaneodynia paraesthetica.—I am, etc.,

S. C. ROGERS.

Rugby, Warwicks.

Measles in the Tropics

SIR,—The *B.M.J.* of 8 February has just reached me, and I was very interested in Dr. David Morley's article about severe measles in the tropics (p. 363).

In this rural part of Nigeria our people know measles to be an infectious disease, but, burdened with too many children, there is nothing the harassed mother can do; she often just has to watch in agony the disease strike down two or three of her children in suc-

cession. These mothers in the past were reluctant to come to hospital because they believed an injection—any injection—would worsen the disease and cause the death of the child. The native treatment consists in covering the child's body with white chalk and giving it repeated drinks of palm wine. No matter what treatment the child is being given and no matter the vigilance of the nurses or doctors, the mother must find a chance of smuggling in a keg of palm wine from which the child and herself have generous helpings day and night.

Some 10 to 15 years ago a measles outbreak occurred at the beginning and end of the dry season, but in the last three years we had a very virulent form which occurred in all seasons; this necessitated our keeping a whole ward for measles. Then came last year the World Health campaign in which some three million doses of measles vaccine were given all over Nigeria. To-day our measles ward is closed—a testimony of the efficacy of the vaccine used, and forceful evidence to convince those in charge of health matters in tropical countries like ours, where there is acute shortage of doctors, that emphasis ought to be placed on preventive rather than on curative medicine.—I am, etc.,

XTO G. OKOJIE.

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Nigeria.

Measles Vaccination

SIR,—Until we know the duration of immunity conferred by measles vaccination there is no strong case for such vaccination. Your leading articles (29 March, p. 794, and 5 April, p. 2) present a few specks of knowledge perched on a mountain of ignorance, and the only rational conclusion is that not enough is known about the dangers of injecting live virus to justify its use for immunization against any but the most deadly diseases.

The grand objective is to eliminate measles altogether, but before this can be attained it may be found necessary to give booster doses of measles vaccine to adults, and these might well be more dangerous than the first doses.

There is one point in the paper by J. H. Connolly and colleagues¹ which has not been sufficiently emphasized. This is that the measles from which their three patients of panencephalitis originally suffered was thought to have been caused by a less virulent strain of virus than usual. This observation would appear to be of some significance in relation to the safety of vaccination with live attenuated measles virus.

Despite Dr. J. Twomey's letter (11 January, p. 116), in which he criticizes my reasoning (7 December, p. 642), I still think there should be a pause in the measles vaccination campaign, and I also think that your leading articles support this view, though you confine yourself to pleas for more adequate surveillance of the effects of all—and particularly new—vaccination procedures.—I am, etc.,

A. W. O. TAYLOR.

Edinburgh 9.

REFERENCE

- 1 Connolly, J. H., Allen, I. V., Hurwitz, L. J., and Mälar, J. H. D., *Quarterly Journal of Medicine*, 1968, 37, 625.