last month. This disease was proportionally most prevalent in St. Pancras, Islington, Finsbury, Shoreditch, Bethnal Green, Poplar, Battersea, and Greenwich. * The Metropolitan Asylums Hospitals contained 6154 scarlet fever patients at the end of the month, against 3722, 3408, and 4847 at the end of the three preceding months; the weekly admissions averaged 1000, against 567, 467, and 840 in the three preceding months. Diphtheria also was considerably more prevalent—40 per cent.—than in September, and was higher than in any month of this year, or the three preceding years; 1803 cases were notified during the month (four weeks), against 937 in October, 1918 (five weeks), 1169 in October, 1919 (five weeks), and 1449 in October, 1920 (four weeks). The greatest proportional prevalence of this disease occurred in Hampstead, Finsbury, Shoreditch, Stepney, Bermondsey, Battersea, and Greenwich. The number of diphtheria patients under treatment in the Metropolitan Asylums Hospitals, which had been 1969, 1709, and 2031 at the end of the three preceding months, further rose to 2777 at the end of October; the weekly admissions averaged 445, against 250, 209, and 322 in the three preceding months. Erysipelas was proportionally most prevalent in Holborn, Finsbury, Bethnal Green, and Bermondsey. Of the 5 cases of poliomyelitis, &c., 2 belonged to Deptford, 2 to Lewisham, and 1 to Greenwich; in the three preceding months the notified cases numbered 9, 13, and 10 respectively. Three cases of encephalitis lethargica were notified during the month, against 9, 5, and 5 in the three preceding months. The notified cases of cerebro-spinal fever numbered 3, against 7, 9, and 5 in the three preceding months. The 27 cases of puerperal fever included 3 in Fulham, 3 in Islington, and 2 each in Paddington, Poplar, Battersea, Wandsworth, and Lewisham.

The mortality statistics in the table relate to the deaths of civilians actually belonging to the several boroughs, the deaths occurring in institutions having been distributed among the boroughs in which the deceased persons had previously resided. During the four weeks ended Oct. 29th, the deaths of 3913 London residents were registered, equal to an annual rate of 11.3 per 1000; in the three preceding months the rates had been 9.8, 10.6, and 10.9 per 1000. The death-rates ranged from 8.9 in Wandsworth, 9.1 in Fulham, 9.6 in Stoke Newington, in Camberwell, and in Lewisham, and 9.8 in Woolwich, to 13.0 in Bethnal Green, 13.4 in Shoreditch and in Stepney, 13.5 in Holborn, 14.1 in Chelsea, and 14.8 in Finsbury. The 3913 deaths from all causes included 418 which were referred to the principal infectious diseases; of these, 11 deaths resulted from enteric fever, 10 from measles, 20 from scarlet fever, 33 from whooping-cough, 99 from diphtheria, and 275 from diarrhoea and enteritis among children under 2 years of age. No death from any of these diseases was recorded in the City of London. Among the metropolitan boroughs the lowest death-rates from these diseases were recorded in Chelsea, St. Marylebone, Holborn, Deptford, Lewisham, and Woolwich; and the highest in Finsbury, Shoreditch, Bethnal Green, Stepney, Poplar, and Bermondsey. The 11 fatal cases of enteric fever exceeded the average in the corresponding period of the five preceding years by 4; of these deaths 3 belonged to Lewisham and 2 to Bermondsey. The 10 deaths from measles were but half the average; of these 3 belonged to St. Pancras and 3 to Poplar. The 20 fatal cases of scarlet fever were 8 in excess of the average; of these, 3 belonged to each of the boroughs of Islington, Hackney, and Stepney, and 2 each to Hammersmith, Bermondsey, and Camberwell. The 33 deaths from whooping-cough were 17 above the average; of these, 5 belonged to Wandsworth and 3 to Camberwell. The 99 fatal cases of diphtheria exceeded the average by 40; this disease was proportionally most fatal in Hampstead, Stoke Newington, Finsbury, Shoreditch, Stepney, and Greenwich. The 275 deaths from infantile diarrhoea exceeded the average by 64; the greatest proportional mortality from this disease occurred in Hammersmith, Islington, Shoreditch, Bethnal Green, Southwark, and Bermondsey. The aggregate mortality in London during October from these principal infectious diseases was 38 per cent. above the average.

The deaths from influenza registered in London during the four weeks ended Oct. 29th numbered 40, against 15, 9, and 21 in the three preceding months, and 22, 18, 1721, 65, and 21 in the corresponding periods of the five preceding years.

TREATMENT OF VENEREAL DISEASES IN LONDON.—

The Minister of Health and the County Councils concerned have consented to an arrangement under which the London County Council will be able, within defined limits, to make necessary modifications in its scheme for the diagnosis and treatment of venereal diseases, without the delay, previously unavoidable, in obtaining the consent of all the participating authorities to any such modification.

Correspondence.

"Audi alteram partem."

THE EDUCATION OF DEAF CHILDREN.

To the Editor of THE LANCET.

SIR.—MR. A. J. Story's letter in your issue of Nov. 12th opens up a question that has long wanted ventilating, and never more so than at the present time. Perhaps I, who have a knowledge of deaf children and the methods of their education based upon some 14 years of unceasing work among them, may be permitted to speak plainly upon it.

I would first express my appreciation of those who cheerfully devote themselves to the instruction of deaf children, a work the most arduous and exacting in the teaching profession and which is followed with a steadfastness of which the reward lies only in results. Mr. Story points out that teachers of the deaf "would welcome with open arms anything that would give their pupils even a serviceable modicum of hearing ability." This I can cordially endorse, for I have found them ever ready to coöperate with the doctor and to help him to the utmost from their stores of experience, provided he will let them do so. Sufferers from deafness are ever upon the look-out for some heaven-sent miracle which will restore to them the sense they lack. They are consequently always eager to kneel in flocks, sublimely credulous, at the feet of anyone who professes to have discovered a short and easy road to the renewal of hearing. The little gods to whom they kneel have, most of them, clay feet. The persons who assert this ability to restore the "snows of yester year" do so from one of two motives—deliberate fraud or complete ignorance. Of the fraudulent I do not intend to speak; I have dealt with such impostors at other times and in other places, including the Court of King's Bench. They will continue to batten upon human infirmity and credulity so long as the press, intent upon giving the public "What it wants" rather than what it needs, will publish their advertisements.

But those who profess to restore hearing from a complete ignorance of the true conditions with which they have to deal stand upon an entirely different footing. I can say, with my friends Mr. Story and Dr. Kerr Love, that I have never known a single deaf child in schools to recover hearing power. But every day I see children, originally believed to be totally deaf, develop a certain amount of hearing as education progresses, which is quite another matter. This developed hearing is neither a new nor a restored hearing. *It was there all the time*, unrecognised, unused. The children had no conception of the meaning of the sounds they heard, no means of asking what they meant. Their hearing, too small to be of use in their physiological education, remained, so to speak, *latent*, until the gradual acquisition of language by education under the oral system brought appreciation of it to its possessor. These are the children which, getting into the hands of someone ignorant of the real facts, will respond to education. Such children make no response to tests when first examined, and to decide whether they have or have not any residual hearing is often a matter of great difficulty. Once education is begun and the child is watched and tested repeatedly, some slight hearing—it may be anything from mere perception of sound to complete vowel hearing as described by Mr. Story—will gradually unfold as teaching progresses and the mind is awakened to appreciation. Every teacher of the deaf knows this; it is his business and he makes every possible use of it. Furthermore, some of the effect of education may be delayed, and I have noticed repeatedly how boys and girls with a limited amount of residual hearing, will, as it were, "blossom out" within a few months of their transference (at 12½ or 13 years old) from the elementary to the secondary school. Of course, a

great deal depends upon individual intelligence, and it is no uncommon thing to see a smart boy making every use of small residual hearing side by side with a dull one who has four times as much but does not, apparently, know what to do with it.

There appear, from time to time, persons who have evolved schemes, more or less original (chiefly less), for "re-educating hearing." Such schemes are neither heaven-born nor new, they are at least as old as the first century of the Christian era, when Archigenes advocated intensified sound and trumpets to remedy defective hearing. Many of these ideas are well exploited, highly vaunted, and then sink into oblivion. A few, a very few, survive, often much modified. What is so deplorable about them is that each one leaves behind it a long trail of wounded—disappointed deaf adults, deaf children, whose education has been neglected for the prosecution of vain experiment, and parents who have bought experience. In practically every case the promoter of the scheme is completely ignorant of the psychology of the deaf child, the method (proved by long and practical experience) of his teaching, and the fact that every teacher of the deaf worthy of the name is making the utmost use of residual hearing every minute he is at work *and by better methods*. The thing is unfortunate, but the poor inventor is by no means alone in his ignorance; he merely shares in that remarkable ignorance of the deaf child displayed by many of the medical profession (even including some specialists), an ignorance which appears frequently to lead doctors into making the astounding and wholly unwarranted statement that a child will regain its hearing at the age of seven! I would, further, emphasise the fact that the deaf child stands upon an entirely different plane to the deaf adult. The latter is already in possession of language and automatic speech. Attempts at restoring hearing in his case, by suggestion or other means, may be successful, but to apply the same reasoning, the same arguments, the same treatment to the deaf child is unscientific and useless. It is to construct the same hypothesis upon totally different and totally unsuitable foundations.

In conclusion, I would point out that there exist individuals who, having found a hypothesis, become so enamoured of it that they work upon it in what Dr. Millais Culpin has so aptly called "logic-tight compartments." Therein enclosed, impervious to every fact which may vitiate their calculations, they justify themselves by a pseudo-reasoning satisfactory to their own peculiar mental complex. Some of the so-called re-education schemes would appear to have been framed in this way.

I am, Sir, yours faithfully,

MACLEOD YEARSLEY.

Welbeck-street, W., Nov. 15th, 1921.

PHYSICAL EXERCISE IN HEART DISEASE.

To the Editor of THE LANCET.

SIR,—An annotation in your issue of Nov. 5th drew the attention of your readers to the value of graduated exercises in the treatment of heart disease. Although the method is an old one, its proper value has as yet found but little appreciation. This is particularly the case in the provinces, where it is practically unknown.

But if this treatment is to be successful it is necessary to take the following precautions:—

1. The exercise prescribed in each case should bear a certain relationship to the condition of the heart muscle.
2. The method ought not to be used in cases which show grave myocardial lesions.
3. In advanced cases it is advisable to make the reaction to work of the arterial pressure and pulse-rate as a sort of standard by which the amount of exercise to be taken can be gauged. Suppose a given amount of exertion produces an increase of pressure, say 10 mm. Hg, and this reaction is considered a moderate one, then the exercises are so graduated that the subsequent treatment will produce about the same reaction. Repeated exercises of increasing intensity, if this method is applied, will not produce a greater strain.

4. In advanced cases one group of muscles should be exercised at one time, the rest remaining passive. If all muscles are exercised at one and the same time an undue strain is brought to bear on the heart, unless the exercises are of so mild a nature as to be ineffective for the purpose. I found the Zander system, which I have been using for the last eight or nine years, the best method for carrying out this treatment.

5. In order to avoid all possible strain it is best to start with more difficult exercises, gradually going down to the easy ones, and then allowing a few minutes for rest.

6. It is advantageous to combine massage with exercises.

7. After the patient has carried out a course of treatment he should be recommended to take graduated walking and climbing exercise.

Graduated exercises carried out with due precaution give far better results in heart trouble than does any other form of treatment.

I am, Sir, yours faithfully,

Liverpool, Nov. 14th, 1921.

J. HARRIS.

RICKETS AND VITAMIN DEFICIENCY.

To the Editor of THE LANCET.

SIR,—Dr. Amy Hodgson's admirable chemical and clinical study in your issue of Nov. 5th throws a valuable new light on the vexed problem of rickets. Any practitioner with experience of rickets could also cite cases in which the diet was in no sense deficient in vitamins. The discrepancies found by various experimental and clinical workers are explainable if we suppose that infants may have a varying capacity to absorb, or utilise, the vitamins presented to them; just as gouty and diabetic subjects have an incapacity to absorb other and grosser articles of diet. Too large a proportion of carbohydrates, or other indiscretions, might well diminish still further the capacity of absorption.

There are likewise thin, tuberculous disposed subjects who may take much fat, yet still remain thin and tuberculous disposed—unable perhaps to utilise the fat or the resistance-aiding vitamins which it contains. Some of these patients were rickety when young, as their deformed chests testify.

I am, Sir, yours faithfully,

E. WARD, M.D., F.R.C.S.,
Tuberculosis Officer, South Devon.

Paignton, Nov. 17th, 1921.

CLAYDEN v. WOOD-HILL.

To the Editor of THE LANCET.

SIR,—The report in your issue of Nov. 19th (p. 1073) upon this important medico-legal case fails, in my opinion, to bring out the facts quite clearly. Stated briefly, these were as follows: The patient sustained a fracture of the femur just below the small trochanter and was treated at Beccles Hospital by methods which were in accordance with the usual surgical teaching. She was not X rayed, because the apparatus at Beccles was not good enough to enable an X ray of the upper part of the thigh and hip to be obtained. She left the hospital at the end of eight weeks walking on crutches, and according to Dr. Wood-Hill's evidence and that of his partner, the fracture was then in a satisfactory position and the limb half an inch short. About ten days after her return home, the leg gave way under the body weight, and considerable pain and swelling occurred. I saw the patient 14 days after the incident, and operated upon the fracture four days later, finding the fracture united with angulation, the shortening being one and half inches.

The allegation of negligence was based upon: 1. A wrong diagnosis of the level at which the fracture took place, due to (a) the absence of an X ray, and (b) failure to examine and "set" the fracture under an anæsthetic. Unfortunately, Dr. Wood-Hill had been induced to commit himself to a sketch showing the probable level of the fracture, in which he placed it too low down in the femur. 2. A failure to treat the limb in an abducted position as the result of the wrong diagnosis. As a result of this plaintiff alleged that the fracture was malunited at the time that she left Beccles.