in communities. The first task has been taken over by the Government. The second has yet to be accomplished. Is not this the time for private organisations and friends of the disabled all over the country to coöperate with the Government in organising and administering assisted industries for these weaker brethren? It cannot be done by machinery alone. Much individual care, skilled supervision, and above all the right atmosphere are necessary to give these men a chance, as well as the new special study of the adjustment of vocation to mental and physical capacity. I have seen the power of work return in apparently hopeless cases under the right handling. Many men labelled "subnormal" regain their full earning capacity. Many others will always need the sheltered life.

My experience at Enham has convinced me that all types of partial disablement ought to be mingled together in these village communities, because the interaction of different points of view is favourable to health and morale. And I earnestly hope that the medical service in these communities will include both mental and physical methods of treatment. To the medical profession at this juncture belongs the task of formulating what is needful for this large remnant of weakened and dispirited men, and putting before the public and the Government a remedy for a distressing state of affairs.—I am, Sir, yours faithfully,

London, August 29th, 1920.

R. FORTESCUE FOX.

THE TIME OF DAY TO GIVE ANTIMONY TARTRATE FOR BILHARZIA.

To the Editor of THE LANCET.

SIR,—In THE LANCET of August 21st (p. 392) Dr. F. G. Cawston, writing of intravenous injections of antimony tartrate, states:—

"Toxic effects are undoubtedly lessened where the injections are given shortly after a light breakfast, instead of later on in the day. This point has been emphasised by Dr. J. B. Christopherson."

In my article in the *Journal of Tropical Medicine and Hygiene* for July 15th, 1919, I did not exactly say this. I related there that one of the most intelligent of my patients, when injected early in the morning, 9.30 or 10 A.M., found the after-effects to be nil, whereas when the injections were given near lunch time, 12.30 or 1 P.M., he always had giddiness, vomiting, and the reaction generally was severe. "It would therefore appear," I said, "that injections should be given some considerable time, three or four hours, before meal-time." I was referring to natives in the hospital at Khartoum, who breakfast soon after 7 A.M. and lunch at 12-1 P.M.

The question of the best time for making the injections, from the point of view of the condition of the stomach and the digestive processes, is in my opinion a very important one. They should not be given when the stomach is full—for instance, just after a heavy meal—when the blood is largely engaged in the portal circulation with the process of digesting the meal, for, if given then, the toxic, depressing action of the drug will be emphasised, the pulse will possibly be slowed and become weaker, the face pinched and perhaps dusky, the pupils contracted. On the other hand, if given just before a meal, when the patient is depressed and perhaps faint for want of food, the toxic effects of the drug will also be emphasised, especially if a meal be taken directly after. This is shown by a feeling of giddiness, retching, perhaps vomiting, reaction generally. It seems only a matter of common sense that the drug, which has a tendency to depress, should not be given at the time when the patient naturally is depressed. The time of day in itself is not important.

But it is of practical importance, especially when dealing with out-patients, who are not under the same control as in-patients are, to tell them they must not engage in exhausting work previous to nor hurry to be in time for the injection, so that they either have no time for a meal or only time for a hurried scramble of bread and cheese and a glass or two of beer immediately before arrival. Therefore my advice to out-patients is to have a quiet morning. A little necessary work will not matter, but a light digestible meal must be arranged

two and a half or three hours before the injection is due. As a light meal I should, for example, advise a basin of good soup with toast or bread, a little fish, and a milk pudding. For a patient in Egypt, the Sudan, or South Africa some corresponding and appropriate food should be taken two and a half or three hours previous to the injection.

It is by attention to details such as these that success is to be attained.—I am, Sir, yours faithfully,

August 24th, 1920.

J. B. CHRISTOPHERSON.

GENERALISED HERPES OR CHICKEN-POX?

To the Editor of THE LANCET.

SIR,—The recent discussion in THE LANCET upon herpes and chicken-pox suggested that a case at present under my care may be of general interest.

My patient, a man 80 years old, spent four hours in the open air watching a cricket-match on June 26th. The next day he was suddenly seized with an acute pain over the outer side of the left leg, with definite tenderness along the course of the external popliteal nerve. I treated him for neuritis, but on June 28th his pain was only slightly less severe. On June 29th I noticed several small papules evenly distributed over the trunk, extending to the shoulders, arms, and back of both thighs. There was no rash on the face, forearms, or legs. The next day the rash had mostly become vesicular, but new papules had appeared with the same distribution with the addition of some over both legs. Over the outer side of the left leg there was also a fairly well marked erythema, which I then attributed to the effect of the liniment. Apart from this erythema, the appearance was indistinguishable from that of chicken-pox of moderate severity. On July 1st an intense herpetic eruption appeared on the left buttock and leg in two well-marked lines, corresponding probably to the cutaneous sacral nerves, and over the sole of the left foot in a single well-marked line corresponding to a possible cutaneous branch of the internal plantar nerve. The whole of the left leg was now painful, but the acute pain at the original site had diminished.

There was no doubt that the patient was now suffering from an attack of herpes zoster, and I recalled a paper by Dr. Cranston Low¹ on the possible association of varicella and herpes zoster. Six weeks after onset the patient still bears pitted marks, still complains of occasional shooting pains and hyperalgesia over the region of distribution. I must mention that previous to the onset of this illness, and commencing on June 14th last, the patient took in all half a drachm of liq. arsenicalis in m² doses three times daily after food as a general tonic. I cannot obtain any history of a previous attack of chicken-pox or shingles.

At present the question in my mind is whether this case has been one of varicella associated with herpes or one of "herpes zoster generalisatus," as described by Dr. Low.—I am, Sir, yours faithfully,

STEWART MCNAUGHTON, M.D. Edin.,
D.P.H. Camb., &c.,

Honorary Physician, Monkwearmouth Hospital.
Sunderland, August 17th, 1920.

The Services.

ROYAL NAVAL MEDICAL SERVICE.

THE following appointments have been made:—Surgeon Commanders: R. L. Jones to *Chatham*; P. H. Boyden to *President*, additional, for Porton Experimental Station; J. R. Muir to R.N. Hospital, Haslar; and R. H. McGiffin to *Raleigh*. Surg. Lieut.-Cmdr. W. H. Murray to R.N. Hospital, Gibraltar. Surg. Lieut. W. J. Colborne to 3rd R. M. Batt., Eastern Mediterranean. Surg. Cmdr. H. W. Finlayson is placed on the Retired List and granted the rank of Surgeon Captain.

ARMY MEDICAL SERVICE.

Major W. Davis relinquishes acting rank of Lieutenant-Colonel. Temp. Capt. D. C. McCabe-Dallas relinquishes acting rank of Major. Capt. J. M. Macfie to be acting Major. Temp. Major G. S. Simpson (Captain, R.A.M.C., T.F.) relinquishes his temporary commission on re-posting. Capt. F. Holmes, from Spec. Res., to be Lieutenant and to be temporary Captain. Temp. Major A. L. B. Green (Major, 1st Hereford R., T.F.) relinquishes his temporary commission. Capt. H. J. Bensted to be temp. Major whilst specially employed. The undermentioned to be temporary Captains: D. E. Hearn (late Captain, R.A.M.C., Spec. Res.), J. D. Judson (late temporary Captain), and H. H. McClelland (late temporary Captain). Major-Gen. Sir H. N. Thompson, half-pay list, retires on retired pay.

¹ Brit. Med. Jour., Jan. 25th, 1919.