Correspondence.

"Audi alteram partem."

THE PRIMARY EXAMINATION FOR THE
F.R.C.S. ENG. :AN APPEAL TO THE PRESIDENT OF THE ROYAL COLLEGE
OF SURGEONS.

To the Editor of THE LANCET.

SIR,—May I ask the courtesy of your columns for the following appeal?—I am, Sir, yours faithfully,

WILLIAM OSLER.

DEAR MR. PRESIDENT,—All who have at heart the interests of medical students must have been gratified to see in this morning's *Times* the continued (increasing?) high percentage of rejections—82! But must we wait for a total rejection before the College realises the rottenness of the present system? System it must be, dear Makins: for are not the teachers who fail so ingloriously among the best of your Fellows (in anatomy at any rate); are not the examiners, who are so successful, picked men of the same class; and the unhappy victims—well, it seems ridiculous to say so—but are they not our very best students? For results, see the *Times*, 27 rejections out of 34!

In your skill and judgment the profession has unusual confidence. Induce the College to relieve an intolerable situation. Abolish a system which is a reproach alike to teachers and examiners, and worst of all a cruel perversion of mental values to the student at the very time of life when such values count. The alternative? Back to John Hunter:—

1. Do away with the necessity for Fellowship classes.
2. Make the candidates spend the time (now wasted in cramming) in the laboratories and hospitals.

3. Let them come to the examiners' board with proofs of personal study and research in anatomy or physiology for the Primary—and, may I add, in pathology or surgery for the Final.

Sincerely yours,

WILLIAM OSLER.

Oxford, May 9th.

* * By all who have the interests of medical education at heart Sir William Osler's appeal will be endorsed. The fact cannot be got over that the unsuccessful candidates, who are as a lot the pick of the students, have been prepared for the Primary Fellowship by the class which finds them later to have been badly prepared.—ED. L.

ACUTE EPIDEMIC ENCEPHALITIS.

To the Editor of THE LANCET.

SIR,—As most of your readers will have learned from papers and correspondence in your journal, and from a memorandum recently issued by the Medical Officer of the Local Government Board, there is a prevalent epidemic of acute encephalitis, but neither of the above sources of information quite covers the symptomatic field.

I have recently seen and verified post mortem two cases of acute hæmorrhagic encephalitis in adults over 40 years of age in which the clinical picture has included a rapidly progressive hemiplegia and aphasia, associated in both instances with epileptic convulsions, and in one with hemianæsthesia, hemianopia, and optic neuritis. It appears, therefore, that the inflammation may affect any part of the brain and produce a great variety of physical signs and symptoms, according to its incidence. There seems to be little or no evidence in favour of its connexion with any food poison, but further information with regard to the nature of the infective agent is urgently required.—I am, Sir, yours faithfully,

Wimpole-street, W., May 14th, 1918. E. FARQUHAR BUZZARD.

BOTULISM.

To the Editor of THE LANCET.

SIR,—The following appears to be another case of "botulism" arising at about the same time as most of those recently recorded, and occurring in a man of 41, who is in an advanced stage of phthisis and whom I attended two years ago for angio-neurotic œdema:—

From March 31st to April 6th he daily ate sausages, which were purchased on March 30th, and were observed to be of a nasty colour before they were finished. Since that date he has had no food of any description prepared from pig. About April 8th he became much feebler than usual and would not dress or exert himself; his temper also became uncertain. On the 16th he caught cold, followed by much

increase in cough and sputum, physical signs of bronchitis, and a temperature varying from 100° to 101.2°. There were some nocturnal delirium, a very foul mouth, profuse sweating, and constipation. These symptoms continued unaltered until early on May 2nd, when right-sided facial paralysis suddenly occurred, the temperature dropping to 97° and remaining after this under 99°. At that time there were no signs of any paralysis of limbs, or oculo-motor muscles, and no ptosis or pupillary alterations, nor was there retention of urine or difficulty in swallowing.

The lethargy has gradually increased to what appears complete unconsciousness, from which he suddenly rouses, though only partially. Slight ptosis of the right eyelid, occasional external squint of one or the other eye, and nystagmus are now present, though the eyes move freely in every direction. There is hypertonia of the muscles of all the limbs, but less of the right arm and leg than of the left, and the right limbs are now parietic. Knee-jerks are increased and there is a tendency to ankle clonus on both sides. Kernig + on both sides. Right plantar reflex is flexor and left extensor. Diaphragm moves well, but there has been persistent hiccough since last night. There are constant clonic movements of the left arm and hand. The fundi, which were examined to-day by my partner, Dr. H. Nuttall, are normal.

I am, Sir, yours faithfully,

Colwyn Bay, May 6th, 1918.

ROBERT E. LORD.

PS.—The patient died 36 hours after the preceding notes were written, the only additional symptoms being difficulty in swallowing which appeared late on May 6th, and retention of urine which necessitated catheterisation on the 7th.

EPIDEMIC STUPOR IN CHILDREN.

To the Editor of THE LANCET.

SIR,—Time alone will determine whether the four instances of the symptom-complex characterised by stupor observed by Dr. F. E. Batten and Dr. G. F. Still, and recorded in THE LANCET of May 4th, "justify the conclusion of a new disease of epidemic origin." That the onset, duration, and symptom incidence of disease processes in general are changing so as to render clinical diagnosis obscure and frequently impossible is unquestionable, and many common instances might be cited—i.e., the alteration in the type of rash of measles. It is reasonable to assume that this change of bodily reaction to disease is due to three main factors: (1) The introduction of new bacterial strains from all parts of the globe; (2) the absence of natural immunity; and (3) lowered resistance from restricted diet.

In five cases, four of which were female children, of similar nature occurring under my care and conforming to no standard of group symptoms, the bacteriological investigations during life being nil, two proved at the post-mortem examination to be tuberculous meningitis, one pneumococcal leptomeningitis, and the remaining case acute military tuberculosis, the last-named presenting the clinical picture described by Professor A. J. Hall in THE LANCET of April 20th as the asthenic type of toxic ophthalmoplegia.

I am, Sir, yours faithfully,

May 6th, 1918.

L.R.C.P.

SERUM TESTS FOR SYPHILIS.

To the Editor of THE LANCET.

SIR,—In THE LANCET of May 4th, in a timely leading article under this heading, you summarised some of the factors involved in the standardisation of the Wassermann reaction. As a firm believer in the desirability of such standardisation I should like to draw attention to one additional consideration.

The technique employed in this laboratory fulfils the conditions laid down in the excellent report issued by the Medical Research Committee. Quantitative results are obtained by varying the amount of patient's serum employed. Until the middle of last year each test included five different dilutions of serum, and the results were recorded by noting the amount of fixation produced in each tube. With the increased material and the improved clinical records available under the scheme now in force it was felt that more strictly quantitative results were desirable, especially in the direction of records of the upper limits of strongly positive reactions, since, by any method involving the use of only a few tubes, this limit is not reached in a considerable number of cases. We have therefore modified our technique by adding to the tubes employed in each test, so that the dilution of patient's serum varies from 1/7.5 to 1/960. This involves putting up nine tubes, including the serum control, but to economise the reagents a preliminary test is carried out using the serum control and the tubes containing the 1/7.5 and 1/120 dilutions. This divides the serum into negatives, positives, and strongly positives, and the intervening or additional dilutions are then tested to obtain the exact dilution which produces the result regarded as