splint." The four-tailed bandage was discarded by me early in the war as being obsolete, the objections to it being so obvious. In its place was substituted a webbing bandage with soft adaptable chin-piece. Two inches of the webbing which passes vertically upwards from the chin is replaced by garter elastic (double thickness, one inch wide). To each piece of webbing at either end is fitted an independent buckle, so that any desired tension can be obtained. With splint in position this bandage efficiently controls any comminuted fragments, bringing them up in position if displaced and maintaining them there, and is, in my opinion, a much simpler and more comfortable device for achieving this than by the screw lever splint.

This bandage also exerts an inward pressure on the lower border of the horizontal ramus of the mandible, and is more than sufficient to overcome the everting pull that occurs in fractures in region of symphysis, and which Major Pickerill obviates by bolting or wiring. That the simpler method of bandaging and splinting does accomplish this end is proved by results, the percentage of non-union of fractures in this area treated on such lines being negligible. The combination of this bandage with the open bite splint entirely obviates the use of suspensory splints objected to by Major Pickerill. One omission in his article is surprising, and that is that there is no reference whatever to the employment of the open bite splint, the advantages of which are so manifold, simplifying as it does the whole treatment of jaw injuries.

As regards the submandibular splint which Major Pickerill uses in the treatment of edentulous cases, I cannot claim to have had any experience with this type. The intraoral supramandibular splint, secured by circumferential wires, being so simple, so efficient in immobilising fragments, in maintaining function, and the end results so uniformly good that occasion has never arisen to experiment with any other.

At the meeting in March above referred to, Major Pickerill made caustic comments on the method of fixation of circumferential wires as being likely to introduce "the unnecessary element of sepsis." Bearing this criticism in mind, his advocacy of a perforating bolt secured by nuts is piquantly inconsistent.—I am, Sir, yours faithfully,

CHARLES H. BUBB,

Honorary Dental Surgeon, the King George Hospital.
Burlington-gardens, W., Sept. 16th, 1918.

A NASAL DRILL IN THE TREATMENT OF ADENOIDS.

To the Editor of THE LANCET.

SIR,—I have been interested since the year 1910 in the observation of cases of chronic lymphatic stasis which have yielded to the treatment designed by Mrs. E. Handcock. In the earlier cases this was applied to the elimination of waste products in the neighbourhood of arthritic swellings; the same principle of artificial lymphatic circulation in later cases showed that the upper air passages could be cleared by external manipulative treatment in many instances of chronic inflammation.

The letters which you have published on nasal drill will draw attention to this undoubted addition to medical knowledge. I am, Sir, yours faithfully.

Harley-street, W., Sept. 24th, 1918. H. BELLAMY GARDNER.

NASO-PHARYNGEAL INFECTION AT THE ONSET OF CEREBRO-SPINAL FEVER.

To the Editor of THE LANCET.

SIR,—Staff Surgeon Fildes's letter in your issue of Sept. 14th, severely criticising Colonel Gordon's views on cerebro-spinal fever, obviously shows his own view to be that many cases of the disease do not have the meningococci in their throats, and he says at the end: "We came to the same obvious conclusion—namely, that Colonel Gordon's statement was much too sweeping, in fact incorrect. Our work is quite well known to Colonel Gordon."

If, Sir, you will turn to the Medical Research Committee's Special Report Series, No. 17, published on August 2nd this year by Staff Surgeon Fildes and Temporary Surgeon S. L. Baker, R.N., you will see on p. 26, under heading, "The Examination of the Patient's Naso-pharynx for Meningococcus," that after mentioning that Flack had found these organisms in this region in all his cases in the earliest stage,

and deduced therefrom that their presence was a valuable diagnostic sign in doubtful cases, these authors proceed:—

"We ourselves are unable to confirm Flack's results as to the constant presence of meningococci in the throat because our swabs were taken on the average nine days after onset, while Flack took his much earlier. Rather less than half our cases showed meningococci in the throat. On general grounds, however, it would appear very probable that meningococci are constantly present in the throat, as stated by Flack; nevertheless, we doubt whether this fact can be taken as being practically diagnostic in certain cases."

It would appear, therefore, that Staff Surgeon Fildes is capable of holding two diametrically opposite views on the same subject at, substantially, the same time.

I am, Sir, yours faithfully,

T. G. M. HINE,

Central C.-S.F. Laboratory, Sept. 19th, 1918.

Major, R.A.M.C.

SANDFLY FEVER OR INFLUENZA.

To the Editor of THE LANCET.

SIR,—In your annotation in THE LANCET of Sept. 14th you deal with the problem raised by Professor G. Sampietro of the belief in Italy of the identity of sandfly fever with the so-called "Spanish influenza." On superficial examination sandfly fever certainly does simulate influenza in epidemic prevalence, sudden onset, and general clinical features, and while it is well known that the signs and symptoms of certain epidemic disease may materially differ according as they occur in tropical, subtropical, or temperate regions of the world, yet there can be no doubt in the mind of the careful clinician that we are dealing with two distinct diseases, and not the same clinical disease or one modified by climatic change. In sandfly fever pharyngeal and laryngeal irritation and catarrh are uncommon, and if present are very transitory, while the pulmonary manifestations of influenza are practically never seen. Local lesions produced by the bite of the sandfly on exposed surfaces of the body occur in over 90 per cent. of patients with sandfly fever, and in any epidemic this should suffice to establish a definite diagnosis. Mortality in sandfly fever may be said to be nil.

We have in sandfly fever, therefore, a rarity of catarrhal conditions of the respiratory passages, a negligible mortality rate, and a definite local skin lesion, in contrast with the general pharyngeal, laryngeal, or pulmonary catarrh, definite mortality rate, and absence of skin lesion in influenza. These suffice to distinguish the two diseases, quite apart from any bacteriological investigations or the prevalence of the sandfly in the district affected.—I am, Sir, yours faithfully,

J. LAMBERT,

Sept. 20th, 1918.

Temporary Surgeon, R.N.

MANGANESE POISONING.

To the Editor of THE LANCET.

SIR,—In the edition just published of the "Nomenclature of Diseases" the metal manganese for the first time finds a place among the poisons. At least its name does not appear in the editions issued in 1896 and 1906. So long ago as 1894 I certified manganese as the primary cause of a young girl's death. Prior to this I had discovered that manganese fumes were emitted from the chimneys of the blacksmith and the plumber during the process of melting the metals they use. The chimneys of these industries never require sweeping and the metallic fumes, along with the products from the combustion of coal such as benzene and naphthalene, go right out to the air. Just as the Gulf Stream is an oceanic current, these fumes form an atmospheric current and travel, especially in the case of the blacksmith, a considerable distance. They are wafted along by prevailing winds, and, gathering moisture, ultimately form a green deposit on wooden fences and trees and the slates and stonework of houses. The deposit in the case of the blacksmith is a bright green and that of the plumber a darker green. The vegetable part of the deposit under the microscope is seen to consist of cells of a very simple character. I have not seen moss near it.

The opinion I formed at that time was that manganese given by the mouth seemed rather inert, but that when injected subcutaneously or inhaled it became poisonous and was cumulative and the symptoms like lead, zinc, and arsenic poisoning.—I am, Sir, yours faithfully,

JAMES GAIRDNER, M.D., D.P.H.

Crief, N.B., Sept. 20th, 1918.

M.O.H., Crief.