appellee refunded the purchase price in fulfillment of his promise, but it cannot be said that this necessarily or conclusively disproved any intent to defraud, particularly when it was not questioned that in all other instances he retained the money obtained by means of the deceit which he was practicing."

As previously stated, the postmaster-general issued a fraud order against Ben A. Hallgren and the Oxybon Company on Jan. 15, 1916.

Correspondence

The Kinetic Drive

To the Editor:—It has occurred to me that since Professors Carlson and Woelfel have made themselves the sponsors of those who see reasons for questioning the validity of the kinetic theory (*THE JOURNAL*, Jan. 22, 1916, p. 295), it might be well to pursue with them an open debate in the pages of *THE JOURNAL*. Certainly if the kinetic theory is false it should be proved so, and that proof should be presented as openly as arguments in favor of that theory have been presented. My proposal would be that this debate be purely on the merits of the case; that it be free from personalities; that each present fully the data on which he founds his opinion regarding any contended point in the discussion; and that the discussion of each point be subject to the generally accepted rules of debate, i. e., that the affirmative have the privilege of final rejoinder.

Will you not let me know whether or not the pages of *THE JOURNAL* would be open to such a discussion, and if so will you find out whether or not Professors Carlson and Woelfel are ready thus to enter the forum?

G. W. CRILE, M.D., Cleveland.

[The above correspondence was referred to Drs. Carlson and Woelfel, who reply:]

To the Editor:—Our reply to such a proposal might well have been anticipated by Dr. Crile. It seems to us that Dr. Crile before making such a proposal should publish the laboratory and clinical data purporting to substantiate the theory. What sort of a "debate" would that be in which most of the evidence is accessible to one side only? Let Dr. Crile publish his "clinical cases"—especially since he is of the opinion that the validity of the theory must be proved or disproved in the clinics—and all his laboratory data relating to the theory, in such form that one can judge their cogency as evidence and let the essential and new facts be confirmed by others. Such a discussion might be useful.

A. J. CARLSON, PH.D.,
ALBERT WOELFEL, M.D.,
Chicago.

The Signs and Symptoms of Impending Death

To the Editor:—In Dr. Reilly's article on this subject (*THE JOURNAL*, Jan. 15, 1916, p. 160) there are a number of statements at variance with established beliefs. Dr. Reilly states that the death rattle is associated with pulmonary edema. The death rattle is caused by the air passing through the mucus which collects at the opening of the larynx through inability to remove it by swallowing.

The statement is made that edema of the glottis is invariably fatal. The glottis is the aperture of the larynx. What is probably meant is edema of the larynx. This winter I have seen a number of such cases. All the patients recovered.

ALBERT BARDES, M.D., New York.

[A proof of the preceding was sent to Dr. Reilly, who replies:]

To the Editor:—After reading the criticism of Dr. Bardes, I may say that I am quite well aware of the mechanism of the death rattle as understood by the laity; but, in my experience, when the death rattle is present there is also present an accompanying pulmonary edema. Doubtless the ultimate cause is the same in the two instances for both symptoms. I

did not state that edema of the glottis is invariably fatal. This is the case only in elderly patients—those over 45 years of age, in whom a fatal issue may be predicted when this symptom is present. As to the term "edema of the glottis," there may be an honest difference of opinion. Osler regards the term "edematous laryngitis" as synonymous with edema of the glottis, or, more correctly, of the tissues from which the glottis is formed. He prefers the term "edema of the glottis." It is a well established term for describing that terrifying condition which begins with a marked edema of the arytenoepiglottidian folds and false cords and sometimes below the true cords, thus practically closing the air passages. In the aged it is practically always secondary to some other disease, and happy is he who can cure all such cases.

THOMAS F. REILLY, M.D., New York.

Treatment of Diphtheria Carriers

To the Editor:—Your answer to the query of Dr. C. J. March (*THE JOURNAL*, Jan. 1, 1916, p. 51) is of value, and if the method of treating diphtheria carriers is thoroughly carried out, the mortality from diphtheria will be reduced. It has been proved that patients discharged, after as many as three negative cultures have been obtained from the nose, mouth and throat, were still diphtheria carriers, the diphtheria bacilli being found in abundance in the deep crypts of the tonsil and folds of the adenoids. The customary swabbing of the nose, mouth and throat is not sufficiently thorough to secure a culture from the supratonsillar crypts or the folds of the adenoids, and, therefore, carriers are being discharged to continue in the spread of the disease. Not one carrier of diphtheria has been discovered who has had a complete removal of the adenoids and tonsils.

Your answer would have been simplified had you instructed Dr. March to have the child's tonsils and adenoids completely removed. This would have instantly cured the child of the disease and prevented the patient from becoming a carrier, as well as the incurable complications that this treatment prevents. T. L. HIGGINBOTHAM, M.D., Hutchinson, Kan.

[COMMENT.—The point to which attention is called by Dr. Higginbotham is a good one. That the removal of the tonsils and adenoids aids in the treatment of diphtheria carriers should have been mentioned.—ED.]

Training of Medical Missionaries

To the Editor:—Apropos the Current Comment on the "Training of Medical Missionaries" (*THE JOURNAL*, Aug. 21, 1915, p. 723), I am moved to give a bit of personal testimony in the hope that it may, by virtue of its coming as a voice from the other side of the world, have the added effect that Dives hoped for, in his conversation with Abraham, as recorded in the sixteenth chapter of St. Luke. I am not dead, rather very much alive to some things, even more so than when living in America. Here in southern Asia, a doctor must be alive, if he would even attempt to diagnose properly and treat the many diseases that occur in his practice. In America I conceived the idea that a medical missionary should be an "all around doctor." Here I have realized that he must be more than that. If he would be of much service medically to those to whom he is sent, he must not only be a good general practitioner, but also, to be of distinct service, he should have specialized in certain branches. Tell every prospective medical missionary that if the need of the civilized country is not "more doctors, but more doctor," doubly, trebly true is it out here.

Will you bear with me one more word: Let there be places where this additional training can be had by those who have offered themselves for foreign fields *for life*. I have found no place where my appointment to a foreign country gave me any advantage when seeking postgraduate training: not even in the hospitals which call themselves by the name of my church was there a single opening.

PAUL W. VAN METRE, M.D., Nakawn Sritamarat,
Malay Peninsula.
Superintendent, Sritamarat Memorial Hospital.