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