foreign body may be reduced to a minimum, but some irritation remains. Whether the patient will tolerate this small annoyance depends upon his temperament, and upon the degree and kind of incentive which led to their adoption. If he can obtain vision through contact lenses which he cannot do by any other means, there is a good chance of his wearing them; but if they are desired in order to improve one's personal appearance by giving up spectacles, then only a small proportion of those who obtain the lenses for this reason will wear them. The rest, when the first enthusiasm has died down, will abandon them, consoling themselves for the financial outlay by a mental promise to wear them on a "special occasion"—which usually does not arise.—I am, etc.,

London, W.1.

SEYMOUR PHILPS.

Manifestations of Malnutrition

SIR,—Regarding epileptiform fits and anorexia occurring in conditions of thiamine deficiency, I feel it important to bring to notice findings which do not accord with those expressed by Dr. R. G. S. Whitfield in his informative article (Aug. 2, p. 164) and Lieut.-Col. Lenox MacFarlane in his letter (Aug. 23, p. 311).

Records were kept of 6,998 Australian and British prisoners of war (designated "F" Force by the Japanese) during 12 months April, 1943, to April, 1944. These men were force-marched through some 300 kilometres of hilly jungle and monsoon weather and through cholera-infected localities, and immediately put on heavy labour, to complete the section of the Burma-Thailand Railway in the Three Pagodas Pass area at the Burma-Siam border. Conditions were appalling, the diet ill-balanced and, on an average, below normal metabolic requirements. 3,087 men died during the year. Beriberi overshadowed most other diseases responsible for the mortality, and was predominantly oedematous in type. It was the main clinical feature in 413 deaths. On return of the survivors to better conditions at Kanchanaburi, the experience of the various Australian and British medical officers engaged was correlated.

We found that (1) anorexia was almost invariable—so much so that nursing personnel were specially detailed to spoon-feed the large numbers unwilling to eat what little there was for their support; (2) epileptiform fits were relatively common among the ill men and often of grave prognostic significance. They were often heralded by nocturnal faecal and urinary incontinence occurring in hitherto stable, well-inhibited subjects. It was a danger signal of sudden death.—I am, etc.,

Edinburgh.

JOHN HUSTON,
Sometime S.M.O., "F" Force.

Hypoglycaemia following Partial Gastrectomy

SIR,—May I make a few remarks on the above article in your current number of Aug. 30 (p. 330), in which Drs. Gilbert and Dunlop demonstrate and draw attention to the hypoglycaemic state that sometimes follows this surgical procedure. Many years ago I noticed the appearance of glycosuria after gastroenterostomy and in some cases of duodenal ulcer, demonstrated that this was due to a brief hyperglycaemia from abnormally rapid emptying of the stomach and absorption of sugar, reproduced the condition in students by duodenal intubation of glucose, and called the condition "oxyhyperglycaemia" instead of the Maclean term the "lag-storage" curve—all this published in your *Journal* (1936, 1, 526). Evensen, O. K. (1942, *Acta med. scand.*, Suppl., 126) confirmed this, quoting 223 references, but omitting any reference to my article—which I thought naughty.

However, although 10 of my cases developed hypoglycaemia (55 to 65 mg. in arterial blood) after the brief hyperglycaemia, only two felt mild hypoglycaemic symptoms. And I would point out that many normals, with a normal blood-sugar curve without oxyhyperglycaemia, show only 50–65 mg. of glucose in venous blood after 1½–2 hours without any symptoms of hypoglycaemia (see Lawrence, R. D. and Keeping, J. A., *Lancet*, 1947, 1, 901). Therefore, although by far the chief factor in producing hypoglycaemic symptoms is the absolute level of the blood sugar, some other individual and obscure factors probably come into play. Gilbert and Dunlop's article is a valuable contribution to the problem of the quick-emptying stomach causing a swing from hyper- to hypo-glycaemia, especially as they suggest a possible remedy.—I am, etc.,

London, W.1.

R. D. LAWRENCE.

Ourselves and the Russians

SIR.—I was much interested to read your leading article headed "Ourselves and the Russians" (Aug. 30, p. 339). This is to remind you that I wrote a letter (Jan. 20, 1945, p. 96) entitled "Aggressive Impulses in Progressive Society" in which, after reading Dr. Williams's book *Soviet Russia Fights Neurosis*, I praised what I understood was the Russian realistic approach to neurosis in their attempts to avoid exploitation by one individual or one section of society of another. I believed then and still believe now that such a condition is invariably to be found in every case of neurosis as one of the precipitating factors. I am of the opinion that unrest (or mass neurosis) in industry and between nations is certain so long as exploitation by the more powerful of the less so continues to be rife. There is unfortunately no doubt that in many ways the employer class exploited the working classes in days gone by. The seeds of the hate then generated still are in evidence in the fact that nowadays there is a strong temptation for the position to become reversed. The workers are unduly suspicious, and in some cases tend to make impossible demands.

It is unfortunate that the Russian *Medical Worker* accuses the *B.M.J.* of taking political sides, whereas in having published my letter, which is surely rather more pro- than anti-Russian, the *B.M.J.* would appear to have contradicted Mr. Radbil's accusations, at any rate in this one instance. On reading my letter the Anglo-Soviet Medical Council wrote to ask if I would care to become a member of their society, which I was very pleased to do.—I am, etc.,

London, W.1.

A. CYRIL WILSON.

POINTS FROM LETTERS

Case of Smallpox with Minimal Lesions

Dr. E. MISKIN (Hove, Sussex) writes: I have been interested in the letters in the *Journal* concerning cases of smallpox with minimal lesions, especially the one of Sept. 6 (p. 395) where a case diagnosed as variola turned out to be herpes simplex. I can distinctly remember a case I attended during the severe epidemic in London at the end of 1901 of a woman who only had three spots—two on one arm and one on the other. . . . She had been revaccinated three years previously, was confined four months before the attack of variola, and was feeding the child herself. So mother and the child (who had been vaccinated one month previously) were both taken into the hospital and again the diagnosis was confirmed.

Acute Non-specific Diarrhoea and Dysentery

Dr. G. R. KERSHAW (Leamington Spa) writes: Permit me to reply to my critics, Dr. G. L. Morgan Smith (Aug. 2, p. 189) and others. Their criticisms contain little with which I am not in agreement or indeed which was not acknowledged in my original communication. Both illustrate exactly, however, that unscientific attitude which it was my purpose to decry—namely, that criteria which they rightly require to be applied to one theory of causation should be demanded of others. Although we cannot nowadays insist on all Koch's postulates being satisfied in their entirety, the principles underlying them remain our yardstick, so that to ascribe a disease of which we are so ignorant to infection caused by an unknown organism which has never been demonstrated, isolated, cultured, or transmitted is the epitome of myth and mumpsimus. Whether we believe infection to be the cause or not, we must acknowledge the experiences of others and admit that we don't know.

Poliomyelitis

Dr. DESMOND URWICK (London, S.W.1) writes: In all articles on poliomyelitis I have read stress has been laid on avoiding crowded places like cinemas and on the importance of infection being conveyed through excreta. Yet, despite the above, apparently the schools are to open this month as usual, although notifications still number 600 or more each week. . . . If an epidemic breaks out at a school and it has to close, who is to be responsible for railway fares and other expenses involved by the children returning home, and what compensation and from whom is a child who may be affected and left paralysed to claim? Why should not the opening of schools be postponed three weeks, and a week added to the spring term and a fortnight to next summer term rather than risk an increase in this pitiful epidemic? Or has it been found in other countries where the disease has been more prevalent that the opening of schools makes no statistical difference? If the decision to open schools is based on this latter consideration, has sufficient attention been paid to the question as to whether the schools in these other countries are as crowded as some of our English schools?