(4) Dietary factors - many overactive tense people give a history of a very poor diet and show evidence of incomplete metabolism in their blood - e.g., bisulphite binding substances. In addition long periods without food can provoke migraine due to a relative hypoglycaemia.

Dr. Hay suggests that migraine, hay fever, urticaria, allergic rhinitis and asthma would be suitable subjects for an initial investigation. Members of the Research Register who are interested in this kind of work are asked to get in touch with Dr. Hay at the above address.

ANNOTATIONS BY MEMBERS OF THE RESEARCH REGISTER

(1) Atypical Glandular Fever?

Dr. June Alexander,
North Ferriby.

'Two years ago in a practice in which I was an assistant we had an epidemic of an odd type of glandular infection both amongst children and adults. A typical case started with pain under the ear and sudden high temperature, up to 103°, by the next day there would be generalised glandular enlargement and the temperature would be less. After about 4 days the child was usually quite well, although the glands remained palpable for several months. However three patients ran a low pyrexia and felt generally unwell for up to three months before they settled. It seemed clinically like glandular fever at first, but in every case serial Paul-Bunnell tests were negative and no case showed a mononucleosis. In adults a leucopenia was the rule and a retrospective diagnosis was made several times when a patient came in complaining of lassitude, and enlarged glands were found. Adults did not seem to have an acute onset. I never felt an enlarged spleen. Both rubella and glandular fever I thought were ruled out as etiological factors because I saw patients who had had these at other times. Throat swabs were of no help. The mantoux reaction was not positive more times than one would normally expect. All the usual agglutinations for abortus, typhoid, etc., were negative. The incubation period was exactly ten days. Eventually my husband, who is a pathologist, took some acute and convalescent serum to Dr. Cathie, at Great Ormond Street, for testing for toxoplasmosis, but the tests were negative. I did some skin testing with toxoplasma antigen, also with negative results. We learned, however, that a similar syndrome had been noted in London, though not named, unless you would include it in the 'epidemic cervical

adenitis' that Tidy described. I have not seen any similar cases for over a year.'

(Dr. Cockburn, of the P.H.L.S., Colindale, has spoken of the interest of his Department in 'the glandular fevers', and the College may later be asked to help in examining these cases more closely. Editor)

Measles

The following two accounts of investigations carried out by members of the Register are of great interest since the work is very similar to that contemplated by the College on a larger scale.

(2) Sulphonamide prophylaxis in measles

Dr. I. Cookson,
Gloucester.

'In view of the proposed investigation by the College into prophylaxis in measles, the results of a small investigation during a recent epidemic may be of interest.

The average number of notifications of measles from the practice is about 40 per annum, but there were very few in the latter half of 1951 and during 1952. Consequently there was a large non-immune population when measles was introduced in 1953, and 100 cases occurred between January 14th, and March 12th. Further sporadic cases during the summer brought the total to 123.

Sulphamezathine was given, in full doses commencing within 24 hours of the eruption and continuing for 2½ days, to two fifths of the cases, the remainder being regarded as controls. It was necessary to exclude 5 patients who developed complications prior to the eruption. Apart from these, the new patients presenting on any given day were either all sulphonamide cases or all controls, the number of 'sulphamezathine days' being regulated to produce the desired proportions. This was not effective in distributing cases evenly, for the proportion of controls in different age groups varied from 30 per cent to 80 per cent. Perhaps this was inevitable in view of the small numbers involved.

Each sulphamezathine case was paired with a control of the same age, having the same past history regarding otitis media and severe respiratory infections, and with a similar severity of attack as judged at the time of eruption. It was possible

to pair only 40 of the 45 sulphamezathine cases, with the following results:

Cases	40	Bronchitis	2	Otitis Media	Nil
Controls	40	Bronchitis	3	Otitis Media	3

A small number of patients could not, or did not, take the prescribed dosage of sulphamezathine, and these included one case of bronchitis.

In this epidemic, the proportion of complications was appreciably less among the cases receiving sulphamezathine, but in 4 per cent of cases, complications occurred before prophylaxis could be attempted. If the 40 controls represent a true cross section, the whole epidemic, in the absence of prophylaxis, would have produced about 23 complicated cases, in twelve of which the complication would have been preventable by the use of sulphamezathine at the time of eruption.'

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(3) The Prevention of the Bacterial Complications of Measles

Dr. D. Craddock,
Plymstock.

'Banks (1949) states that fever hospitals which adopted sulphonamide prophylaxis routinely found that the incidence of otitis media and pneumonia was cut down almost to nil during the period of prophylaxis.

I commenced this method of prophylaxis four years ago, since when I have attended about 150 cases of measles. Each has been given sulphamerazine and latterly sulphadimidine for five to seven days, the usual dose for a five-year-old being 0.5 gm. 8 hourly in emulsion form. In no case has otitis media or pneumonia developed during the period of prophylaxis, although in 2 cases otitis media and in 1 case a mild bronchitis developed after the prophylaxis was discontinued. No child apart from these required bed rest for longer than seven days after the appearance of the eruption.

I stopped using cremomerazine after the reports of renal complications and death following its use, and have now replaced sulphonamides by oral penicillin since the new salt DBED Dipenicillin was known at Great Ormond Street to be reliably absorbed in every one of 101 children. (Cathie and MacFarlane, 1953).

References: BANKS, H.S. (1949) The Common Infectious Diseases
CATHIE, A.B. and MACFARLANE, J.C.M. (1953)
British Medical Journal, 1, 805

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(4) A card-index of Diseases

Dr. H.H.A. Elder,
South Norwood.

'It has been apparent to me for some time that, after twenty-eight years of general practice, if I had kept a card-index of diseases, I would now have a mass of extraordinarily useful information. I am interested in the Natural History of Diseases, in particular the variations in longevity in individual diseases and the mode of death. In thirty years one sees quite a few lifetimes, and one would get interesting answers to the question of 'what happens to ...?'

I have in mind an index whose headings would be individual diseases or lesions, (what happens to spider naevi?) and whose cards would represent a patient with his history throughout.

This is rather a long-term concept with many technical difficulties, in change of address, etc., but if even a small number of younger general practitioners could be induced to carry it out, I feel the results would be well worth while.'

ANNOUNCEMENTS

The Research Newsletter

In this second issue of the Research Newsletter appear the first contributions from members of the Research Register. These are very welcome, and it is hoped that full use will be made of the circulation of the Newsletter in the future.

This Newsletter, perhaps in a slightly different form, may later be published in 'The Practitioner'. This will enable other members of the College, and research workers in other fields, to keep in touch with the work which is being done. The Directory and the Announcement Section, which will contain information likely to be of interest to members of the Register only, will not be published.

It is feared that owing to secretarial difficulties in the earlier stages of the work of the Research Committee, certain members of the Register did not receive the first Newsletter. For this reason the Directory Section is being reproduced in full, up to the date of issue of Newsletter No.2.

Any member who has not received a copy of the Newsletter No. 1. and who wishes to do so, is asked to write to the Chairman of the Research Committee.