and may have to treat the disease he should purchase the equipment and learn to use it. There is no room for lazy men in the treatment of diabetes.—I am, etc.,

Tel-el-Kebir, Egypt.

D. HAMILTON,
Capt., R.A.M.C.

Prevention of Dental Caries

SIR,—A masterly review of the distribution among the tribes and nations of the world of dental caries, and possible causes, by H. H. Neumann, of New York, was published last year as a letter in the *Lancet* (1947, 1, 806). He concluded that "the factors commonly blamed, such as mineral deficiencies, fluorine deficiency, poor dental hygiene, inadequate sunshine, constitutional factors, vitamin deficiencies, and overuse of starch and sugar in the diet, have little effect on endemic dental decay, and do not explain the peculiar geographical distribution. The consistency of the food, the table manners of the people, and the extent to which cutlery is used are far more important. The disuse odontoprosis which leads to dental caries can be prevented and to some extent treated by restoring to the teeth their proper work of chewing . . . by adding sufficient toughness to what we eat." Earlier in the letter he suggests that "the addition of some hard breadcrumb (old Swedish or Italian type of bread) to the daily diet would suffice to maintain fairly good teeth with a reasonable low caries incidence."

What a simple way of saving an enormous amount of suffering and waste of money on tooth-brushes and powders, stoppings, extractions, and artificial dentures. Teach, in the mothers' clinics, to use as little as possible cutlery and soft food and give children tough crusts to chew. Lady Mellanby has laid great stress on dietetic factors. Can she lend her authority to the spread of the use of toughness in the diet?—I am, etc.,

Smallfield, Surrey.

LEONARD HILL.

Pioneers of Social Medicine

SIR,—Sir Arthur MacNalty's generous review of my Heath Clark Lectures (Sept. 4, p. 476) gives me an excuse for commenting on the publication itself. With rare exceptions, of which a course by a professor emeritus of epidemiology and vital statistics is not one, academic lectures do not pay the cost of publication. Sales merely slightly reduce the bill to be defrayed from trust funds. I should therefore have supposed that in these days of austerity it would have been sufficient to issue the lectures in paper wrappers and to put them on sale at less than the cost per copy of publication. That any member of the public, other than a lunatic at large, would be tempted by a green cover with gilt lettering and crest to pay 12s. 6d. for a booklet which can be read through in a couple of hours is, to me, incredible. However, the disgust with which I look at this ugly little trollop is partly due to injured vanity. Even medical statisticians *dream* of having readers other than personal friends.—I am, etc.,

Loughton, Essex.

MAJOR GREENWOOD.

Genu Valgum

SIR,—In discussing the aetiology of genu valgum in Mr. H. A. Brittain's excellent article (Aug. 21, p. 385) omission is made of a simple mechanical observation. I have had opportunity of observing many infants who have developed knock knee as a direct sequel to tibial bow legs. Many babies have bow legs at birth due to a cramped position *in utero*, often an example of a large foetus in a small mother. If these cases are followed up during the first two years it will be found that as spontaneous correction of the bow legs takes place in the lower half of the tibial shafts the tibial arc straightens and the ankles diverge, resulting in genu valgum.

During the transition stage a familiar picture is seen comprising persistent femoral anteversion, genu valgum, slight tibial bowing, and an intoed gait. The intoeing is due to the combination of the femoral anteversion and the internal rotation of the tibial bow legs. With natural development the femoral anteversion and the tibial bowing are usually corrected, with resultant disappearance of the intoed gait. The residual deformity is now the knock knees, with prominent internal femoral condyles and widely separated malleoli. We must not

assume that all children pass through the stages described, but careful follow-up from babyhood will show that it is not uncommon. This development I described in greater detail in *Physiotherapy* (June, 1948).—I am, etc.,

Birkenhead.

HORACE DAVIES.

Reactions to Intravenous Sclerotics

SIR,—I should like to report the following acute allergic reactions following intravenous injection of venous sclerotics. I understand that such reactions are uncommon; out of many hundreds of injections of varicose veins by sodium morrhuate (usually 5%, occasionally 10%), I have seen only these two.

Case 1.—A man aged 64, nervous type and given to alcohol, was given 1.75-ml. doses of sodium morrhuate (5%) over a period of 14 months (1935–6). In 1943, owing to recurrence of the veins, he was given further injections of 5% sodium morrhuate as follows: Sept. 18, 2×1.75 ml.; Oct. 16, 2×1.75 ml. Half to one hour following the last injection he had the following symptoms: tingling of hands and feet, marked generalized itching, and collapse. This was regarded by me when reported as a nervous reaction aided by the fortification with alcohol before and after the injection, but he reported the same symptoms after the next injection. I therefore ceased using sodium morrhuate and gave him five subsequent injections, 3 ml. of 10% sodium salicylate, without any after-effect.

Case 2.—A man aged 48 was given 24 injections of sodium morrhuate. The first was of 2×1.75 ml. (5%), the subsequent ones being increased owing to the poor reaction to 2×1.25 ml. 10% sodium morrhuate. These were given over a period of three years. He was not a particularly nervous type, nor particularly given to alcohol.

At the 24th injection he had the following reaction: Within 10 minutes he complained of tingling and itching in the hands and genitals. This increased after he had gone half a mile, and the itching became general and intense. He collapsed about a mile away, fortunately outside the ambulance station. He was taken to hospital, where I saw him 50 minutes after the injection was given. He had an acute generalized urticarial rash. Pulse was good. He was given an injection of 0.4 ml. of liq. adrenaline hydrochlor., and in two hours he had recovered.

Fourteen days after this reaction he was given an intravenous injection of 4 ml. of 30% sodium salicylate and had a precisely similar allergic reaction, together with a feeling of swelling in the windpipe, this time in the consulting-room, where he had been kept. He was given the same treatment and he recovered in the same manner.

Acute allergic reactions following the intravenous injection of sodium morrhuate are uncommon. In the second case reported above the recurrence of an allergic reaction after changing to a completely dissimilar chemical substance must be even rarer.—I am, etc.,

Purley, Surrey.

C. E. TAYLOR.

Fibrositis

SIR,—Surely the aetiology and pathology of fibrositis and its clinical manifestations were settled and agreed on long ago—since the days when Rabagliati termed it "perimyositis rheumatica," and Gowers gave it the name of "fibrositis," and Stockman, fully 50 years ago, expounded the whole matter, and demonstrated microscopically the lesions in the white fibrous tissue and how best to feel the nodules when the skin is lubricated with vaseline. But it is needless to say more. Thousands of doctors are satisfied, and have been for many years, as to what fibrositis is, its cause, its alleviation if not cure, and its treatment. It is an important and interesting subject, but a thing quite apart from the lesions of an intervertebral disk.—I am, etc.,

St. Andrews.

R. O. ADAMSON.

Fibrositis and the Weather

SIR,—Whatever fibrositis is or is not, it is real enough to those who suffer from it. Many are able to tell with monotonous regularity when the weather is about to change for the worse. In Palestine, with its rapid succession of dry heat and damp cold in certain regions, it was common, often in the form of headache. The Arabs, who are presumably tough and uninhibited, would often ask for aspirin for this condition.

The point has been raised before, but I still do not know, and no pathologist has told me, why an old wound aches in damp weather. I have often thought that the fibrositic tissue was in some way structurally impaired, similarly to scar tissue. If the effects of weather are so striking in this condition it