MR. W. D. HARMER, 80

St. Bartholomew's men in particular, laryngologists in general, a host of former students who sat under a most inspiring and encouraging teacher, as well as a large company of grateful patients and friends, will join in good wishes to Mr. William Douglas Harmer on the attainment of his 80th birthday on August 25.

In the closing years of the last century Mr. Harmer left his native Norfolk (where the records of his family go back

to the reign of Henry IV, but without previously a doctor among them), by way of Uppingham School and King's College, Cambridge, to make his name at St. Bartholomew's in London, in which hospital his career has been largely spent, and on the staff of which he is now the senior surgical consultant. It was in general surgery that he first made his mark. In 1901 he took the M.C.(Cantab)—changed in late years to M.Ch.—and contributed his first articles to his hospital journal on general surgical subjects. In due course he was elected assistant surgeon at Bart's and became warden of the Medical College. He succeeded Sir D'Arcy Power as surgeon in charge of the throat department, and was in fact the virtual founder of that department as a separate entity. The first paper he wrote in his special field of surgery appeared in 1907; it was on a subject to which he often returned in his writings—malignant disease of the larynx. The article was followed by many other contributions, some of them describing original forms of treatment. His great experience in this sphere was summed up many years later in his Semon Lecture in the University of London, when he took as his theme the treatment of malignant disease of the upper respiratory and alimentary tracts. His name appears in various textbooks and journals as the author of articles on the surgery of the nose and throat, notably in Carson's *Modern Operative Surgery*. With Dr. N. S. Finzi, the well-known radiologist, he devised a technique of interstitial radiotherapy which is still in use and is known as the Harmer-Finzi operation. The two also founded one of the first consultative clinics to combine surgery and radiotherapy in the treatment of malignant disease—an example followed by other departments at St. Bartholomew's and elsewhere.

A lion-hearted surgeon, Mr. Harmer has been a most inspiring teacher, and the young men he has trained have remained devoted to him. Many of them have served on the staffs of London and provincial hospitals. After his relatively early retirement from active work at Bart's (in order to allow a colleague to be head of the department for a time, since otherwise they would have had to retire together) he continued to serve as surgeon to the Mount Vernon Hospital, and he is still in consulting practice in Portland Place. After the death of his brother in 1932 he was called upon to assume the chairmanship of the family business in Norwich, and he gave that new responsibility close attention until quite recently.

Douglas Harmer has been an active participant in many forms of sport—a good shot, an excellent fisherman, a three-handicap golfer (with wooden clubs of his own making), proficient on the ice (in his youth he skated from Cambridge to Peterborough—an achievement which, it is said, subsequent winters have not permitted anyone to repeat), and an enthusiastic skier, who in 1909—when Davos had scarcely been heard of—went on a long ski-ing expedition in the wild mountains of Montenegro, where the "madness" of the Englishman was suspected as a cover for subversive activities. He is now a keen gardener at his home at Littlestone-on-Sea in Kent, where he can sometimes be seen grafting apple trees in a March gale. Mrs. Douglas Harmer, whom he married 47 years ago, has for many years taken a prominent part in the work of the Ladies' Guild of the Royal Medical Benevolent Fund. One of their three sons, Mr. Michael Harmer, is a surgeon in London.

Over two thousand years ago the Roman writer Varro, who himself lived to 88, said that his 80th birthday warned him to pack his baggage. But Mr. Harmer's baggage is still well spread about and in full employment, and we trust that it will be long before he considers the time has come to begin putting his things together.

Correspondence

Because of the present high cost of producing the Journal, and the great pressure on our space, correspondents are asked to keep their letters short.

Bornholm Disease

SIR,—Dr. Gilbert Dalldorf (*Journal*, August 1, p. 287) asks if there is any information available in Great Britain of concurrence or competition of poliomyelitis and Bornholm disease. I have been interested in these diseases for some years, and the following information may be of value.

It is difficult to give an entirely accurate indication of the incidence of the two diseases, because in hospital practice one tends to see all the poliomyelitis and little of the Bornholm, whereas in general practice it is difficult to see the overall picture in a sufficiently wide area and in a sufficiently large number of patients. At the Harborough Road Infectious Diseases Hospital, Northampton, from 1949 to 1951 I saw all the cases of poliomyelitis admitted from Northamptonshire and North Buckinghamshire, which include a mixed rural and industrial population of approximately 400,000. These amounted to approximately 200 cases. During that time, although on the look-out for the disease, I saw or heard of only a few cases of Bornholm disease. It may well be that other cases occurred and were treated by general practitioners, but certainly there was no epidemic corresponding to those of poliomyelitis. I formed the impression that the cases of Bornholm disease occurred outside the epidemic period of the poliomyelitis, either a few weeks before or after.

On the other hand, in the Oxford Hospitals covering a comparable population, again mixed industrial and rural, with the additional University population, poliomyelitis is a relatively infrequent disease, but large epidemics of Bornholm disease have occurred, especially in the years 1950 and 1951. In the latter epidemic Warin *et al.*¹ demonstrated the presence of a Coxsackie virus of the B group.

Again in 1947 in military hospital practice I saw numbers of cases of poliomyelitis, but no Bornholm disease, from the

Catterick military camp.³ This camp is in close geographical proximity to the rural area of Wensleydale, in Yorkshire, where Pickles⁴ made his original observations on Bornholm disease, but there is little actual contact of populations, as most of the troops spend their leisure hours in the larger towns to the north and east, or on leave in other parts of the country. I made an inquiry among the general practitioners of Wensleydale, and gained the impression that there was little or no poliomyelitis in this dale, which runs some 20 miles into the Pennine Hills, but that there had been cases of Bornholm disease for some years previously.

These facts seem to be in conformity with the views quoted by Dalldorf that there is in fact clinical and epidemiological evidence of competition between these diseases. This competition does not appear to completely exclude the other disease, in my experience, but that may be due to the fact that I have not localized the cases sufficiently accurately in season of year or geographically. Bornholm disease is well known for the extremely localized nature of the outbreaks, and it may be that poliomyelitis cases in Oxford in the year in question did in fact come from parts of a town or county unaffected by the former disease.

In 1949 and 1950 in Kettering, Northamptonshire, I was able to find evidence of Cocksackie virus Type A₂ infection by complement-fixation test in five cases diagnosed as non-paralytic poliomyelitis, and follow-up of contacts revealed 25 cases of illness all with positive complement-fixation tests to this virus comprising the following: paralytic poliomyelitis, 6; non-paralytic poliomyelitis, 10; Bornholm disease, 6; infective hepatitis, 3. Antenatal controls from the same town in 1950 gave only two positive complement-fixation tests in 35 tested.⁴

During 1950, out of 92 cases of poliomyelitis from Northamptonshire and North Buckinghamshire, I obtained specimens of sera from 80 patients which were tested in the laboratory of the late Dr. Marshall Findlay for evidence of complement fixing antibodies to the Cocksackie virus Dalldorf Type A₂. Of these approximately 60% were positive and the percentage of positives was the same in both paralytic and non-paralytic cases. In the same year I was able to trace only seven cases of Bornholm disease, and these all had complement-fixing antibodies to the Dalldorf Type A₂ Cocksackie virus in high titre of 1 in 20 or greater than 1 in 20. Unfortunately these cases were not tested for evidence of antibodies to the Cocksackie virus B types, such as has been found in association with Bornholm disease elsewhere.

The whole ecological relationships of these viruses needs to be carefully investigated, but work in this country is at present very considerably handicapped by lack of adequate virological laboratory facilities. I have the impression that competition does in fact exist between poliomyelitis and Bornholm disease, but whether this is a direct interference phenomenon between the poliomyelitis virus and the Type B3 Cocksackie virus, or whether there is yet another stage in the process such as an interference phenomenon between a Cocksackie virus Type A found to be associated with poliomyelitis in Northamptonshire and the Type B Cocksackie virus of Bornholm disease, would seem to need further investigation. It is not only in this field that further work is necessary, but also in discovering whether there is any ecological relationship between the Cocksackie viruses, the poliomyelitis viruses, and the yet undiscovered viruses of cases of meningo-encephalitis which appear to have become so much more common in the past three years.

One last observation concerns the severe epidemic of poliomyelitis in Denmark in 1952, when the Island of Bornholm had the highest number of notified cases of poliomyelitis, 140 per 100,000 population.⁵ Is it just chance that this island which gave its name to the disease some 20 years or more ago should be so affected with poliomyelitis? Pickles refers to Wolter's description of remarkable epidemics named "Haffkrankheit" which affected fishermen on the shores of the Frisches Haff, a narrow gulf communicating with the Baltic, as belonging to the same family of diseases as Bornholm disease, with the important difference of a substantial mortality among the sufferers. Wolter identified these outbreaks with one in 1529 in the Haff of Stettin, part of an epidemiological phenomenon known as the "English sweat," and in an attempted elucidation of the aetiology brought in the theory formulated by Sydenham and expounded by Pettenkofer that epidemic disease is "conditioned by place and time." In conclusion I quote Pickles⁶ on Bornholm disease: "Epidemic myalgia is of importance only as a mimic of well-known dangerous conditions, but the resemblance to this more serious malady (Haffkrankheit) is close, and it would be imprudent to conclude that future appearances of the disease may not have a more ominous significance."

Clearly much more research is required into the ecological factors of these diseases and particularly the questions of virus interrelationships, virus interference, and virus exalta-

tion. Dare we hope that this country will not lag behind the fine example of virus research set by America?—I am, etc.,

Oxford.

R. WIGGLESWORTH.

REFERENCES

- ¹ *British Medical Journal*, 1953, 1, 1345.
- ² Dixon, G. J. (1948). *Ibid.*, 1, 1175.
- ³ *Ibid.*, 1933, 2, 817.
- ⁴ Voss, H., and Bentham, F., personal communication.
- ⁵ *Lancet*, 1953, 2, 196.
- ⁶ *Epidemiology in Country Practice*, 1939. Wright, Bristol.

Medical Semantics

SIR,—The Arabic origin of *nucha*, *mater*, *basilic*, and *cephalic* is not my suggestion, as Dr. A. M. Woolman (*Journal*, July 25, p. 225) seems to think. The problem has long engaged those interested in Semitic philology and arises from the strange fact that these words are not found in any classical text. *Basilic* and *cephalic* first appear in a ninth-century translation of Galen into Latin from the Arabic. The subject is fully discussed by Hyrtl (*Arabische u. Hebräische in der Anatomie*, Vienna, 1879) and by Rabin and Singer (*Prelude to Modern Science, being a Discussion of the History, Sources etc. of the Tabulae Sex of Vesalius*, Cambridge, 1946). Rabin and Singer think these words came through rather than from the Arabic, but their origin is anybody's guess. As to *mater*, Dr. Woolman has misunderstood me. This word seems to be a translation into Latin of the Arabic word meaning *mother*.

Whether Germany is north, south, or east of the British Isles is immaterial. The point is that the classical stream, like most streams, did not run in a straight line but was kept south of Central Europe by the Alps. This is an elementary fact of history and geography. Dr. Woolman says that "most German doctors have a more thorough knowledge of Latin than their English colleagues." This I am prepared to believe. It has, however, nothing to do with the fact that intermittently for 1,900 years England was bathed in the classical stream—by the Roman occupation and later by the Norman conquest and the close association with France in the Middle Ages—for the most part of which period countries to the north of the Alps were in a state of barbarism. It is just because Germany was outside the mediaeval classical stream and not because of any superiority in classical education of to-day that, in Dr. Woolman's words, "in English medical writings the Latin terms are often anglicized, in Germany the original Latin is usually employed." Innumerable instances could be given. In order to come into line the Germans had to substitute *ulcus* for *Geschwür* because they had no such word as *ulcer* in ordinary speech. Dr. Woolman thinks *Erreger* more convenient than *offending organism*. *Erreger* is not primarily a medical term but a term in general use meaning agitator, exciter; *offending organism* is new to me.

When I said that German words are clumsy I was, of course, speaking as a non-Teuton. We, after all, are in the great majority. Whether *Schnecke* is more elegant than *cochlea* is a matter partly of taste, partly of nurture. I think I am correct in saying that to the majority of non-Teutons German medical words are as cacophonous (*missklanglich*) as they are cacoptic.—I am, etc.,

Histon, Cambs.

FFRANGCON ROBERTS.

Breast-feeding in the Oxford Survey

SIR,—It is, I think, unfortunate that the study which Dr. Alice Stewart and Dr. Celia Westropp have made of the relationship of bacterial infections to artificial and breast-feeding in infancy (*Journal*, August 8, p. 305) should have been published in a journal which is the main source of medical news in general practice. I do not doubt the validity of their conclusions in relation to the case material of their survey, and at one point they remark, "That breast-feeding has advantages to both mother and child which will not show on a weight chart no paediatrician will seriously deny" (I do not know why it should be only paediatricians who might deny it, nor why they should be inclined to do so light-heartedly). But elsewhere they say that the survey