

knowledge of the dangerous nature of his illness. Temperature 102° F.; pulse 84 and good.

Dr. C. W. Daniels of the London School of Tropical Medicine was kind enough to see him with me next day, and out of his vast experience to give his valuable advice. The prognosis in his opinion was extremely favourable, provided that good diuresis could be maintained, because dilution of the urine with an equal quantity of water rendered the mixture almost transparent. I found the parasite in the blood on the 17th (sub-tertian variety), but none on the 18th as is usual. The urine, which gave the usual tests for blood and showed a very heavy deposit upon standing, contained many granular casts, but no red blood corpuscles. No quinine or purgative was given, but 2 ounces of fluid every quarter of an hour. The urine was passed at the rate of 4, 3½, 4, 4½ pints respectively in successive periods of 24 hours' duration, and at the end of 84 hours (3½ days) after the initial rigor showed no chemical trace of blood. The hæmoglobin of the blood on the third day of the illness was about 70 per cent., the lips, gums, and nails were bloodless, and loud hæmic bruits were audible all over the præcordium. To-day (May 31st) he is feeling very well and looks it.

Out of my very limited experience it seems to me that these two cases definitely support Dr. Harford's views: (1) Quinine is essential for malaria and malarial subjects; (2) small regular doses should be used, as in Africa, not large irregular doses, as in Burma; (3) regular daily dosage is better than regularly intermittent dosage; and (4) regular dosage should be continued for some considerable time after arriving in England.

As regards blackwater fever, which seems to be becoming more and more every year a disease with which even the general practitioner may be called upon to deal, it is important to remember: (1) The disease is a hæmolysis and not a hæmorrhage; (2) the great danger is suppression of urine owing to clotting of the blood in the renal tubules; (3) much fluid means much urine and safety; (4) the first 48 hours are the critical ones, in which all depends upon treatment; and (5) alcoholic stimulation is not contra-indicated as in hæmorrhage, and is often imperative.

I am, Sir, yours faithfully,

Fleet, Hants, May 31st, 1910.

J. E. FRERE.

"A CASE OF LYMPHATISM."

To the Editor of THE LANCET.

SIR,—In the opening paragraphs of the article published in THE LANCET of May 14th, p. 1347, under this heading, Dr. L. P. Burt and Dr. J. R. Collins describe a condition in which there was noticeable enlargement of the thyroid gland together with tachycardia and dyspnoea. "The thyroid gland formed a large rounded tumour in the neck, larger on the right side than the left. The pulse varied from 100 to 150 per minute. On admission there was great dyspnoea." No attempt is made to furnish any explanation of the rapid super-vention of urgent dyspnoea. The account of the necropsy states that there was no evidence of compression of the trachea, and we are left without any explanation of the urgent dyspnoea which called for the operation of partial thyroidectomy.

Passing to consideration of the cause of death, we have the statement that "the heart apparently ceased to beat five to seven minutes after the cessation of respiration," while a little lower down, in commenting upon the mode of death in cases of lymphatism, the following view is expressed: "It seems certain that there is present in these cases of lymphatism a morbid susceptibility to shock, and that a stimulus which in a normal subject would be quite harmless may give rise to a fatal inhibition of the heart."

The authors seemingly conclude that death was due to the effect of chloroform inhalation acting upon a patient subject to a condition of lymphatism, and I would call attention to what seems an important omission in the report of such a case. No mention is made of the length of time during which chloroform narcosis had been maintained prior to the super-vention of death. Seeing that their publication had in view the demonstration of a special inability on the part of the subjects of lymphatism to withstand the deleterious effects of chloroform inhalation, it might, I think, have been expected that this point would have been made clear. The authors seemingly hold the opinion that the predisposing

cause of death in the case they describe was without doubt a condition of lymphatism, but they have supplied no satisfactory proof that such was in reality the case.

They lay considerable stress upon what they consider an abnormal hypertrophy of the lymphatic tissues contained in the mucous membrane of the alimentary canal and of the mesenteric lymphatic glands. I would venture to ask with what knowledge it is possible to arbitrate between such an hypertrophy as may be looked upon as compatible with a normal state, and such a condition of overgrowth as should be rightly held to constitute evidence of a pathological state.

I am, Sir, yours faithfully,

EDGAR TREVITHICK, M.D. Cantab.

MEASLES AND THE POST-OFFICE AUTHORITIES.

To the Editor of THE LANCET.

SIR,—May I be permitted to add to Dr. Collier's letter in a recent issue that modern text-books support his practical experience. In the latest issue of a popular text-book on "Sanitary Law and Practice"¹ I find the following: "The infection of measles is not commonly conveyed by healthy persons, hence it is unnecessary to exclude from school the children of infected households if they have themselves had measles."

Again, Washbourn and Goodall, second edition, 1908 say: "It is spread chiefly in a direct manner by those suffering from it, but there is reason to believe that the infection may be harboured in fomites and conveyed by third persons." (The italics are mine.) It may be of interest here to mention that the experience of certain towns, amongst them Aberdeen and Edinburgh, which abandoned the notification of measles after a trial in each instance of over 20 years, shows how little effect at present administrative measures have on the control of this formidable disease, the reduction of whose huge indirect mortality is exercising the minds of all medical officers of health, and certainly merits the enforcing of more drastic measures to secure that end. Amongst such measures I would suggest the classification of measles with such diseases as scarlet fever, diphtheria, &c., and the taking of proceedings under the Public Health Acts against such parents as wilfully expose children suffering from the disease to the risk of the general community.

I am, Sir, yours faithfully,

June 10th, 1910.

J. P. CULLEN.

SPINAL ANÆSTHESIA.

To the Editor of THE LANCET.

SIR,—I note in THE LANCET of May 7th under the heading "Spinal Anæsthesia" that your annotation says, "In the Indian Medical Gazette the fatality was clearly attributed to the excess of strychnine employed."

Surely, in his anxiety to exculpate novocaine the writer has worded his remark badly. A reader would gather that the dose of strychnine in this case was in excess of what is usually given with safety. Probably what he meant to convey was that death was held to have been possibly due to excess of strychnine having reached the nervous centres of respiration—not implying quite the same thing as the administration of an overdose of strychnine. It is not the particular drug employed nor the size of the dose that is the uncertain factor in spinal anæsthesia, but the difficulty of controlling its distribution.

I am, Sir, yours faithfully,

Madras, India, May 25th, 1910.

P. C. GABBETT,
Major, I.M.S.

THE MATRONSHIP AT ST. BARTHOLOMEW'S HOSPITAL.

To the Editor of THE LANCET.

SIR,—The recent appointment to the matronship of St. Bartholomew's Hospital has occasioned much adverse criticism both in medical circles and from nurses holding the certificate of the hospital. May I, as one of those nurses, briefly explain why we consider we have just cause for objection? Firstly, the age limit of 40 announced in the

¹ Robertson and Porter, second edition, 1909, p. 252.