Compliance with the regulations in every particular may absolve the various airways corporations from charges of carelessness or neglect when supported by all the necessary certificates required by the regulations, but nobody could possibly claim that they are an absolute preventive. Only quarantine can do that. To insist on quarantine in the case of every passenger is manifestly unnecessary and impracticable. It was to avoid delay and inconvenience to travellers by sea that the system of sanitary surveillance was adopted by the Paris Convention, and on the whole it has worked well. It must not be forgotten that in travelling by sea infectious disease may reveal itself in the course of the voyage. Travel by air, by reason of its speed, is deprived of that natural safeguard to a very great extent.

To conform to the different conditions as far as possible, recourse is recommended to preventive inoculation by the Air Convention. As we know from past experience, inoculation is by no means an absolute preventive. It may, in fact, modify diseases to a sub-clinical and much less easily recognized type, in which the sufferer is just as much a possible source of infection. Moreover, non-carriers may be converted to carriers. This appears to have been foreseen to some extent by the adoption of a form of sanitary surveillance (*vide* "Health Regulations for Entry into the United Kingdom") and the "warning card" to be given to the patient's doctor. This measure is by no means foolproof. Pressure of business and shortness of sojourn are apt to cause the patient to "fight the disease" so that he may be able to get through his work in the time at his disposal. He may try to rationalize his symptoms as "another go of my old dysentery (or malaria)" until it lays him low and he has to call in a doctor, by which time he will probably have spread infection. His doctor may be unfamiliar with tropical diseases and inclined to accept the patient's own diagnosis until the illness takes a more serious turn.

I do not think too much value should be given to "personal declarations of health" for the same reason. It has not been unknown in the past for an individual to make a false statement for reasons of expediency to avoid being held up. Persons who make false statements or fail to comply with instructions may be a great menace, and if detected should be liable to heavy penalties. It would be a sound step if every airport which receives aircraft from overseas had provision for the temporary reception and rapid diagnosis in cases of illness in persons "deplaning." This should have facilities for blood and stool examinations on the spot, and the airport medical officer should be a man with considerable tropical experience. Such provision is a matter for each country to make the arrangements which it considers to be most efficient. It is not uncommon to find that persons who have lived in hot countries are carriers of typhoid or dysentery. I have seen a perfectly fit and healthy person who, in the course of a routine examination, was proved to be a cholera carrier. These are risks that have to be taken.

It would be too much to hope that we may continue to escape from air-borne infection indefinitely. Hence the importance of adequate provision for isolation and rapid diagnosis.

I wonder who invented the horrible words "disinsectization" and "disinsection"? Would not "disinfestation" have served the purpose?—I am, etc.,

Brookwood, Surrey.

H. M. STANLEY TURNER.

Appendicitis in the Young Child

SIR,—Dr. Howard Williams is to be congratulated on his paper (Nov. 8, p. 730) on the above subject. There is, however, a point in differential diagnosis which appears to me to need stressing and which I have not seen pointed out before. It is the inverted respiration (inspiration—pause—expiration—immediate inspiration) which is often found with the onset of peritoneal involvement. This is usually looked upon as a sign of intrathoracic disease and is especially misleading, as some 20% of cases of acute appendicitis in children are associated with or immediately follow upon an upper respiratory infection. The mechanism is the same whether the chest or the abdomen is involved; the breath is held in inspiration in the one case because of the pain of pleural involvement, in the other case because of the pain of peritoneal involvement, and the association of inverted respiration with the latter infection is particularly noticeable in childhood, where diaphragmatic respiration is naturally greater than costal respiration. Movements of the alae nasi are frequently present with the altered respiratory rhythm.

The correct diagnosis depends on the definite finding of focal abdominal tenderness or rigidity. This can be confirmed in cases of serious doubt by aspiration of the peritoneal cavity, a method I have never used but have seen employed in the U.S.A. with satisfactory results. The normal cell content is

about 2,300 per c.mm., and is mainly composed of mononuclears and lymphocytes. The pulse, respiration rate, temperature, and lymphocyte count are of little value, and x-ray films both of the chest and of the abdomen may be misleading.—I am, etc.,

Sheffield.

JUDSON T. CHESTERMAN.

Anaesthesia for Head and Neck Surgery

SIR,—The flexible metal tube with mouthpiece described by Dr. J. G. Bourne (Oct. 25, p. 654) is an interesting piece of equipment. For some time an ordinary Hewitt's airway has been used in the same manner with good results. The fixed curve of this airway holds the tube so as to prevent deviation towards the oesophagus; it obviates the use of introducers, as does the curve given to the tube by storage in a circular tin. When large tubes are in use the airway required takes up a good deal of space, and there may be some difficulty in sliding it along the blade of the laryngoscope even if the Macintosh spatula is in use. Dr. Bourne's tube should be an advantage in these cases.

The use of "tubarine" for intubating cases of head and neck surgery is perhaps debatable, as a suitable dose of thiopentone given slowly, followed by nitrous oxide with a little trilene or ether by passive ventilation, has been found to facilitate laryngoscopy and intubation. The same mixture is used for maintenance, and local analgesia of larynx and trachea is not required. It is felt that this sequence, using only a small amount of volatile anaesthetic, is less depressing than curarization; admittedly it takes more time.—I am, etc.,

Glasgow.

C. T. BARRY.

Control and Treatment of Diphtheria

MONSIEUR.—Je viens de lire avec un vif intérêt votre "leading article" du *Journal* de March 22 (p. 384) ainsi que la suggestive étude de Dr. James Fanning (p. 371). Cette lecture me suggère les réflexions suivantes.

D'après Collins, 7% seulement des enfants non soumis à l'immunisation contractent la diphtérie au cours des 15 premières années de la vie. Pour que l'immunisation soit efficace, elle devrait donc protéger plus de 93% des enfants inoculés au toxoïde. Or, comme je l'ai montré dans un article—"Fréquence de la Diphtérie chez l'Enfant dans ses Rapports avec la Vaccination"—le pourcentage des Schick-négatives par l'immunisation active ne dépasse pas 85 à 90% (Ramon). La vaccination au toxoïde ne peut donc pas être efficace.

Vous dites qu'en 1947 en Angleterre 50 à 60% seulement des enfants sont inoculés. En 1941 cette proportion était forcément beaucoup plus faible et ne peut pas expliquer la baisse qui a commencé à ce moment. Tous les partisans de la vaccination antidiphtérique (Goldfley, Ramon, etc.) sont, en effet, d'accord pour dire que l'immunisation ne commence à produire ses effets que lorsque 40 à 50% au moins de la population infantile est immunisée. Si la diphtérie a beaucoup diminué en Angleterre depuis cinq à six ans, elle a diminué dans de bien plus grandes proportions dans des pays où l'on n'a pas vacciné. En Suède, par exemple, de 1919 à 1938 le nombre des cas a passé de 40,514 à 113 et celui des décès de 2,000 à 10.

Vous estimez que le renouvellement des injections de toxoïde rendrait l'immunisation plus efficace. L'expérience prouve qu'il n'en est rien (voir mon étude, "La Multiplication des Injections de Rappel Rendra-t-elle Efficace la Vaccination Antidiphtérique?"). Veuillez agréer, mon cher Confrère, l'expression de mes sentiments les plus distingués.

Lyon, France.

ROBERT RENDU.

A Method of Abdominal Palpation

SIR,—I was interested to read Dr. E. W. Price's article (Nov. 1, p. 703) describing his method of inducing relaxation of the abdominal wall, which seems ideally suited to ambulant patients or those already in the erect posture. In this country most patients are already supine at the time of examination, and time would be wasted in getting them up, just as with Dr. Price's ambulant African cases time would be wasted by getting them to lie down.

I have for some years used the following simple means of inducing relaxation in supine patients who, through nervousness