IMMUNISING AGENTS Name .....

Address .....

Name of Agent	No. of Injections	Date of Administration	Name of Agent	No. of Injections	Date of Administration	Name of Agent	No. of Injections	Date of Administration
Salk Vaccine	1st		Diphtheria Toxoid	1st		Combined Anti-Diphtheria and Whooping Cough Antigen	1st	
	2nd			2nd			2nd	
	3rd			3rd			3rd	
	Booster			Booster			Booster	
Triple Antigen	1st		Combined Tetanus Toxoid and Diphtheria Toxoid	1st		Tetanus Toxoid	1st	
	2nd			2nd			2nd	
	3rd			3rd			3rd	
	Booster			Booster			Booster	
Other	1st		Other	1st		Other	1st	
	2nd			2nd			2nd	
	3rd			3rd			3rd	

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EARLY PROPHYLACTIC AND TREATMENT ANTI-SERA

Name of Agent	No. of Injections	Date of Administration	Name of Agent	No. of Injections	Date of Administration	Name of Agent	No. of Injections	Date of Administration
Diphtheria Anti-toxin (Prophylactic)			Tetanus Antitoxin (Prophylactic)			Other		
Diphtheria Antiserum (Treatment)			Tetanus Antiserum (Treatment)			Other		

IMMUNISING VACCINATIONS (OTHER THAN "SALK")

Name of Agent	Date of Vaccination	Positive Response or Immune Response	Name of Agent	Date of Vaccination	Response	Name of Agen	Date of Vaccination	Response
Anti-Smallpox (Calf lymph)			Anti-Tuberculosis, B.C.G.			Other		

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Rather than distribute batches of the cards themselves all over Tasmania to various centres in the hope that people would take one as required and have it completed, we distributed application coupons via council offices, doctors' waiting-rooms, and chemists. We also advertised the scheme widely in the newspapers and the advertisement contained an application coupon. We felt that this method of distribution of the cards would encourage people to treat them with more respect. At the same time, we supplied cards to some of the hospitals and to doctors who requested them for the purpose of completing them and issuing them to patients. We felt that about 10% of the population would be sufficiently interested to obtain cards forthwith and that, by repeated advertising and the gradual spread of interest in the scheme, possibly 30% would eventually request these cards.

The scheme was commenced in July, 1959. So far over 3,000 people have applied for cards directly; 32 doctors have distributed over 6,000 cards and approximately 2,500 cards have been distributed by hospitals. We estimate that about 11,500 people have been supplied with cards and it is considered that it is an encouraging start, considering that this is a new project.—I am, etc.,

J. EDIS,
Director-General of Health Services,
Tasmania.

Temporary Paralysis after Polio Vaccine

SIR,—In describing what happened to his child following vaccination, Dr. M. S. Sabour (*Journal*, November 14, p. 1021) might have been describing what happened to my child following vaccination with Burroughs Wellcome vaccine, the only difference being that the vaccinated arm (the left) was affected.

It has been suggested that in such a case a series of injections of the vaccine should subsequently be given starting with 0.1 ml. and working up to 1 ml. I am afraid I have not yet had the courage to do this.—I am, etc.,

London, S.W.19. N. H. BARLEY.

Carcinoma of Fallopian Tube

SIR,—I was interested to read Mr. Derek Jefferiss's report (*Journal*, November 14, p. 1002) of a case of primary carcinoma of the Fallopian tube. I have just had a similar case, the details of which I append.

A married woman, 53 years of age, well built and rather obese, was admitted from casualty with a history of five days' abdominal pain and symptoms of intestinal obstruction, having previously been perfectly well. On examination a large mass was felt in the pelvis. Laparotomy revealed a large mass in the pelvis involving both ovaries, uterus, and sigmoid colon. Secondary deposits were found on the mesentery and on the bladder. As a palliative procedure oophorectomy, salpingectomy, and hysterectomy were performed and a transverse colostomy made.

Specimen.—The corpus uteri together with both Fallopian tubes and ovaries. The organ is 7.5 cm. long, 8 cm. wide, and 4.5 cm. thick. Both ovaries are cystic, and measure 9 cm. by 4 cm. and 7 cm. by 5 cm.

Microscopical Examination.—Sections from various positions show the lesion to be a primary carcinoma of the Fallopian tube with spread to the myometrium and to the ovary.

—I am, etc.,

St. Giles's Hospital, London, S.E.5. C. S. LYGONIS.

Tongue-tie

SIR,—Mr. Denis Browne's wise words and beautiful photographs (*Journal*, November 7, p. 952) should convince the many who still believe that "tongue-tie" is a myth. It is a very real and not so very rare congenital deformity.

Treatment of this has fallen into disrepute because in the past the normal fraenum of the tongue has been divided when there was absolutely no indication for it. This was done, I think, owing to a misunderstanding and a failure to realize that there is a dual meaning for the words "tongue-tied." First there is the physical one, meaning that the tip of the tongue is tied down to the back of the lower jaw by a tight congenital band; and, the second, an abstract meaning and an expression in common usage in the English language, referring to someone who cannot express himself adequately or at all.

In the past many parents thought that, if their child did not speak at the time they expected it to, its tongue was tied. If, therefore, it was untied it might then be able to speak. The surgeon or midwife in the old days sometimes also fell into this trap. The ancient practice of "snipping the tongue" to make a child speak is now well recognized as barbarous. But the pendulum has swung too far, and many go as far as to say "tongue-tie" does not exist, when it does. However, when

present, it only causes a minor defect in articulation, and often some difficulty in feeding. A severe defect in speech, or very late acquisition of intelligent speech, is most often due to subnormal or retarded mental development, for which division of a normal fraenum of the tongue is a forlorn method of treatment.

Treatment of a truly tongue-tied baby, whose fraenum is short, is now often neglected. These babies can be seen nearly every week in the out-patient department of any big hospital. The degree of disability is variable and debatable, but not the existence of the deformity. Although in the past all my patients who have suffered from this condition have been small babies,[1] recently a young man aged 22 came to me because he was tongue-tied. This interfered with the pronunciation of certain consonant sounds, especially "D" and "T," and he asked me to free his tongue. I freed his tongue and his disability disappeared. If his short fraenum had been divided when he was a baby, he could have been saved unnecessary embarrassment at school and in his work afterwards. The fact that he found this deformity troublesome should be a guide to parents and help them to decide that a small operation is necessary, although disability may not be apparent in a small baby unless it has had feeding difficulties.

Perhaps, as we cannot or would not alter the English language, it might be wise to sacrifice with sadness the simple Saxon description of the congenital defect and call it a "short fraenum of the tongue."—I am, etc.,

Leeds, 1. MICHAEL C. OLDFIELD.

REFERENCE

[1] Oldfield, M. C., *Lancet*, 1955, **1**, 528.

New Sulphonamides

SIR,—I read with interest the letter by Dr. A. Crowcroft (*Journal*, October 24, p. 826) on the successful use of prophylactic sulphonamide in controlling the spread of bacillary dysentery infection in a mental hospital ward. He rightly emphasizes the administrative problems involved when infection occurs in overcrowded wards now inconvenienced in many hospitals by internal alterations and modernization.

I can confirm the value of prophylactic sulphonamide in limiting the spread of dysentery infection in mental hospital wards. After experimenting with streptomycin administered prophylactically without success in June, 1958, we were faced with the problem of 27 cases of *Shigella flexneri* Type Z dysentery occurring in seven female wards with a total population of 600 patients—all possible contacts due to temporary cross-sleeping arrangements. The potential spread was fearful to contemplate, and every one of these patients was given a daily prophylactic dose of 0.5 g. phthalylsulphathiazole continuously over a period of two to three months. No toxic reactions were encountered and no more cases of dysentery occurred. The period of chemoprophylaxis was probably prolonged unduly, but I had in mind the danger from the subclinical case and the intermittent excreter.

In January, 1959, two patients with a history of previous attacks of dysentery developed a recurrent attack after transfer to a geriatric infirm ward. Prophylactic tablets were given and no new cases occurred. In March, 1959, two dysentery excreters were detected during a routine examination of old cases, and prophylactic tablets were again exhibited and no acute cases developed. In July, 1959, a female patient in one of the seven wards mentioned developed acute dysentery (first attack) and tablets were given to 80 contacts. No other case occurred.

I am of the opinion that, when dysentery is endemic in closed populations, prophylactic sulphonamide is effective in limiting the spread of infection, but periodic stool examinations are necessary to detect the intermittent carrier state. It is of interest to speculate whether the newer, long-acting sulphonamides such as sulphamethoxypyridazine successfully used by Dr. Crowcroft offer any advantage over the older drugs, but my experience certainly shows that phthalylsulphathiazole can be given over a long period of time without apparent harm, and is effective in protection against Flexner dysentery. And this confirms the report of Ross,[1] who successfully used the drug for the control of Sonne dysentery in a residential nursery.—I am, etc.,

Middlewood Hospital, Sheffield. F. T. THORPE.

REFERENCE

[1] Ross, A. T., *Med. Offr*, 1954, **91**, 95.

When to Tie the Cord

SIR,—To support Dr. A. E. Chisholm's theory in his letter (*Journal*, October 17, p. 759), I can add the experience of seeing embolic gangrene of the leg in a neonate, when the nurse was in the habit of aiding the return of cord blood to the baby before tying the cord.

I took the day-old child with a white, "dead leg" to the late Mr. Hobill Cole, then senior surgeon, Melbourne Children's Hospital, who told me this was no uncommon case and was due to the temporary patency of the ductus arteriosus (in all normal babies) allowing systemic embolism rather than pulmonary infarcts. Whether embolectomy (unknown in 1918?) would have saved the leg (and others) in these modern times is problematic. But don't invite it. Tie early, and—an old tip still useful—to avoid bleeding from umbilical arteries as the jelly of Wharton slowly shrinks, use silk-covered, round hat-elastic—three or four ties of the 2- or 3-mm. thick stuff. Far safer than linen-thread. About 5% of babies have a long process of their own skin along the cord, and in that type at one time I used to tie the elastic flush with the abdominal wall. The final result was a practically navel-less child, very neat, but the cord was a little slow to separate. The slight possibility of enclosing a bit of gut or bladder, and the need to watch the stump for at least 14 days, made me desist after doing a hundred or so cases, but perhaps the method could be modernized, so as to prevent hernia in later life.—I am, etc.,

Bishop's Stortford, Herts. R. A. R. WALLACE.

Syphilis and Mental Deficiency

SIR,—While it is true, as stated by Dr. J. D. Redmill (*Journal*, October 17, p. 759) and by Dr. G. L. M. McElligott (*Journal*, October 31, p. 888), that a number of cases of venereal disease are treated privately or otherwise than at the usual clinics, mental deficiency due to syphilis tends to show itself at an early age, and such patients are therefore admitted for investigation to a children's unit or to a special hospital. In my experience over a number of years at the Lock Hospital, and at Queen Mary's Hospital, Carshalton, it was a relatively small proportion of congenital syphilitic children showing mental defects that were admitted to the hospitals. Such cases always manifested themselves by backwardness in general development, and especially inability to sit up by the age of 2 years. It is of interest to note that these children (according to my