So called "direction" is similarly an outgrowth of the salary idea. The Minister pretends that the aim is a better distribution of doctors, but this is obvious eyewash. The simple fact again is that it is an essential part of a salaried service. A salaried school teacher, salaried dustman, or salaried M.O.H. cannot earn his living as such except where a vacancy in a service occurs. The same would be true of salaried general practitioners. The Minister's real reasons for this objectionable feature, too, therefore evaporate when the salary idea is removed.

Let us then keep the salary idea in the forefront of the picture. Let us, if he is persistent, fight the Minister on this issue, which if won can win all, but which if lost *must* lose all.—I am, etc.,

West Bromwich, Staffs.

D. SAKLATVALA.

SIR,—Among many possible disadvantages to general practitioners working under the new Health Service scheme there is one attraction which will surely count for much. It is likely that simple pathological investigations and routine radiographs with expert interpretations will be available to patients without the necessity of first consulting a specialist.

In many places in this country the fantastic situation exists whereby a general practitioner who wishes to have his patient's blood count estimated or his chest x-rayed must first obtain the approval of a consultant. Under such a system the patient is often unnecessarily inconvenienced by having to wait in an already overcrowded out-patient department, the specialist is given unnecessary work, and the general practitioner is denied the right of direct control of his patient's case, as in the event of his suspicions being justified, and an abnormality being found in the blood or the chest film, he is often not considered capable of dealing with it. In such circumstances is it surprising that a diminishing number of newly qualified men are looking to general practice to give them satisfaction for their abilities?—I am, etc.,

Southampton.

J. L. LEWIS.

The So-called Health Service

SIR,—Surely we can agree that private practice must be defended from wilful destruction. There will be a great many patients and doctors who prefer it to State medicine. The two forms of service could run side by side; but Mr. Bevan intends that there shall be no alternative to his plan. It obscures the facts to say that under his Act doctors need not join the Service and are free to practise outside it if they so choose. All hospitals are to be seized, and no doctor outside the Service is to have access to them for treating his or her patients; and the Act empowers the Minister to deal likewise with nursing homes if he deems it desirable—which means of course that they *will* be seized if it is found that they enable private practice to be carried on. In short it is to be made impossible for a doctor to earn a living except as a Government employee. He is not forbidden to, oh no, he will just be prevented.

Certain writers in this *Journal* and elsewhere seem to think that it is our moral duty to become salaried State officials because that represents the will of the people. To me that appears wide of the mark. The masses have no more idea of the consequences than a child who wants to bathe in a whirlpool. The medical profession holds a key position as one of the guardians of personal freedom—our own included, though some have foolishly suggested that we ought not to pay any consideration to this latter—and I submit that even those who wish to work in a State medical service should decline to join until the provisions for State monopoly and dictatorship embodied in the present Act are abolished.—I am, etc.,

Birmingham.

D. PRIESTLEY SMITH.

Penicillin Lozenges

SIR,—Some investigations are being made at the Dental Department of this hospital concerning the effects of penicillin lozenges and other preparations used locally in the mouth. Correspondence in the *B.M.J.* in recent months indicates interest in the subject, and it would be much appreciated if those who have had cases of discoloured and sore tongue following the use of penicillin orally would kindly communicate with the writer of this letter, giving details.—I am, etc.,

Dental Department,
Guy's Hospital, London Bridge, S.E.1.

W. G. CROSS.

Penicillin Treatment of Carbuncles

SIR,—The dosage of penicillin in the treatment of carbuncles described in "Any Questions?" (Feb. 1, p. 207) is cumbersome and administered only with considerable inconvenience to the patient. In a busy casualty department I have found that even very serious carbuncles are cured by twice-daily injections of 200,000 units given intramuscularly for five days.

A typical case is that of a man aged 33 with a large carbuncle of the upper lip with early sinuses inside the nose and at the muco-odontal junction. He had had the condition for five days before coming to hospital. Insistent requests to incise the carbuncle were firmly refused, and the patient was assured of considerable relief in one or two days and virtual cure within five days. He was then started on a course of 200,000 units twice daily for five days. After 24 hours the patient felt much better, and sloughs were removed on the third and fourth days. In view of the dangerous site of the carbuncle infra-red was given as an additional precaution, and continued for three days after the full course of penicillin. By the eighth day no further treatment was necessary. All the while the patient was ambulant, and he attended Casualty for his injections.

For surface carbuncles local hot applications are used, and only dry dressings are necessary at the end of five days. Infra-red is not used as a routine. There have been no metastatic complications whatever with this treatment. I have found that penicillin in oil does not give the same dramatic results even when high dosage—250,000 b.d. for four days—has been used. The advantages of the high-dosage penicillin therapy described lie in its dramatic success without surgical interference and in its simplicity; the patient is ambulant throughout treatment, which can therefore be carried out in the consulting-room or in a casualty department. There is the minimum of dislocation of the patient's life, and more hospital beds are freed for other purposes—a not inconsiderable factor at the present time.—I am, etc.,

Mitcham, Surrey.

S. GOLDWATER.

Reiter's Disease

SIR,—The triad of symptoms grouped together as "Reiter's syndrome"—viz., purulent conjunctivitis, polyarthritides, and urethral discharge—as described in the *B.M.J.*, Aug. 10, 1946 (p. 197), is sufficiently unusual to make diagnosis of the condition easy. Such a case treated in this hospital recently illustrates the condition, and in view of its apparent rarity seems worth recording.

CASE REPORT

A battery sergeant-major aged 25 developed a scanty mucoid urethral discharge on a troopship returning to India from U.K. on Aug. 22, 1946. There was a history of exposure on the 9th; he was assumed on dubious grounds to be suffering from gonorrhoea and given a course of penicillin (total 150,000 units) without benefit. The discharge continuing, he was admitted to C.M.H., Secunderabad, on Sept. 3. Repeated smears failed to show any gonococci, though there were extracellular Gram-positive organisms. On Sept. 8 he developed a subacute arthritis of the mid-tarsal joints of the right foot with reddening of overlying skin, and the right eye showed intense conjunctivitis with chemosis and mucopurulent discharge. The urethral discharge at this time was so severe that there were numerous meatal erosions. The eye was treated locally with mercuriochrome and saline irrigations, and he was given a sulphathiazole course for 5 days (30 g.). This improved the urethral discharge but not the other symptoms, and on Sept. 10 he was complaining of stiffness of the left temporomandibular joint and pain in the left tarsal joints as well.

By Sept. 17 the conjunctivitis had settled and the urethral discharge was much less, but he was running a remittent pyrexia of 99–100° F. (37.2–37.8° C.) and sedimentation rate was 100 mm. first hour. Both the mid-tarsal joints now showed signs of inflammation and the left knee was somewhat swollen. A second course of penicillin (30,000 units 3-hourly for 30 injections, total 0.9 mega-units) had no effect on either the pyrexia or the arthritis, and on Sept. 27 the left mandibular, both mid-tarsal, and left knee-joints were still unchanged. In October he developed a huge effusion in the left knee, and 50 ml. of greenish fluid were withdrawn on the 15th; this was sterile on culture. During late October there was a recurrence of urethral discharge, which was again improved by a short course of sulphathiazole. The pyrexia settled by mid-November. On Oct. 30 B.S.R. was 50 mm./hour, on Nov. 25 22 mm./hour, and by Dec. 7 it had fallen to 7 mm./hour only. The arthritis of knees and tarsal regions slowly subsided, the later stages

being helped by quadriceps exercises and radiant heat. Subsequent convalescence, though slow, was uneventful. Negative investigations included stool examinations, culture of urine and 24-hour specimen for the acid-fast bacillus, x rays of the affected joints and also of the chest. Leucocyte counts in the acute stage varied between six and nine thousand cells per c.mm. (P.: 70%; L.: 25%; M.: 3%; E.: 2%). Blood culture was sterile.

The patient illustrates the salient features of the disease, including the liability to sudden serous joint effusions and the subacute but self-limited course. The duration of nearly four months coincides pretty well with the cases written up by Jackson and by Wrigley (*ibid.*, p. 199). He also appears to have been helped by sulphathiazole as were their cases.

It is one of the many annoying features about medicine in India that many special investigations are not available, including the gonococcal complement fixation test, but there was no clinical doubt that this was not a case of gonococcal arthritis but of the rarer Reiter's syndrome.—I am, etc.,

K. W. G. HEATHFIELD,
Capt., R.A.M.C.

Secunderabad, India.

SIR,—The article by Flight-Lieut. W. P. U. Jackson (Aug. 10, 1946, p. 197) and comments on same by Drs. R. N. Herson and Frank Marsh (Aug. 24, p. 275) and by Dr. Joseph Denfield (Oct. 12, p. 555) have moved us to write this letter. In 1943 in our article on virus infection of genitalia (*Rev. chil. Hig.*, 5, 253) we referred to the existence of a positive Frei test, eye fundus oedema, and of deep iliac lymph node inflammation in typical and *frustes* forms of so-called Reiter's disease and attributed the syndrome complex to the action of lymphogranuloma venereum virus. In some cases the disease was accompanied by an abacterial urethritis, but in most the discharge contained gonococci. L.V.-gonorrhea association is not infrequent, as pointed out by us in 1943 (*Brit. J. vener. Dis.*, 19, 37).

A similar condition to that observed in males was described by us in women in 1944 (*Obstet. Gynec. Lat.-amer.*, 2, 9). The existence of a positive Frei test, typical L.V. eye fundus findings, and other evidence of L.V. infection were also found by us in so-called Behcet's syndrome and also published in aforementioned articles. If colleagues have interest in reading articles published in Spanish, reprints will be gladly forwarded on request.—I am, etc.,

Santiago, Chile.

W. E. COUTTS.

Cerebral Malaria in Great Britain

SIR,—Both in Britain and in tropical climates malarial infection is frequently associated with intercurrent infections. Parasites may be found in blood films and the prognosis altered accordingly. Acute bronchitis, pneumonia, and typhus fever (10% of my 493 cases), and cerebrospinal fever were perhaps the most noteworthy associated infections in my experience in the Far East (1942-6). I had three cases of meningococcal meningitis associated with malaria (positive blood films). Treatment was directed to the meningitis first, and the malarial infection was concurrently treated with quinine and mepacrine.

It therefore caused me some surprise to read that Dr. Walter Broadbent (Jan. 4, p. 32) was so ready to diagnose cerebral malaria in the case of a man with fever and meningism who had recently returned from West Africa, even assuming that he found malarial parasites in blood films. In my experience meningism was not always found in cerebral malaria, and in such a case as he describes I could not have rested content without first examining the cerebrospinal fluid to exclude meningitis. Although in this particular case his diagnosis was correct and was to be commended, I submit that the assumption that every case of fever associated with meningism and positive blood film is one of malaria only may lead to disaster, because meningitis, which may sometimes be present in addition, may escape recognition and treatment. Likewise pneumonia may often escape recognition where malaria cases are diagnosed by blood films. Indeed, it was my custom in my division of the military hospital in which I was stationed to be on the look-out for chest signs among the many malarial cases under treatment. It was not an infrequent occurrence to recognize pneumonic signs in cases previously missed by medical officers.

I think these points should be mentioned in view of the fact that malarial relapses may at any time arise among certain persons returned from overseas, and may come under the care of practitioners inexperienced in (and sometimes ignorant of) the disease and its associations. Relapses of malaria are common in the cold weather, but fresh cases are only likely to arise in spells of hot weather. While the disease should be suspected in any person with fever recently returned from an endemic area, and cases in doubt should be treated, it is of equal importance to see that superadded infections such as pneumonia and meningitis should not remain untreated in the early stage, even in those cases in which parasites are found on examination of the blood films.—I am, etc.,

Windsor, Berks.

PHILIP H. WILLCOX.

Early Diagnosis of Tuberculosis in Adolescents

SIR,—In view of the great increase of tuberculosis among the 15-25-years group of the population and the impracticability of mass radiography as a general routine, would it not be a good thing if all "school leavers" were tested by the tuberculin patch or inunction method? "Negative reactors" could then be followed up by repeat tests at frequent intervals of, say, about three months.

This type of test would be simple to apply and would be less terrifying to the child (or parent) than "the needle." It would also save the time of parents and children who might have to attend some clinic—perhaps at a distance from both home and school—for mass radiography. It would be a simple test, quickly applied and easily checked, and should help to keep under supervision all "negative reactors" when they enter industry or other spheres.

If the result of the test were entered on the school medical record card it would (or should) reach the doctor on whose panel list the young person is entered. If there is a medical officer—as there is in Aberdeen—to supervise the health of the students, it could be forwarded to the university medical officer or the training centre medical officer and so complete the follow-up during those years of great susceptibility.—I am, etc.,

Aberdeen.

WINNIEFRED M. GRAY.

Chemoprophylaxis of Rheumatic Disease

SIR,—It has been, rightly or wrongly, attributed to the rarity of nasopharyngitis that acute and chronic rheumatic polyarthritis and rheumatic heart disease, common to both tropical and temperate zones,^{1,2} are unknown among nomadic Lapps.³ For fifteen years it has been noted that a nasopharyngitis (phase 1) or indeed a mild gastro-enteritis precedes the efflorescence of rheumatic fever or idiopathic rheumatoid arthritis (phase 3) by a "latent" phase 2 of 5-40 days.^{4,5} The chemoprophylaxis of phase 1 is based on the assumption that haemolytic streptococci (group A) are the essential organisms in their bacterial flora. In my experience this is not necessarily so.

The action of penicillin or sulphonamides is not anti-rheumatic.⁶ The latter aggravate a smouldering rheumatic infection and must be used cautiously. Even in the latent phase 2 frequent electrocardiograms disclose myocardial mischief. Further Swift,⁷ who has emphasized that in children a chronic rheumatic carditis may show persistent activity for months and even years, notes that subclinical rheumatic relapses occur with a frequency hitherto unsuspected, as disclosed by the careful records of body temperature, sleeping pulse (over 80 abnormal for children, adult normal 60-65),¹⁴ and ancillary laboratory tests. Because abnormalities may be transient, electrocardiograms are needed daily or bi-weekly. While other abnormal causes must be excluded with positive tests, both the E.S.R. and leucocyte count (examined prior to noon because of diurnal tides,⁵ abnormal—9,000 or over)¹⁵ may be normal in the presence of active infection; in such cases the formol-gel reaction is abnormal.⁷ Usually there is a close correspondence between E.S.R., leucocyte count, and body temperature (10 minutes orally).

An invaluable common sign, hitherto undescribed, of rheumatic infection is a sudden onset of mild to moderate tenderness and tenseness of finger pads, the overlying skin being dark red in colour, transient in 48 hours but aggravated by trauma (watch-