the "postural" and "osseous" cases presents no difficulty, and is too well known to call for any description, but the subdivisions of "trace," "moderate," "severe," and "extreme" leave too much to individual judgment. They are excellent terms to use to the patient's friends, but are too vague to find acceptance if any more precise classification is available. I maintain that we have this in the method of Professor Rudolf Klapp and Dr. Fränkel of dividing all cases into three grades, each easily recognisable, and each resting upon a definite anatomical basis.

There is no need to repeat the analysis of these three grades given in my letter published in your issue of Oct. 14th, but Mr. Roth misapplies to them my description of the three distinct stages in the underlying anatomical changes in the thoracic skeleton. My correct statement regarding the three clinical grades of cases was as follows: "These grades pass imperceptibly one into the other. But, with experience in examination, there is little difficulty in relegating any one case to its proper grade: the distinction is about as definite as that between degrees of burn." The truth of this comparison is a strong argument in favour of this method of classification.

Mr. Roth has some difficulty in understanding the second grade of case in which the bones have not yet undergone any fixed alteration in shape and in which the deformity, rendered possible by the elasticity of the ribs and their cartilages, is maintained in great measure by muscular and ligamentous shortening holding the contorted thorax in malposition. There is no mystery about lateral curvature of the spine and the soft parts behave as they do in other deformities—viz., the muscles and ligaments will become shortened or lengthened according to diminished or increased strain. Thus they will be shortened on the concavities of the curves and lengthened on the convexities. It was in recognition of this phase and of the importance of restoring the mobility of the thoracic framework that the "creeping" exercises were devised, and therein lies the explanation of the excellent results derived from them.

I am, Sir, yours faithfully,

Cavendish-place, W., Oct. 28th, 1911. J. S. KELLETT SMITH.

THE ETIOLOGY OF SCARLET FEVER.

To the Editor of THE LANCET.

SIR,—In THE LANCET of Oct. 28th you publish a communication from Dr. R. W. C. Pierce, medical officer of health for Guildford, on the subject of the Etiology of Scarlet Fever. In the communication he mentions that I called the attention of Dr. J. C. Thresh, medical officer of health for this district, to the fact that I had a sequence of four sporadic cases of scarlet fever, in each of which there was a septic wound or a septic condition of some sort. The cases were as follows: 1. A boy, aged 9, sleeping and living amongst five other young children, developed a typical scarlet fever rash, throat and tongue. It was not possible to move him until two days after I had diagnosed his condition, so that he had to remain amongst the other children. None of them caught it. He had an abscess and a septic condition of the sole of the foot. 2. A young lady had had her ears pierced and the wounds became infected. About 14 days afterwards she developed a rash very like scarlet fever and undoubtedly connected with the septic condition of the lobes. This certainly was not a typical case of scarlet fever. 3. A child of 8 showed a typical scarlet fever rash. She lived in an isolated cottage and had not been near other children or people for several weeks. She had a septic sore from an abrasion on the front of the tibia. 4. A young woman had a lot of teeth removed under gas for pyorrhœa alveolaris. She developed scarlet fever a few days afterwards.

These four cases, occurring one after the other, long distances apart, arising from no previous cases as far as I knew, and giving rise to no fresh cases in their own homes as they were either isolated at home or sent to the fever hospital before the peeling stage, made me think whether there was a condition common to them all to account for the onset. The common condition to all I found was a septic one on some part of the body.

Until such a condition is found to be present in a large percentage of sporadic cases in sparsely populated districts the observation is not worth much. It would be interesting to hear other medical officers of health on the subject.

I am, Sir, yours faithfully,

Stock, Ingatestone, Oct. 30th, 1911.

HERBERT CARDIN.

OLD AND NEW VIEWS ON THE TREATMENT OF CONSUMPTION.

To the Editor of THE LANCET.

SIR,—Dr. C. Theodore Williams in his excellent Harveian oration on the new views on the treatment of consumption, published in your last issue but one, mentions that 54 different theories have prevailed in bygone ages—that is, from the time of Hippocrates to the time of Dr. Hughes Bennett. And these theories are as diverse as they are numerous, and testify to the lively imagination of their authors, and, as a rule, mistake predisposing causes for the *causa vera*, which, "though long suspected, was never actually discovered till Robert Koch appeared on the scene." May I be permitted to mention an addition to the list, and which, I believe, surpasses all others in value, and is a piece of work of equal magnitude with Koch's own, which it preceded by almost 14 years. I mean, "Études sur la Tuberculose: Preuves rationnelles et expérimentales de sa spécificité et de son inoculabilité. Par J. A. Villemin, professeur agrégé à l'École Impériale du Val-de-Grâce, 1868; à Paris, chez J. B. Baillière et Fils, éditeurs." The 17^{me} Étude is a most remarkable production; any one having read the work will believe that Villemin listened to the exhortation of "l'immortel Harvey," as we say on this side of the Channel, "to search and study out the secrets of Nature by way of experiment," and that he did it successfully.

I am, Sir, yours faithfully,

Paris, Oct. 30th, 1911.

EUGENE DUPUY.

BIRMINGHAM.

(FROM OUR OWN CORRESPONDENT.)

Physical Defectives.

A SPECIAL subcommittee of the Birmingham Education Committee has issued an exhaustive report concerning all cripples in the city, both adults and children. It has taken the committee two years to tabulate and collect the facts. The object was to find out why people became cripples, what could be done to prevent it, how cripples earn a living, and in what trade they are most successful. The answers to these questions are given at some length. There are 1001 cripples (546 males and 455 females) over 16 years of age. Of these 334 (212 males and 122 females) are being maintained by the three local boards of guardians, 180 being in infirmaries and 154 in workhouses. In the Birmingham workhouse and infirmary out of a total of 2636 inmates 272, or 10.3 per cent., are cripples. Of the 1001 cripples in the city about one-fifth, or 214, were able to work under ordinary conditions, and 145 could do some useful and remunerative work if workshops could be provided in the centre of the city. They were not so handicapped that they could not go to and from their work, but they could not compete with ordinary workmen. Employers were loth to engage them. The third class, 111, were unable to go to and from a central workshop. The Cripples' Union was doing a great work, but had not sufficient funds to cover the ground. The last class, comprising 531 cases, could do no remunerative work, and 334 of these were maintained by the guardians. There were 728 cripples under 16 years of age, some of whom will recover, but the committee did not think this number would be large. Mrs. Hume Pinsent, in presenting the report to the Education Committee, said she believed it was the first report of the kind ever made in England. She appealed to the medical profession to read the report and see if they could give satisfactory answers and information on the questions asked. Dr. H. W. Pooler pointed out that the great majority of cases of tuberculosis of the bones and joints were due to infection from food, chiefly milk, which children took in their earlier years.

Greater Birmingham and Special Schools.

None of the outside districts about to be taken into the city have made special provision for defective children with the exception of Aston, which has a small school for the deaf. The other districts send most of their deaf children to institutions, and in all the districts blind children are sent to institutions. The percentage of defective children in the school population will probably not differ materially in the new districts from the percentage known to exist in the old