elastic adhesive bandage is one of the most important and valuable weapons in the treatment of varicose ulceration.—I am, etc.,

London. W.1.

R. ROWDEN FOOTE.

SIR,—Mr. Harold Dodd's satisfaction (November 5, p. 1046) with the end-results of his method of inducing thrombophlebitis in the saphena trunk at ligation operation for varicose veins can hardly be shared by all readers. For, with proper surgical candour, he reports in his series of over 1,000 patients so treated in three years two cases of deep thrombophlebitis and one of pulmonary embolus, all happily recovered.

It is therefore apparent that even when the most favourable conditions obtain—viz., Mr. Dodd using his own method, with his operative skill, finely tempered by wide experience in operating on these cases over many years, and his exacting supervision—the dangerous sequelae, deep thrombophlebitis and pulmonary embolism, cannot be wholly avoided. I must add my commentary that in an unselected run of over a thousand patients whose varicose veins are left unabraded and un.injected neither deep thrombophlebitis nor pulmonary embolism is to be expected.—I am, etc.,

London. W.1.

H. M. HANSCHALL.

Visual Defects in Young Children

SIR,—While the pilot survey carried out by Dr. P. A. Tyser and Mr. T. W. Letchworth (November 5, p. 1022) proves the value of the early ophthalmic examination of young children, it is not possible at present to cover the whole of the pre-school child population by such means. But it is possible for school nurses to discover among school entrants of 4 and 5 years of age, by means of picture-type test cards like those devised by Dr. Beale Collins, most of the children with defective vision. Children with squints are sent as a matter of course for ophthalmic investigation.

In York last year 6.9% of school entrants were found to need treatment or supervision at an ophthalmic clinic, 4% having squints. More than half the children with squints had already been seen by an ophthalmologist. Eighty per cent of the 4-year-olds and 97% of the 5-year-olds are able to co-operate in the testing of their vision by means of picture-type test cards. To leave school-children until the age of 7 or 8 years before testing their vision is a mistake, as irreparable damage may have been done by then.—I am, etc.,

York.

F. B. SHEVLIN.

SIR,—May I suggest two additions to the visual survey of young children suggested by Dr. P. A. Tyser and Mr. T. W. Letchworth (November 5, p. 1022)? The first is the cover test, which can be used as soon as a child will fix its vision on a torch attentively for even a few seconds. Very little experience is necessary to enable an examiner to notice a phoria which is likely to develop into a squint.

The second is a subjective test to which most children of 3 will respond. Each eye is tested separately with the ordinary twelve-sided threepenny bit. With very little encouragement they will name heads and tails as "the man" or "the bunch of flowers." They always guess when they cannot see, but it takes only seconds to find the distance at which you cannot catch them out. This gives a direct comparison of the visual acuities of the two eyes. In good light recognition at 2 metres is about equivalent to 6/7.5.—I am, etc.,

London. S.W.1.

CHARNWOOD.

Treatment of Cutaneous Anthrax

SIR,—There are three points in Dr. L. Hoyle's letter (October 15, p. 875) with reference to the treatment of cutaneous anthrax which should not be allowed to slip by uncriticized.

1. To deprecate the use of penicillin after trying it therapeutically in two cases only and without quoting the dosage is unwarranted, particularly as the recent literature indicates that penicillin is the most effective readily obtainable antibiotic against *B. anthracis*. Incidentally, in our series of cases there was no great increase in the inflammatory reaction around the

lesions, nor any marked elevation of the patient's temperature. All that was noticed was a mild increase in local irritation which did not arouse anyone's concern.

2. We should be interested to have experimental evidence or otherwise of the assumption that penicillin used therapeutically is bactericidal for *B. anthracis*.

3. We do not think that patients relish receiving 100 to 200 ml. of anthrax antiserum subcutaneously. They are far more comfortable and develop no ill-effects (apart from slight generalized pruritus on or about the eighth day) following intravenous administration.

In spite of the production of more effective modern remedies for this infection, we still agree with our forebears that cutaneous anthrax constitutes a severe disease, and do not for a moment think of altering that opinion.—We are, etc.,

J. A. HOLGATE.

R. A. HOLMAN.

Leeds.

Vaccination During Measles

SIR,—Due to a misunderstanding a baby of 7 months was inadvertently vaccinated during what later transpired to be the acute catarrhal stage of morbilli. The history of this case was as follows.

The baby was vaccinated on May 30, 1949. His mother had stated he was free from infection and had no skin rash. During the insertion of the lymph the child made a sudden movement, producing a linear scratch 1 in. (2.5 cm.) in length. Blood was drawn. He was seen urgently on June 4 at 11.30 p.m. He had developed a rash on the body the day before. He appeared ill and lay apathetic in his cot; there was distressed respiration, anxious look, and dry irritating cough. The temperature was 102.5° F. (39.1° C.), and the pulse rate was rapid; the tongue was furred. There was evidence of Koplik's spots. Slight nasal catarrh was present, but no definite conjunctivitis. There was a generalized morbilliform rash, more pronounced in the groins. Chest: no definite areas of dullness, rales scattered throughout both lungs, and poor air entry over two circumscribed areas of the left lower lobe. The site of vaccination was already in the marked vesicular stage, with cloudy contents, and was about the size of a halfpenny. Penicillin injections and sulphadiazine were started. The next day showed no improvement, but the rash had coalesced in the groins and had spread to the face, where six days later it had faded to brownish mottling. After ten days the child's condition had improved markedly and convalescence was uneventful.

On June 5 his sister was unwell for 24 hours, and in exactly 14 days this girl and her sister developed measles, thus establishing the diagnosis in the first case.

One would have hesitated to make a diagnosis of measles owing to the possibility of transient scarlatiniform and morbilliform rashes during vaccination, but the development by the child's sisters of typical measles within 14 days, with a definite indication of the exact date of infection, established the diagnosis.—I am, etc.,

Wigmore, Kent.

GORDON STRONG.

Revaccination of a Case of Post-vaccinal Myelitis

SIR,—I am reporting the following case history, though the combination of events makes it a very rare occurrence. While searching through the literature on vaccination I was unable to find a record of a similar incident.

The patient, a male aged 34 years, was vaccinated against small-pox when a member of the Army in 1941. Twelve days later he developed fever, backache, paralysis of the lower limbs, and retention of urine. He was diagnosed as suffering from post-vaccinal myelitis and treated at an Army infectious diseases hospital for three months. During this time he steadily improved. When discharged, he had a weakness of the lower limbs and lack of bladder control to a mild degree. Subsequently he was invalided from the Army and accepted by the Repatriation Commission as suffering from transverse myelitis (post-vaccinal) due to war service.

I saw this man approximately two months ago when he had just been appointed to a position overseas. His duties entailed a lot of travelling from one country to another, so that a valid vaccination certificate was essential. At this time he walked with a slight limp and both knee-jerks were exaggerated. In searching through the literature and discussing this with my colleagues, conflicting opinions were obtained. It seemed that revaccination with the minimum of

trauma would not be hazardous. Accordingly I made three superficial insertions with a needle through a drop of calf lymph on the outer part of the upper third of the left arm, adjacent to the site of the scar of the previous vaccination. A well-defined reaction of immunity appeared within twenty-four hours and faded by the eighth day. During this time the patient remained well, though on the third day he had a slight headache and some backache. This may have been significant. He has since taken up his appointment and remained well.

—I am, etc.,

Melbourne, Australia.

F. S. PARLE.

Infant Feeding

SIR,—It was most refreshing to read Professor R. S. Illingworth's article on the feeding and management of infants (November 12, p. 1077), for during recent years it seems that nurses have been trained (1) to feed the baby at 4-hourly intervals, no matter how it cries; (2) to allow it in the mother's room at feeding times only; (3) not to pick it up and nurse it when crying. How very absurd all this is, and how contrary to the dictates of nature. One should observe, and take lessons from, the lower animals. I thought that after half a century of practice I was becoming old fashioned, and I thank Professor Illingworth for showing me I am not. Both in labour and in the management of the infant the wisest dictum is to let nature have its way, and only interfere when it fails.—I am, etc.,

Upholland, Lancs.

J. THOMSON SHIRLAW.

Buccal Ulcers Caused by Isoprenaline

SIR,—Soreness (or ulcers) of the buccal mucosa as described by Dr. M. Campbell (November 19, p. 1176) are indeed a rare side-effect of sublingual tablets of isoprenaline (isopropyl-nor-adrenaline). I have encountered it in only two out of approximately two hundred asthma patients. The difficulty was easily overcome in these cases by using the aerosol instead of the tablets. Attention should be drawn, however, to the fact that if oral mucosal absorption is desired the tablets should not be sucked, as Dr. Campbell states, but allowed to disintegrate slowly,¹ otherwise most of the substance is dissolved in excess saliva and swallowed into the stomach, from which its effect is weak and uncertain.²—I am, etc.,

London, W.C.1.

H. HERXHEIMER.

REFERENCES

- ¹ Konzett, H., *Klin. Wschr.*, 1940, **19**, 1303.
- ² Gay, L. N., and Long, J. W., *J. Amer. med. Ass.*, 1949, **139**, 452.

Treatment of Erysipeloid with Penicillin

SIR,—I should like to add a few observations to Dr. R. A. Bush's memorandum (October 29, p. 964) and Dr. N. V. Sapier's letter (November 19, p. 1175) on the subject of penicillin for cases of erysiploid. It is difficult to collect a large number of these cases on which a proper evaluation of treatment can be made. However, as an industrial medical officer supervising workers in the fat and bone trade, I usually see eight or nine such cases each year.

Penicillin therapy was first started in 1947 and, as in the cases reported by Drs. Bush and Sapier, relapse often occurred, especially pain and swelling in the joint. In 1948 daily injections of penicillin in oil were used, and, provided treatment was continued for at least three days, no relapse occurred. Such injections were painful, and, as the cases continued working, there was a tendency to default after the second injection, the acute condition having subsided. Most of the men agreed to the third injection after the point was explained to them.

This year, 1949, procaine penicillin has been used in ten cases. All have completed three days' treatment without complaint of pain. Symptoms subsided in 24 hours, and no relapses have occurred. The dosage used is 400,000 units on the first day and 200,000 units on subsequent days. It therefore appears that satisfactory control can only be obtained by a prolonged maintenance of a high blood level.—I am, etc.,

London, E.16.

J. F. ERSKINE.

Definition of Senility

SIR,—Your correspondent, Mrs. M. N. Hill (November 19, p. 1179), raises a legitimate query concerning the nomenclature of senile states. I have elsewhere (*Psychiatry: A Short Treatise*, 1948, Bristol) suggested that Letienne's "senescence" be adopted to represent the normal signs of wear and tear met with in old people in contrast to "senility," which would represent its pathological correlate. Senescence would then be regarded as the natural process of growing old, just as adolescence is the natural process of growing up.

This theoretical distinction may of course present difficulties when we try to correlate the two concepts with physiological involuntal changes on the one hand and definite pathological lesions on the other. Indeed, some workers hold that uncomplicated senile death is a rare occurrence. The important changes, apart from the obvious physical ones, occurring in senescence are of the nature of reductions, and these affect practically the whole range of life's potentialities—in the field of emotion, of conation generally, and of intellectual output. There occurs a restriction in desires, affections, and in the capacity for empathy. Acquisitive ambition, whether in the direction of physical prowess, financial enrichment, or fame seeking, is no longer as compelling as formerly. Diminution, too, occurs in the capacity for perception, attention, receptivity, and memory. When these reductions reach a certain arbitrary degree we speak of senility.—I am, etc.,

Kingswinford, Staffs.

WM. A. O'CONNOR.

The G.P. and E.C.T.

SIR,—I would point out to Dr. Robert Thompson (November 19, p. 1178) that the object, in which it appears to have failed, of my letter (October 29, p. 984) was to elicit the views of other G.P.s. We already know, having had them reiterated, the views of the enthusiast. Dr. Thompson asks, "What is wrong with a second course of E.C.T. or even a third?" Has Dr. Thompson any idea of the horror and dread with which patients approach their third and subsequent shocks? This is a matter not usually mentioned by enthusiasts. Perhaps they have scotomata for the point.—I am, etc.,

Launceston, Cornwall.

DONALD M. O'CONNOR.

SIR,—True there has been considerable correspondence in these columns on E.C.T., and we have learnt a good deal about it from the various opinions expressed, but I still feel Dr. Donald M. O'Connor (October 29, p. 984) has asked a very important question and one which can be answered only by the G.P. who is in constant contact with the patients who have been treated. He can give a much clearer picture than any social worker can in a follow-up of how the patient is adapting to his environment as a result of treatment.

In my work I see a number of patients who have had E.C.T.; some have responded well while others have not. There are patients who would appear to belong to the same diagnostic category and whose environments are in some way comparable, yet they show very divergent responses. I am sure there are many psychiatrists who would welcome the observations of general practitioners regarding the results of this treatment in the various types of neurotic illness.—I am, etc.,

Bishops Stortford, Herts.

D. N. HARDCASTLE.

Conceptions of Right and Wrong

SIR,—Dr. Douglas McBain (November 5, p. 1050) has given the simplest and most lucid account of the meaning of the word "wrong" as used in the M'Naghten rules that I have yet seen. Whether he is entitled to our thanks for this is another matter, as his explanation seems to me to make the situation even more chaotic.

"Wrong" (in the M'Naghten rules) Dr. McBain says means morally wrong, not legally wrong, and he gives chapter and verse to prove it. But, he says further, when a person knows