Now I am convinced that the affection described by Laennec in his paragraph on "acute suffocative catarrh of adults and children" is not the affection which I endeavoured to describe in my clinical lecture. It may be frankly admitted that all acute suffocative affections of the lungs, as Dr. Auld indicates at the end of his letter, present certain general resemblances to one another, but this by no means implies that they are the same either in degree or in kind. If Laennec's description be compared with that in my lecture important differences will be found which, to my mind at least, conclusively prove that the two accounts do not refer to the same affection.

Laennec is dealing with an acute suffocative catarrh "affecting the whole, or a very large portion, of the mucous membrane of the lungs"; I am dealing with acute suffocative pulmonary oedema. The duration of the catarrh "is from 24 to 48 hours, or at most some days." The duration of the suffocative oedema in my cases was on an average about six hours. In suffocative catarrh, at the end of 24 or 48 hours, or at most some days, "either the patient dies, or expectoration commences and puts an end to the suffocation, and the disorder then follows the progress of a simple acute catarrh." In suffocative oedema "almost simultaneously with the onset of the dyspnoea—a most important diagnostic point—expectoration of a perfectly white, finely frothy, watery sputum begins." In acute suffocative catarrh "while the suffocation lasts there is little cough" (I use here the words in my copy of Forbes's translation, which are a little different from those in the quotation), "and the expectoration, if any, is altogether pituitous or fluid." In acute suffocative pulmonary oedema "the frothy fluid seems to flow up the trachea and is expelled with a 'hawk,' as if clearing the throat, but there is no cough in the ordinary sense of the word."

The affection described by Laennec is a matter of days; that described in my lecture is a matter of hours. In my first case there was no cough or spit either before or after the suffocative attack had passed off, which it did in about six hours; the suffocation and the profuse expectoration were contemporaneous and both ceased together. These are differences as to the essential nature of the two affections which, to my mind, no degree of general resemblance can reconcile, and which convince me that I have not mistaken cases of acute suffocative catarrh for acute suffocative pulmonary oedema.

I am, Sirs, yours faithfully,
Glasgow, Feb. 24th, 1902. JOHN LINDSAY STEVEN.

THE PREVENTION OF WATER-BORNE DISEASES IN THE ARMY.

To the Editors of THE LANCET.

SIRS,—On reading your leading article on the above subject in THE LANCET of Nov. 30th, 1901, p. 1507, I was reminded of the hugely beneficial effects of the cream separator in prolonging the keeping time of butter. This machine must separate not only cream and milk but also cream and germs. It seems permissible, therefore, to wonder whether some adaptation of the centrifugal principle might not prove efficient as regards water and germs. Such an apparatus would probably be less cumbersome and more rapid in its action than any yet proposed—given only its efficiency.

I am, Sirs, yours faithfully,
Hamilton, Victoria. R. W. HUGHSTON, M.B. Melb.

A METHOD BY WHICH DEPOSITION OF MOISTURE ON THE LARYNGEAL MIRROR MAY BE PREVENTED WITHOUT THE AID OF HEAT.

To the Editors of THE LANCET.

SIRS,—I have no knowledge of the "crayon anti-buée" to which Dr. Walker Downie referred in THE LANCET of March 1st, p. 589, but the desirable result of preventing the deposition of moisture on a laryngeal mirror may readily be brought about by rubbing the mirror with a piece of damp soap. The smeared surface thus produced is polished by rubbing off the film of soap with a soft cloth. A mirror so prepared will not become clouded if breathed upon for some time (over an hour provided the tongue does not touch it)—a point of some value if a lengthy examination has to be made.

The fewer instruments with which a practitioner has to be provided nowadays the better, and as soap is always at hand the simplicity of the process has much to recommend it. Why soap should have this effect I do not pretend to explain, nor do I know who was the first to apply it for the purpose mentioned.

I am, Sirs, yours faithfully,
March 4th, 1902. ETONENSIS.

ISOLATION HOSPITALS AND WELL-TO-DO PATIENTS.

To the Editors of THE LANCET.

SIRS,—Will you please tell your readers accurately and fully what would happen if anyone in what are called the "upper classes" catches small-pox? I myself, through the accident of birth and industrious sires belong to the class who toil not, and I have no idea, nor has my medical attendant, whether in the event of my catching small-pox I shall be able to enjoy the illness at home, or whether I shall be hauled out of bed and carted by force to a Metropolitan Asylums Board small-pox hospital. Nor if allowed to remain at home do I know who will be allowed to attend me or what precautions will be enforced to prevent the spread of the infection. No doubt I ought to know, but I find that nobody seems to know. If you are good enough to reply will you also tell us what would happen if the same state of things occurred outside the limits of the Metropolitan Asylums Board's area. No object in giving my name, so allow me to sign myself—

Yours faithfully,
March 2nd, 1902. SILVER-SPOON.

** To a certain extent our correspondent's question has been answered in a leading article which appeared in THE LANCET of Feb. 1st, 1902, discussing isolation accommodation. A member of the upper classes catching small-pox will be well advised to do as the medical officer of health advises. A sensible medical officer of health would never insist upon the removal of a patient to an isolation hospital who could be effectively isolated in his own house and properly attended by his own medical man. Outside the jurisdiction of the Metropolitan Asylums Board the circumstances would be altered by the fact that there might be no isolation hospital. If there were one, the medical officer of health to the urban or rural authority would be the best person to advise whether an individual case should be nursed at home or not. We may add that our correspondent is too modest, for if his sires had not placed him on the top shelf he would soon have got there by himself.—
ED. L.

AN INDIAN MEDICAL STUDENT'S GRIEVANCE.

To the Editors of THE LANCET.

SIRS,—I have for some time been seeing a notice put up on one of our university boards about the "West African Medical Staff" services. I did not pay much attention to that till I have seen THE LANCET of last week (Feb. 8th). In that under the heading "The West African Medical Staff" I notice that among other qualifications a European parentage is necessary for the candidature for the services. This excludes those who are, though British subjects, yet fortunately or unfortunately not born of European parents; this therefore excludes Indian medical students as well. Now do I wish to draw the attention of the British public, specially of those class of peoples who are of unbiased mind—I mean the members of the medical profession—to the injustice thus done to the Indian medical students of this country. Why should those of us who have come up to this country, been educated in the distinguished universities, studied, worked, been examined and passed together alongside the white men, I am at a loss to understand, be refused a right which our fellow students will enjoy? Shall I understand, then, that this is a distinction of colour and nothing else? It is all very good to extend a hand to accept a help from India in time of need. We do not grumble at it, we do not refuse it, though famine and pestilence have become our daily visitors. Everyone knows how assistance in various shape from Indian princes and Indian contingents was utilised in the present South African