less normally to vestibular tests is either hysterical or malingering? If he does not, I cannot understand why he refers to the views expressed by me. If he does, he undertakes a very serious responsibility, for all of us see many men, deaf as the result of explosions, whose future will depend largely upon the reports furnished by otologists.

It would occupy too much space to criticise Dr. McKenzie's views seriatim, but I may perhaps allow myself one or two remarks. Among his cases are some in which he himself admits organic lesion of the internal ear, and yet vestibular reactions were normal or increased. The occurrence of such instances would, in common justice, negative the assumption that the presence of a normal vestibular reaction is indicative of purely functional trouble. Again, it appears to me that Dr. McKenzie is too prone to assume that deafness is functional. For example, he says, "bearing in mind, however, the fact that hysterical or functional deafness, like any other manifestation of this disorder, is often obstinate and persistent." Now, as I pointed out in my previous letter, hysterical deafness can only be diagnosed with certainty after it has been cured, therefore it cannot be diagnosed with certainty *while it persists*. It may, indeed, be strongly suspected, but can Dr. McKenzie give any other absolute proof? Apart from the presence of a suggestive history or the existence of unmistakable hysteria, can he even give a list of symptoms which would afford very strong reasons for suspicion?

I am, Sir, yours faithfully,
Edinburgh, Nov. 19th, 1917. P. McBRIDE.

CIRCINATE RASHES AFTER ANTITOXIN.

To the Editor of THE LANCET.

SIR,—In an annotation in your issue of Nov. 17th you write: "With the production of an antidiphtheritic serum of high potency the appearance of serum disease, so frequent in the early days of antitoxic treatment, diminished almost to vanishing point." The following figures show the percentage incidence of serum rashes during the treatment of diphtheria in the hospitals of the Metropolitan Asylums Board from 1898 to 1914 inclusive:—

Year.	Percentage incidence of rashes.	Year.	Percentage incidence of rashes.
1898	45.0	1907	25.0
1899	34.5	1908	30.3
1900	42.6	1909	30.3
1901	43.6	1910	30.6
1902	47.4	1911	30.6
1903	44.8	1912	30.1
1904	43.1	1913	31.2
1905	32.8	1914	32.9
1906	30.6		

I believe the actual incidence to be higher than these statistics indicate owing to failure to observe or note all rashes, but they are sufficient to show that, though a drop took place after 1904, serum disease has not "diminished almost to vanishing point."

You describe the rashes 20 years ago as follows: "Exanthem of urticarial type; more rarely rashes occur resembling scarlatina or measles." In a letter I wrote you referring to an article by Captain S. Wyard on anaphylaxis, and which you kindly published in your issue of Jan. 27th last, I drew attention to the circinate erythema as being next in frequency of occurrence to urticaria. In the *British Medical Journal* some 15 years ago, Stanley, I think, stated that the circinate erythema was more common than any other eruption. This has not been so for a number of years, but although the circinate erythema is much less common than the urticaria, it is not uncommon. Captain Wyard, in his letter in your issue of Feb. 10th, said the circinate rash had not come under his observation, but I presume his experience lay amongst adults. At all events, the fact that a circinate rash does occur, and that it is next in frequency, is well known to those experienced in serum disease.

Among those who have not undergone serum treatment previously the days of election for the first appearance of the urticarial rash are the seventh, eighth, and ninth after injection, and it may appear at any time subsequent to the injection up to the fourteenth or fifteenth day, but rarely

later. In those who have undergone serum treatment previously the urticarial rash is almost invariably accelerated. It may appear within a very short time, and most commonly does so in about 24 to 48 hours. The circinate erythema occurs from about the tenth to the twentieth day, and is much more common in those who have suffered from a previous urticaria. It is true that continued high temperature does occur rarely, and also diarrhoea, but it has not been my privilege to see serum disease simulate enteric fever.

Anaphylaxis is rare, and I have not yet seen a case follow upon anti-anaphylactic treatment, but the anti-anaphylactic treatment does not appear to make any difference to the acceleration of the serum disease which I mention above.

I am, Sir, yours faithfully,

FREDERIC THOMSON.

North-Eastern Hospital, Tottenham, N., Nov. 19th, 1917.

RECURRENT ATTACKS OF FEVER.

To the Editor of THE LANCET.

SIR,—The disease discussed by Dr. R. V. Solly (Sept. 8th, p. 386) and Professor Tanner Hewlett (Oct. 8th, p. 552) can hardly be rat fever. I have recently attended a well-marked case for 12 months, in which rat infection could be pretty certainly excluded, or, indeed, a wound of any kind. The only organism found in the blood was *Bacillus faecalis*, and the febrile attacks occurred on the average every 10 days.

The patient was an active, vigorous old man, in good health, except for some prostatic trouble. In the early part of October, 1916, he was attacked with fever, rigors, hiccough, and oedema of the right lower limb. No thrombosis could be detected, but the swelling continued. The fever returned from time to time and settled down to fairly regular attacks every ten days, which continued till his death, Nov. 5th, 1917. Between them he picked up and even got out of doors in fine weather. The onset was marked with a shiver, headache, and great drowsiness, and followed by obstinate hiccough and vomiting. The fever only reached 100° F. or 101°, and fell in a day or two. The pulse did not rise above 80. The leg remained white and oedematous for about nine months, but during one attack a red flush spread over it like an ordinary erysipelas. A cultivation was taken from near the edge of the oedema, and a vaccine was made from the *Bacillus faecalis* found there by Professor I. Walker Hall. The result was remarkable, in that after two or three doses the massive swelling of the leg vanished entirely, but the patient so feared the reaction that he could not be induced to continue them or to have galyl. The febrile paroxysms went on. Sulphur, quinine, and cinnamon had no effect. He finally failed to take food and died much emaciated. The heart was at one time dilated and irregular, but recovered after the vaccine.

It was clearly not malignant endocarditis, nor erysipelas. Shearman and Moorhead noted 11 cases in Egypt in soldiers where this organism was found, but the relapses did not exceed two or three. The chills, vomiting, and slow pulse were present in their patients.¹ More often the *B. faecalis* is not associated with clinical symptoms.

I am, Sir, yours faithfully,

Clifton, Bristol, Nov. 19th, 1917.

GEORGE PARKER.

SIR RICHARD CROFT AND THE CASE OF THE PRINCESS CHARLOTTE.

To the Editor of THE LANCET.

SIR,—I much wish I could support my friend Dr. Hingston Fox in the two points he advances in this matter. The facts of the case, however, prevent my doing so.

1. Dr. Fox states that Queen Charlotte was attended in her confinements not only by Mrs. Draper, the midwife, but by Dr. William Hunter, the official accoucheur. If Dr. Fox will look into the "Obstetric Diary" kept by Dr. Hunter, and printed by Dr. Stark, he will see that Dr. Hunter was never called in until after the baby was born, and his official duty was limited to feeling the Royal pulse and examining the Royal placenta.

2. Upon the authority of Wadd, Dr. Fox states that Sir Richard Croft possessed the M.D. degree. Wadd was a gossipy, merry writer, and would not, I think, be considered an authority in the matter. Neither the "D.N.B." nor Burke's *Baronetage* gives Croft a degree. He practised medicine at Oxford for a short time, but the *Alumni Oxonienses*

¹ Brit. Med. Jour., Dec. 30th, 1916.