an excellent account of the recent work done in the Burns Unit established in the Glasgow Royal Infirmary.

Students, practitioners and operating surgeons will be well repaid by reading "Illingworth" and, no doubt, in another fifteen months a third edition will be as welcome as the second is now.

DOCTORS IN THE MAKING: THE ART OF BEING A MEDICAL STUDENT. By Arthurt W. Ham, M.B., and M. D. Salter, M.A., Ph.D. London: Medical Publications, Ltd. 1944. Pp. 120. Price 9s. 6d.

Although every student's career is beset with difficulties we never realized, until reading this book, that they could be so many and complex. We feel that a prospective medical student would be terrified rather than encouraged. The graduate in medicine will be reminded of the shortcomings of his student career with tolerant and quite unrepentant amusement.

We are not quite sure for whom the book is intended. It does not seem to be a book which the average medical student in his early years will read; it might be of interest to those who are responsible for the supervision of students in general.

Correspondence.

WEST AFRICAN "P.U.O."

TO THE EDITOR OF THE "JOURNAL OF THE ROYAL ARMY MEDICAL CORPS."

Sir,—Having just completed one year's work as Officer i/c Medical Division in a West African Military Hospital, I was interested in the paper by Captain Elliott published in the Corps Journal for May, 1944. With much of what the writer says I am in agreement, but four of his statements appear to warrant further discussion.

(1) In Table I "P.U.O." appears second on the list of predominant medical diseases, with 166 cases. Now this is a high figure and should not be specified as such without some further description of what the group comprises. We are all familiar with the short illness of which "P.U.O." is perhaps the most honest description—considerable numbers are liable to occur among troops in any tropical area. But a final diagnosis of "P.U.O." implies an extensive and prolonged series of negative investigations and is normally frowned upon, and rightly so, by Military Medical Authority. Short term fevers with negative findings obtain a variety of names with a view to circumventing this difficulty. In Egypt it was "Sandfly Fever," in West Africa it may be "Clinical Malaria." But a clinical diagnosis of malaria with negative blood films may be made with reasonable certainty in many cases and, in fact, often constitutes from 20 to 30 per cent of all final diagnoses of malaria. (It is obvious of course that the proportion of such diagnoses depends on the reciprocal efficiency of the clinician and the laboratory.) This is just my point; what are Captain Elliott's "P.U.O.s"? If they represent what has been described as clinical malaria, the percentage, about 14, is commendably low. If, however, "clinical malaria" is included in the 1,038 cases, then a residuum of 166 unexplained pyrexias is extraordinarily high.

(2) Captain Elliott mentions that both European and African blood donors must be assumed to be infected with malaria and that the "transfusion officer's lot is not a happy one." But he does not mention the relatively high incidence of yaws-syphilis amongst Africans and the still higher incidence of positive Kahn reactions. That many of these may be transient or due to tertiary yaws does not make the problem any easier and in practice it may mean the exclusion of perhaps a third or more of potential African donors.

(3) Under the heading Cerebrospinal Fever in Africans, he attributes failure of chemotherapy in the fatal cases to "a coincidental encephalitis." Does this mean a meningococcal encephalitis, which is of course a recognized lesion occurring in meningococcal infection?
And why was the failure due to an encephalitis; might not the reverse be true? One would like to know more about this.

(4) Lastly, Captain Elliott makes the astonishing suggestion that in bacillary dysentery the dosage of sulphaguanidine or sulphasuxidine may be adjusted in direct relation with "the fluid volume of the stool."

Does this mean the volume only of fluid stools, or of the fluid part of a stool? How is it measured, especially if there are 100 or more dysentery patients in the wards at one time, as may frequently occur in an endemic area? In point of fact, the volume of the stools is to the progress of the disease in inverse proportion in severe acute cases of bacillary dysentery. There may be thirty or more stools in twenty-four hours but such stools at this phase each consists of a few c.c.s only of non-faecal tenacious blood-stained mucus, aptly compared, in some instances, with pneumonic sputum and in fact they will not pour out on inversion of the bedpan, a fact which I was able to observe many times in the Middle East. The total volume of such stools, if it could be measured in any easily practical way, which I doubt, is often very small. Captain Elliott would, on his system, reduce the dose of the drug during this stage, just when it is most needed.

West Africa,
July, 1944.

I am, Sir,
Yours, etc.,
W. M. Priest,
Lieut.-Colonel, R.A.M.C.

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VISUALIZATION OF LIVER ABSCESES.

TO THE EDITOR OF THE "JOURNAL OF THE ROYAL ARMY MEDICAL CORPS."


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Fig. 1.—Encapsulated empyema after replacement and lipiodol injection.