hemolytic index of human serum, and with this means determine the syphilitic factor of the serum, gives a much higher percentage of positive results than the test described above, but the guinea-pig system does not give any higher percentage of positive results than the Wassermann using the antihuman system.

JOHN FUNKÉ, M.D., Atlanta, Ga.

LOW TYPHOID DEATH RATE OF RICHMOND, VA.

To the Editor:—I wish to express my gratification in connection with what you have to say concerning Richmond's 1919 typhoid record (*THE JOURNAL*, March 6, 1920, p. 672). I am glad that you agree that our rate of 3.7 is quite an extraordinary one for a Southern city.

It is gratifying to see in Table 6 that Richmond is the only city south of the Potomac and Ohio rivers appearing in the first rank, and that even those Southern cities which appear in the second rank come in at the tail end, while the third rank and fourth rank are composed entirely of Southern cities. In other words, if the cities of over 100,000 population are ranged in the order of their typhoid death rates, Southern cities, with the exception of Richmond, are found entirely at the bottom.

Your statement that "it is evident that the maintenance of a low typhoid death rate is not to be taken as a matter of course without the exertion of constant vigilance by the local health authorities" is certainly true. I know that in the case of Richmond our constantly decreasing rate has been due to constant effort and watchfulness. This year we shall have a hard job holding down to last year, and, in fact, there is little, if any, chance of our duplicating our 1919 rate. Unfortunately, our first three cases this year all terminated fatally, and besides this, we have had one more death, so that, although only seven cases have been reported this year, we have already had four deaths, against a total of six in 1919.

As an illustration of the desire on our part to have accuracy at all cost, I may state that the death certificate in the case last mentioned came in to us with influenza and septicemia given as the cause of death. The blood specimen taken on the last day of illness, however, showed the presence of the typhoid bacillus. We had considerable difficulty in persuading the physician to change his diagnosis to typhoid fever, but eventually accomplished this object.

When I entered office in 1906, every physician with an average practice treated at least half a dozen typhoid cases every summer, and our busiest practitioners counted it a poor year when they did not have twice that many cases. In recent years we have had only about one case to every three or four physicians, and scarcely this number in private practice. One result of this, I fear, is going to be that the average physician will not see enough typhoid fever to become reasonably skilful in its handling, and this may result in an increased case fatality. This can be obviated only by hospitalization of all typhoid cases, a course which has many other things to commend it.

E. C. LEVY, M.D., Richmond, Va.

Director of Public Welfare.

"HITHERTO UNDESCRIBED SIGN IN DIAG- NOSIS OF LETHARGIC ENCEPHALITIS"

To the Editor:—I was much interested in the description by Dr. Thomas F. Reilly (*THE JOURNAL*, March 13, 1920, p. 735) of a hitherto undescribed sign in lethargic encephalitis. This sign (the abnormal involuntary twitching of muscle bundles) was apparently not present in last year's epidemic, but has been noted with regular frequency in the cases coming under observation this year. There are apparently three types of influenzal invasion of the central nervous system which have, as a distinguishing feature in common, these myoclonic movements: One type is associated with a diffuse neuralgic syndrome, toxic delirium and a fatal termination. Another type presents only myoclonic movements and a neu-

ralgic syndrome which proceeds to an early recovery. The third type presents the foregoing symptoms, which after a variable time become merged into a pure syndrome of lethargic encephalitis. There is no doubt that all these phenomena are simply the expression of the same infectious agent.

Dr. Reilly considers the term "lethargic" unfortunate, as the condition of the patient belies the designation. In this connection I would consider the term "encephalitis" equally misleading. I refer particularly to those cases which present only diffuse myoclonic movements and neuralgic symptoms. As stated before, this type of case reveals no evidence of "encephalitis" on close scrutiny. Lethargic encephalitis is becoming a sort of junk-heap on which every infection with neural manifestations is being dumped. In the interest of scientific and clinical accuracy, a revision of the nomenclature would indeed be welcome.

CHARLES ROSENHECK, M.D., New York.

Queries and Minor Notes

ANONYMOUS COMMUNICATIONS and queries on postal cards will not be noticed. Every letter must contain the writer's name and address, but these will be omitted, on request.

SYRUP OF THYME

To the Editor:—A short time ago I received a sample of "Pertussin" and used some in an obstinate case of bronchitis with excellent results. I have since received a catalog from a pharmaceutical firm, which advertises syrup of thyme. I have searched for a formula to make my own syrup of thyme, but have not been able to find one. Will you publish one?

E. F. BENNER, M.D., Salfordville, Pa.

ANSWER.—The subjoined formula yields a product very similar to "Pertussin" in taste, flavor, composition, and probably in activity as well:

Fluidextract of thyme	15 c.c.
Glycerin	15 c.c.
Syrup	to make 100 c.c.

The original German preparation contained 1.5 gm. of sodium bromid in each hundred cubic centimeters, and this might be added to the foregoing formula with advantage, so far as action is concerned. However, a sample of "Pertussin" purchased in the open market in the United States failed to respond to tests for bromids.

As fluidextract of thyme is not official, this formula is presented as furnishing an acceptable preparation:

Thyme, in No. 60 powder..... 100 gm.

Moisten with a mixture of:

Water	25 c.c.
Alcohol	15 c.c.
Glycerin	10 c.c.

After standing five hours, pack in a percolator. Exhaust with a menstruum of alcohol, 1 volume, and water, 3 volumes. Reserve the first 85 c.c. of percolate. Concentrate the weak percolate to a soft extract and dissolve in the reserved portion. Make up to 100 c.c. by addition of a mixture of alcohol, 1 volume, and water, 3 volumes.

Other aromatic expectorants, such as terebene, terpin hydrate or creosote, might be expected to have similar but greater effect in chronic bronchitis.

Care of the Eyes.—To read or study when tired or drowsy is to strain the eyes to a dangerous degree. Avoid evening study whenever possible. If you are using your eyes by artificial light, be sure the light does not shine directly into the eyes, and try to have it come from behind and to the left side so as to avoid the harmful glare. Never sit with the gas or electric light directly in front of you. If electric light is used, the bulbs should be wholly or partly frosted. The best form of artificial illumination for the eyes is the so-called indirect system, where the light is reflected from the ceiling and walls of the room in a soft glow and where all glare is entirely hidden by an opaque shield.—W. M. Carhart, *Pub. Health*, Michigan, September, 1919.