for insurance practitioners to put in notices of resignation from the N.H.I. service and for members of National Service and Ministry of Pensions Medical Boards to do likewise. This would serve to show this dictator-minded Minister that we are by no means disposed to walk into his parlour or to succumb to his ruthless threat of force, and that we at last realize that we can place no trust whatever in his word. Having marked our disapproval in this unmistakable fashion, we could then settle down with quieter minds to hold our plebiscite, and to get ready for the inevitable conflict.—I am, etc.,

Wolverhampton.

A. VICTOR RUSSELL.

Sulphamerazine Treatment of Pneumonia in Adults

SIR.—The results obtained by Drs. H. Joules and S. D. V. Weller (*Journal*, Dec. 13, 1947, p. 947) are interesting, but we are told little about the type of pneumonia. Radiological details and detailed leucocyte counts are not given, and apparently the pneumococcus was isolated in only 53 cases—28% of the total series. There is no mention of blood cultures in the severe cases. The satisfactory response with such small doses of sulphamerazine would appear to be due in part to the mildness of many of the infections.

Sulphamerazine's easy absorption and slow excretion are noted, but no mention is made of the fact that in the blood 80% is bound to the globulin fraction of the plasma—i.e., only 20% of the blood sulphamerazine is available for antibacterial action (Heffner, 1945). Hence the importance of moderately large doses of the order of 30 g. over 4 to 5 days in order to maintain, as Genecin *et al.* (1945) have found, blood levels of 12 to 16 mg. per 100 ml. In a small personal series of 68 African patients suffering from lobar pneumonia treated with this drug (Johnston, 1947) the advisability of this latter dosage was confirmed. Sulphamerazine is a valuable drug in the treatment of pneumonia, but it should be given in adequate doses, bearing in mind also the recent warning limitations concerning penicillin.—I am, etc.,

Aberdeen.

R. N. JOHNSTON.

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SIR.—The article by Drs. Horace Joules and S. D. V. Weller on the sulphamerazine treatment of pneumonia in adults (Dec. 13, 1947, p. 947) attracted my particular interest this week, as we have under treatment at the present moment our second case of anuria in a male, due to obstruction of the lower end of both ureters by concretions of sulphamerazine crystals.

I had in mind to publish full clinical details of these two cases at a later date when full recovery has occurred. It seems timely enough, however, to bring to the notice of your readers that sulphamerazine is capable of producing anuria even when used in reasonable doses, for in both cases to be reported the patients had no more than 1 g. four-hourly for less than a week. This is more than advised by Drs. Joules and Weller, but nevertheless not excessive. Both patients were instructed to take large quantities of fluid, but were not given alkalis. Fortunately, the obstruction was quite easily overcome by ureteric catheterization and lavage with a 5% solution of sodium bicarbonate.

Sulphamerazine is used far less commonly than sulphamezathine, yet so far in our district we have no knowledge of calculus having occurred from sulphamezathine, and it would appear, therefore, that if the therapeutic effects of the latter compound are as good as those of sulphamerazine the British drug is the safer of the two.—I am, etc.,

Chelmsford, Essex.

M. D. SHEPPARD.

Penicillin in Scarlet Fever

SIR.—Your annotation on penicillin in scarlet fever (Dec. 6, 1947, p. 915) is based solely on the work of Meads *et al.* (1945) and Jennings and de Lamater (1947) and ignores every publication by British workers and many important American papers. The penicillin treatment of infections of the oral cavity and upper respiratory tract has followed a logical sequence since Garrod (1944) stressed the sensitivity of a wide range of mouth organisms. The role of penicillin applied locally to the mouth has been investigated by numerous workers. MacGregor and

Long (1944) indicated the probable value and limitations of penicillin pastilles in acute and chronic streptococcal tonsillitis. Mowlem (1944) drew attention to the extraneous organisms that invade the mouth during penicillin treatment.

Vollum and Wilson (1945) and MacGregor and Long (1945) discussed the method of spread of drugs in the oral cavity. Symons (1945, 1946), Archer (1945), Dodds (1946), Christie and Preston (1946), Long (1946a, b; 1947a) in this country, and Karelitz *et al.* (1947) in America, have discussed the role of penicillin in the treatment of diphtheria and have provided much information on the effect of the drug on secondary infection. Long (1946a, b; 1947a, b) has compared the effects of local and systemic penicillin on the flora of the mouth and upper respiratory tract and has suggested the need for a dosage of 1,000,000 units a day for three days. Rantz *et al.* (1947) noted that "post-streptococcal disorders were not observed in a small group of patients who received 500,000 to 1,000,000 units of penicillin in 80 hours."

I suggest that to exclude all reference to these publications is to detract from the value of your contribution. For instance, the statement that "the three risks of scarlet fever, then, are the primary toxæmia, the early endogenous invasion, and the late exogenous reinfection, and no one treatment is likely to combat all three" is not compatible with published information on the subject. It would seem to me that if the pathogens can be eliminated in a matter of hours in the early stages of the disease the toxæmia will be halted, local spread prevented, and the patient will be rendered non-infectious.

The work of Jennings and de Lamater from which your contributor obtains most of his information indicated quite clearly that, in spite of a dosage of 400,000 units daily, pathogens were not eliminated from the throat, and complications due to local spread of infection occurred. The obvious conclusion is that this dosage was too small. Since it would be insufficient to remove the highly penicillin-sensitive organisms from the gum pockets it could scarcely be expected to remove the more resistant streptococci from the tonsillar crypts, while the risk of rendering organisms penicillin-resistant by under-treatment cannot be ignored.

It would be unwise to predict the future of penicillin in the treatment of scarlet fever, diphtheria, acute haemolytic streptococcal tonsillitis, and the associated carrier states (for they are one problem, not many). It is probable that when we know what dosage of penicillin will eliminate all pathogens from the oral cavity and upper respiratory tract in the minimum time, and if we can show that in the case of infections associated with toxæmia the level of antitoxin reaches a lower titre in the blood of those treated with penicillin than in a control group receiving no penicillin, we will be on the way towards the solution of our problem.—I am, etc.,

London, W.C.1.

DAVID A. LONG.

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Diet and the Nation's Health

SIR.—It is surely time we had some hard facts about the nutritional position to-day, instead of the flood of opinion—usually pessimistic and more or less uninformed, misinformed, or merely malicious—which is obtaining headlines in the public press, and even finds a platform in your own columns.

The speakers for the motion at the recent Hunterian Society debate were doubtless convinced of the worth of their opinions, but, if your report (Nov. 29, 1947, p. 882) is substantially correct, Sir Jack Drummond spoke nothing less than the truth when he claimed that "no concrete facts had been brought forward to support the view that there had been deterioration