population so long as their pneumoconiosis does not become complicated by tuberculosis, when the prognosis is much worse. The more rapid the onset of pneumoconiosis, and usually, therefore, the younger the man, the greater the liability of conversion at some time to silico-tuberculosis and the worse the prognosis. Cases with "massive fibrosis" have a worse prognosis, and cases with open tuberculosis seldom live more than two years. The liability to develop open tuberculosis appears to be much greater in those cases of pure silicosis than in the various forms of mixed dust pneumoconiosis such as those of coal-workers and foundry workers.

This is shown by the much higher tuberculosis death rates that have prevailed in the pure silica risk industries than in coal-mining and foundries. Other forms of pneumoconiosis than silicosis—for example, asbestosis, aluminosis, berylliosis—are much less likely to predispose to tuberculosis.

The frequency with which tuberculosis is found to complicate pneumoconiosis depends upon the diagnostic criteria and upon the material used for the study. For instance, in post-mortem examinations of coal-miners Rogers found tuberculosis in 75.8% of cases with massive fibrosis, Gooding found it in 26% of all cases. Theodos and Gordon found a positive sputum in 13% of cases of miners addicted to alcohol, whereas in a community survey in a coal-mining district in Cochrane (unpublished) found that only 1% of all cases of massive fibrosis had a positive sputum. The diagnosis of tuberculosis on the grounds of a positive sputum is the only way of making the diagnosis certain. When clinical and radiological criteria are also admitted, the proportion of cases of pneumoconiosis with tuberculosis will tend to range from about 5% to 75%, depending upon the selection of cases and the diagnostic whim of the observer.

Shortening the List of Notifiable Diseases

Q.—Can a local authority shorten the list of notifiable diseases in its area as well as lengthen it?

A.—"Notifiable disease" is defined by section 343 of the Public Health Act, 1936, as any one of nine named diseases, plus any infectious disease which the local authority (with the approval of the Minister) may declare to be a notifiable disease within its area.

A local authority has no power to shorten the list of named diseases, but only those which become notifiable by a resolution of its own council. To remove such a disease from its list a further resolution of the council is required and also the approval of the Minister.

In addition, the Minister has power to make regulations under section 143 of the Public Health Act, 1936, for the treatment of persons affected with any epidemic, endemic, or infectious diseases, and for preventing the spread of such diseases. These regulations include provisions requiring notification of the diseases to which they apply, and may extend to the whole of England and Wales or any part thereof. Regulations made by the Minister may of course be amended or revoked by him.

Eosinophils in C.S.F.

Q.—What are the causes of eosinophilia in the C.S.F.?

A.—Very little is known about the incidence of eosinophils in the cerebrospinal fluid, and less still about their significance. Only rarely are these cells seen, and then mainly in cerebrospinal fluid and in some cases of acute meningitis, and it has been held that there has been no blood admixture. Eosinophils might also be found in the C.S.F. in allergic conditions.

NOTES AND COMMENTS

Implantation of Hormone Pellets.—Dr. R. P. Edkins, Ph.D. (Pharmaceutical Research Department, Organon Laboratories, Mootherwell, Lanarks), writes: With regard to the previous notes on this matter (Feb. 4, p. 146, and Mar. 4, p. 632) it must, as Mr. A. R. G. Channings states, be regarded as dangerous to boil these pellets, as most of the hormone substances used soften or actually melt under this treatment, and at the same time any determination of hormone content by the variably successful method by which either aseptically or long-exposure pellets which have been accidentally contaminated may be sterilized without fear of melting or distortion consists in keeping the pellets in a solution of (0.05%) cetrimide (0.025%) or other substance having similar bactericidal activity, at a temperature not below 37° C. or above 80° C. for 24 hours; the addition of a small percentage of a surface active agent such as cetrimide (0.025%) to the phenol solution (other bactericide, provided there is no reaction between the adrenal cortical substances used and the pellets which have already been implanted and which have either been intentionally or extruded.

Poisonous Snakes.—Sir Harold Scott (BRAINTREE) writes: Your expert in his reply on the treatment of bites by poisonous snakes ("Any Questions?" April 4, p. 793) rightly stresses the specificity of antivenin. As the use of such is generally urgent and they may need to be immediately available, a first-aid treatment which will delay the action of the poison deserves to be more widely known. Almost 30 years ago (in 1924) the fact was observed that soaps could detoxify snake venoms, and in 1945 Ahuja and Brooks in India showed that local injections at four or five points surrounding the site of the bite, each of 0.5-1 ml of 5% emulsion of "lifebuoy" carboxic soap (say to a total of 5 ml.) might delay the action of the poison for some hours, at least two and often more. Carboxic soap is found in bars, and might be kept made up in a 5% strength at local dispensaries in countries where snake-bites are likely to occur. Bleeding should be encouraged by crucial incisions.

Our Expert writes: I agree that a local injection of soap emulsion in the region of the bite might be worth trying in an emergency, but it should be stressed that it is only a first-aid treatment, and should never be regarded as a substitute for antivenin. The idea of using soap suspension in this way arose from some work on the effect of surface-tension suppressors on tissue poisons, including bacterial toxins and some venom substances, which might delay the action of the poison deserves to be more widely known. Almost 30 years ago (in 1924) the fact was observed that soaps could detoxify snake venoms, and in 1945 Ahuja and Brooks in India showed that local injections at four or five points surrounding the site of the bite, each of 0.5-1 ml of 5% emulsion of "lifebuoy" carboxic soap (say to a total of 5 ml.) might delay the action of the poison for some hours, at least two and often more. Carboxic soap is found in bars, and might be kept made up in a 5% strength at local dispensaries in countries where snake-bites are likely to occur. Bleeding should be encouraged by crucial incisions.

Correction.—The figure for Foundation Membership of the College of General Practitioners given in the legend to the map in the Journal of May 2 (p. 990) should have read 1,807.

In the article entitled "Controlled Hypotension in Neurosurgery with Hexamethonium and Procaine Amidite" (May 2, p. 961) by Dr. David Aserman, acknowledgment was inadvertently omitted to the fact that the procaine amidite used in the investigation was generously supplied by Messrs. E. R. Squibb and Sons.