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 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, beryllosis—are not predisposed 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a positive sputum in 13% of coal-miners examined, whereas in a community survey in a coal-mining district Cochrane (unpublished) found that only 1% of all cases of massive fibrosis had a positive sputum.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 diseases notifiable in its area as well as lengthen it?

A.—“Notifiable disease” is defined by section 143 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 rare cases are seen, and then mainly in cerebral syphilis and in some cases of acute meningitis, though, provided there has been no blood admixture, eosinophils might also be found in the C.S.F. in allergic conditions.