has a total of between 200,000 and 400,000 alcoholics, and that the death rate from alcoholism has for the last 20 years been rising.

Given the committee's knowledge of a threatening public health situation, what did it envisage as the likely impact on health of its proposals? It says that the health consequences need watching and suggests that there should be continued research monitoring, but it goes on to conclude that the recommendations as a whole will probably not have any adverse effect on health. In an important passage (p. 46) the committee makes an assertion which shows something of its approach to these questions: it states that at one extreme total permissiveness would have a large adverse effect on health, while at the other extreme unacceptable repressive policies would have considerable impact of a contrary sort. Then it makes this key assertion, "Any solution which fell well within these limits would, we feel, be largely neutral in its impact on consumption."

The impression is given that the committee is set on policies of relaxation for reasons other than those concerning the public health. From the public health point of view the report's main proposals must be condemned as untimely. Their adoption in practice would be to risk a further increase in alcoholism, with its attendant dangers to harmony in the home and life on the roads.

Retinal Veins in Multiple Sclerosis

The eyes, those windows on the soul, may often given an indication of an underlying general or neurological disease.\(^1\)\(^\text{-}\)\(^5\) Multiple sclerosis presents with optic neuritis in 10-20% of patients and with some ocular symptoms in about 30% of patients.\(^6\)\(^\text{-}\)\(^8\)

One ocular feature of multiple sclerosis which has caused interest and discussion over the years is the sheathing of the retinal veins first described by Wilbur Rucker in 1944.\(^9\)\(^\text{-}\)\(^10\) He has recently reviewed his own and others' experience of this condition.\(^11\) Sheathing is seen as a fine, opaque border to the veins of the retina, and is thought to be of significance in relation to multiple sclerosis only if it occurs at a distance from the optic nerve head. Many conditions such as papillitis and papilloedema may cause sheathing of the veins at the nerve head. Other changes also included within the term of "sheathing" are soft, opaque clouds in the vitreous over the veins, which may be more acute phenomena. The parallel sheathing of veins may be due to slight thickening and increased visibility of the vein walls, and may remain for many years.

These changes are seen only with difficulty, and require that the pupil be fully dilated and the ophthalmoscope light not too bright. Though more than 500 cases have now been reported, other workers have failed to find evidence of retinal-vein sheathing despite diligent search.\(^12\)\(^\text{-}\)\(^13\)

The sheathing of the retinal veins never causes symptoms, and is therefore of little importance in itself. But it may on occasions be of help in suggesting a diagnosis of multiple sclerosis, though few would rely on it, parti-

Transmission of Cholera

The recent outbreak of cholera among passengers on an airliner travelling from Great Britain to Australia was confirmed as due to the el tor vibrio. The Australian authorities were quickly led to suspect the smörgåsbord that was taken on board for economy class passengers at Bahrain as the vehicle of infection. The water from the aircraft was shown to be perfectly satisfactory. Only economy class passengers were affected; none of the crew and first-class passengers had the smörgåsbord. The recognition of two other cases among passengers on a flight in the opposite direction, which had also taken on smörgåsbord about the same time, helped to confirm this. All the evidence was that this was a food-borne outbreak. Thus cholera, traditionally considered to be the classic example of a water-borne disease, was presenting as a food-borne infection. Many questions may be asked about the method of spread of el tor cholera and the significance of the cholera carrier today.

It is certainly true that countries where sewage disposal is inadequate and where a clean water supply is lacking may suffer from water-borne outbreaks. In many areas of the world water is drawn for drinking and cooking from the very rivers and ponds into which defecation takes place. But in the present pandemic of el tor cholera there has been much evidence of case-to-case spread. In the Philippines the infection was found to be transmitted from person to person until a water supply was contaminated, as a result of which an explosive outbreak occurred. An explosive outbreak in Istanbul was rapidly brought under control by the
chlorination of the city's water supply, but these have been mere incidents in the spread of the infection. The nomadic fishermen along the coast of West Africa carried the vibrios from person to person and from country to country. The social gatherings at funerals in parts of West Africa were also important opportunities for the dissemination of the vibrios from person to person.

Though symptomless excreters of cholera vibrios were known from the early days of bacteriology, until recently the healthy carrier was thought to play little part in the spread of the disease. Z. Benčić and R. Sinha\(^1\) have recently re-examined the situation and showed that in endemic areas, when there were no obvious clinical cases, cholera vibrios were still present in healthy carriers in the community.

The spread of any organism in the community depends on many factors—for example, the number of organisms necessary to produce infection, the length of time they are excreted by a carrier, and their viability outside the human body. In several respects the el tor vibrio differs from the classical vibrio. It appears to have greater viability, for it can be isolated from night-soil and, perhaps more importantly, from foodstuffs for days after it has become impossible to isolate classical vibrios. Cases with mild diarrhoea and symptomless excretors are four to five times more numerous than those with the full clinical picture of cholera in outbreaks caused by the classical vibrio, whereas with the el tor vibrio such cases are 20 to 40 times more numerous than cases with the full clinical picture of the disease.\(^2\)

There have been few reports of true chronic carriers of cholera vibrios. The majority of patients are no longer excreting after a few days and very few excrete longer than a few weeks. The infectivity of an excreter depends on the nature of the stool. A diarrhoeic stool is more likely to be infective than a formed stool, chiefly because splashing and formation of aerosol\(^4\) encourages dissemination. It would seem from experimental studies with healthy volunteers that a large dose of vibrios is necessary to produce infection. Many millions of vibrios—quite sufficient to infect—may be ingested with contaminated water. Vibrios may multiply in foodstuffs until the number of organisms is sufficient to cause infection. This may perhaps have occurred in Bahrain, particularly if refrigeration was inadequate. There is no evidence that an animal reservoir of cholera vibrios exists outside man, so that although water or food may be contaminated and be vehicles in the spread of infection the human carrier will continue to have an essential role in the dissemination of the disease.

The el tor vibrio is behaving differently from the classical vibrio. Many cases present as mild diarrhoea and may be easily dismissed as gastroenteritis. Nevertheless the el tor organism can produce severe cholera, with the risk of extreme dehydration, just as the classical vibrio does. It is well, therefore, to be prepared to treat such cases with adequate fluid replacement. To combat the electrolyte disturbance and acidosis a suitable replacement fluid, such as Hartmann's ringer-lactate solution, must be used.\(^5\) However common the vibrios become in Britain, no one should die of so treatable a disease.

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**Sarcoïd Heart Disease**

Sarcoïdosis is a systemic disease in which characteristic granulomatous follicles are present in various organs.\(^1\) The sarcoïd follicle consists of an aggregation of epitheloid cells with a variable number of giant cells, usually of the Langhans type with peripherally disposed nuclei, surrounded by a narrow zone of lymphocytes. The sarcoïd follicle, unlike that of tuberculosis, has no central caseation nor is it heavily invested with lymphocytes. No organ of the body is exempt from attack, and the lesions are protean. They include pulmonary infiltration and fibrosis, enlargement of lymph nodes, spleen, and liver, and osseous foci, as well as lesions of the skin, eyes, salivary and lacrimal glands, the pituitary, and the central nervous system. The most important lesions of sarcoïdosis affect the lungs, where conglomerate follicles may progress to a diffuse fibrosis which is potentially lethal by leading to right-sided heart failure. Indeed, though the course of the lesions is towards healing, the resulting scar tissue can cause serious dysfunction when a vital area is involved.

Apart from the secondary effect on the heart in progressive pulmonary sarcoïdosis, primary cardiac disease is also recognized. The first case with epicardial and superficial myocardial lesions was described in 1929,\(^2\) and the first death directly attributable to myocardial sarcoïdosis was reported in 1937.\(^3\) Since then further cases have been reported and a distinct clinical syndrome has emerged.\(^4\) The patients are usually young or middle-aged adults of either sex, and often have previous stigmata of sarcoïdosis. The commonest clinical presentation is the sudden development of a disturbance in rhythm, usually heart block, which may be complete and precipitate a Stokes-Adams syndrome. It is not surprising that many of these cases die suddenly, and sometimes there is no suspicion of pre-existing myocardial disease. Congestive heart failure may also occur, but it is distinctly less common than sudden death. Both valvular and pericardial disease are rare, but a case with recurrent pericardial effusions has been described.\(^6\)

Recently P. Ghosh and his colleagues have described six further cases of granulomatous myocardial disease, of which four were certainly sarcoïdosis.\(^7\) The sex distribution was equal and the ages ranged from 37 to 59 years. Four of these patients died suddenly, though one also had evidence of previous heart failure. Two other patients died in congestive heart failure. In one case, a woman with multiple sclerosis who died suddenly, only a solitary granulomatous nodule was found in the left atrium and there was no other evidence of sarcoïdosis. In another woman, who was known to have had previous sarcoïdosis and who died in heart failure, only non-specific scar tissue was found in the atrioventricular node. In the other four cases there were typical lesions in the myocardium as well as follicles elsewhere in the body.

In the four undoubted cases of myocardial sarcoïdosis there were small areas of tough, greyish-white tissue scattered throughout the myocardium. The walls and septum of the left ventricle were particularly involved, but in one case there were also nodules in the wall of the right atrium, and in another the aortic valve was affected. In contrast to sarcoïd lesions elsewhere in the body myocardial foci are less well defined and seem to be sinuous and diffuse. There are also fewer giant cells, but the presence of such lesions in patients with established sarcoïdosis elsewhere is sufficient to confirm the diagnosis of myocardial sarcoïdosis.

It is evident that the condition can easily be misdiagnosed as myocardial fibrosis secondary to ischaemic heart disease.