Harrison's conclusions as to the relative value of the tests is as follows, referring to the benzidine test as Method 1 and Gregersen's slide (benzidine) test as Method 2.

"Method 2 really amounts to making the technique less sensitive to us, to avoid the preparation of the patient's cough swab, and for this reason it is essential in Method 1. In common with others, the writer has sometimes found the slide method negative when the test tube method has given definitely positive results which have been proved to be significant. His conclusion is that the first method is the method of choice, but that the second is a useful bedside test of more limited value and which should be employed only when the proper laboratory facilities for Method 1 are not available.

So much for the scientific aspect of Dr. Ogilvie's results. Dr. Rutherford Darling's appeal to logic, if possible, is more unfortunate.

Mailleau states "Mill's Method of Single Difference", that is, the method of experiment, thus:

"When the addition of an agent is followed by the appearance, or its subtraction, by the disappearance of a certain phenomenon, the agent is remaining the same, that agent is causally connected with the event."

This canon refuses Dr. Ogilvie's hypothesis.

Yours, etc.

September 18, 1933.

References.

A. G. Ogilvie: The British Medical Journal, April 23, 1927, page 755.

G. A. Harrison: "Chemical Methods in Clinical Medicine", 1929.

Mailleau: "Introductory Text Book of Logic."

DIAGNOSTIC SWABBINGS IN DIPHTHERIA.

Sir: In the Medical Journal of Australia of September 9, page 358, in the discussion of a paper by Dr. Leslie Hurley, read before the Victorian Branch, Dr. Derham is reported as supporting Dr. Hurley in "referring to the taking of diagnostic throat swabs in cases of diphtheria as being useless or worse than useless from the therapeutic point of view".

Incidentally I cannot find any reference to diphtheria throat swabs in Dr. Hurley's paper which is published in the same number of the journal. Perhaps in revising the paper for publication he cut this out as being too sweeping a generalization, or likely to mislead the casual reader.

If this was indeed his second thought, I am in accord with him. It is true that the diagnostic swabbing is of little value as a guide to treatment. Treatment should be begun at once on the clinical evidence. Every hour of delay in giving antitoxin, for example, while waiting for the bacteriological report, may be prejudicial to the patient.

But for confirmation of the clinical diagnosis swabblings are essential. Such confirmation is not merely of academic value. On it may depend serious consequences in regard to isolation, school attendance, occupational restrictions (for example, in a milk vendor and dairymen). It is true that the swabbing results are sometimes surprising. An obviously diphtheritic throat may give a "negative" and an innocent looking surface a positive result. Some of the "positives" may be due to diphtheroids and some of the "negatives" anomalies to defective making of the swabbing. The swab has not been rubbed on the actual diphtheritic surface or the material collected on the swab has not been transferred to the culture medium.

Even with these limitations diagnostic swabblings cannot be dispensed with. And probably Dr. Hurley also is of this opinion.

Yours, etc.

R. MILLARD,
Clinical Tutor in Infectious Diseases, University of Sydney.
135, Macquarie Street, Sydney, September 20, 1933.

THE USE OF IODINE IN THYREOTOXICOSIS.

Sir: I have read, with pleasure and profit, Dr. Poate's article on the "Use of Iodine in Thyreotoxicosis". It is so clear and practical that I hesitate to criticize anything in it. However, I wish that the author had emphasized certain points in the paper, and I venture to refer to them here in this letter.

All through his article he clearly and most necessarily points out the uses of iodine, and its limitations, and says, "propos of the treatment of primary thyreotoxic conditions that:" What iodine does when made up in these patients, the clinical results in most cases are very striking, for the time being." Quite so, but I wish that the last four words had been in italics, for the qualification is vital. Similar prominence, when he is speaking of secondary thyreotoxicosis, might also have been given to the statement that: "Whenever iodine is given, the consistency of the thyreoid gland must be watched carefully, as, once it becomes firm, the dose should be reduced to a minimum or discontinued." On page 413 the two paragraphs dealing with the moment when the patient is found to be fit for operation, after the very important preliminary treatment, and describing what evils may follow, are this is not properly to be appreciated, might have been given greater prominence. Iodine, in the cases Dr. Poate is dealing with, has its great value for a certain time; continued after the happy moment, harm follows. Somewhat, indeed, it reminds me, in not a very analogous way, of the use of lactate of lime in chilblains. If that drug has not done what one wishes in eight days or less, it should be left off. Dr. Poate rightly advises the use of Lugol's solution, and no doubt it is the best form we have just now in which to administer iodine. Why? Because it has iodide of potash as a constituent. Dr. Poate elsewhere refers to the need of that iodide, but it would have been quite proper to have accentuated the inherent virtue of Lugol's solution because of its constituent iodide of potash. I remain not wholly convinced that belladonna is an evil drug, but Dr. Poate rightly advises the use of paraldehyde by the mouth. As to sedatives, I am afraid that I remain unconvinced of the virtues of "Barbenyl", "Luminal" et cetera, nor do I quite accept his praise of paraldehyde by the mouth. Lastly, I wish very much that Dr. Poate had told us clearly his position with regard to the anaesthetic to be used when an operation on the gland is called for. Rightly he has pointed out the evils of an inhalation anaesthesia which induces cyanosis, but in his section on treatment I am sure we would all have wished to hear whether he uses local or general anaesthesia. If the latter, in what form? Perhaps he might add to his excellent article some amplification of it on the lines I have indicated.

Yours, etc.

R. SCOT SKIRVING.
Sydney, September 22, 1933.

SIR: In his article in your issue of September 23, speaks of "a deficiency in the iodine content of thyroxine" (page 413). This, of course, can never be. Thyroxine is a definite chemical compound, C_{4}H_{11}O_{3}I_{3}N.

Yours, etc.,

G. A. SAMPSON, M.B., Ch.M.
Brisbane, September 25, 1933.

INFLUENZA.

Sir: I wonder if any other of your readers has noticed the following symptom in influenza patients during the present epidemic. When the patient has been undisturbed for some time, there is a slight or sometimes well marked dulness over a lung area. On placing the bell of the stethoscope over the dull spot, while the patient takes a deep inspiration a crepitation is heard. The sound resembles that produced.
by stripping gummed fabric from a resonating surface, the gum being "tacky." It occurs only during one or two respirations following the rest period. When the crepitus is no longer heard the dulness will be found to have disappeared.

Long after the temperature has become normal and the patient is progressing towards recovery the symptom may persist.

The character of the sound in association with the transient dulness leads me to infer that it is of vesicular origin.

The effect is probably produced by a gluing together of vesicular walls. It indicates that even during the acute stage one should encourage deep breathing and, by varying the position in which the patient lies, prevent any part of the chest from being held immobile during long periods. At regular intervals he should be induced to undertake over-breathing exercises. In convalescence, the sooner he returns to active life the better.

Possibly the gluing in the vesicles may account for the proneness to relapse in those patients, and some cases of free hemorrhage may well be produced by tearing the glued walls apart.

Yours, etc.,

WILLIAM P. KELLY.

38, MacGregor Terrace,
Paddington,
Brisbane. Undated.

**Diary for the Month.**

OCT. 10.—New South Wales Branch, B.M.A.: Executive and Finance Committee.
OCT. 12.—Queensland Branch, B.M.A.: Council.
OCT. 17.—New South Wales Branch, B.M.A.: Ethics Committee.
OCT. 18.—Western Australian Branch, B.M.A.: Branch.
OCT. 19.—Victorian Branch, B.M.A.: Clinical Meeting.
OCT. 21.—New South Wales Branch, B.M.A.: Medical Politics Committee.
OCT. 25.—Victorian Branch, B.M.A.: Council.
OCT. 26.—South Australian Branch, B.M.A.: Branch.
OCT. 26.—New South Wales Branch, B.M.A.: Branch.
OCT. 27.—Queensland Branch, B.M.A.: Council.
NOV. 1.—Western Australian Branch, B.M.A.: Council.
NOV. 2.—South Australian Branch, B.M.A.: Council.
NOV. 3.—Queensland Branch, B.M.A.: Branch.
NOV. 5.—New South Wales Branch, B.M.A.: Organization and Science Committee.

**Medical Appointments.**

Dr. A. R. Southwood (B.M.A.) and Dr. E. A. Johnson have been appointed members of the Advisory Committee under the Poisons and Drugs Act, 1908, South Australia.

Dr. H. McI. Birch (B.M.A.) has been appointed Deputy Superintendent of the Parkside Mental Hospital, and also Deputy Superintendent of the Hospital for Criminal Mental Defectives, under the provisions of The Mental Defectives Act, 1913, South Australia.

**Medical Appointments Vacant, etc.**

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xviii.

**Children's Hospital (Incorporated), Perth, Western Australia:** Junior Resident Medical Officers.

**Hosanna Presbyterian Hospital, Hobart, Tasmania:** Junior Resident Medical Officers.

**Metropolitan Infectious Diseases Hospital Board, Adelaide, South Australia:** House Physician.

**New South Wales (Community) Hospital, Incorporated, Sydney, New South Wales:** Physician for Children's Clinic.

**Parramatta District Hospital, Parramatta, New South Wales:** Junior Resident Medical Officer.

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**Medical Appointments: Important Notice.**

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch, named in the first column, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.I.

**BRANCH.**

**APPOINTMENTS.**

| New South Wales | Honorary Secretary, 135, Macquarie Street, Sydney. |
|----------------|--------------------------------------------------|
| Victorian Branch | Honorary Secretary, Medical Society Hall, East Melbourne. |
| South Australian Branch | Honorary Secretary, 65, Saint George's Terrace, Perth. |
| Queensland Branch | Honorary Secretary, 65, Saint George's Terrace, Perth. |
| Western Australian Branch | Honorary Secretary, Medical Society Hall, East Melbourne. |
| Australian Native Association. | Ashfield and District United Friendly Societies' Dispensary. |
| Friendly Societies Lodges at Casino. | Manchester Unity Medical and Dispensary Institute, Oxford Street, Sydney. |
| Combined Friendly Societies, Claremont and Kangarilla districts. | Friendly Societies Lodges, Wellington, New Zealand. |
| Brisbane Associated Friendly Societies Medical Institute. | Combined Friendly Societies, Claremont and Kangarilla districts. |

**Editorial Notices.**

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