were obliged to set up a plate and very gradually build up their practices. This they usually did without much difficulty. We must hope that the executive committees (on which women doctors are not really adequately represented), now that they have some say in the matter, will protect their interests.

In public health and the ministries there are a number of women and some are in very responsible positions; women are doing research and there are many women consultants all over the country, though it is noticeable that in certain areas large hospitals, especially non-teaching hospitals, have no women on the staff. It is, I think, the first step which counts; once a woman has been appointed, if she is a wise woman and good at her work, our male colleagues get used to the idea and the next time a woman applies she is more or less considered on her merits. The first woman to be appointed anywhere has a great responsibility, as if she is not found to be a good colleague the

pendulum swings back and another chance is not given for some time.

There are several professors in the big teaching schools, there are women doctors in the higher academic positions and the big main administrative councils, and there is one of whom we are particularly proud, Professor Hilda Lloyd, President of the Royal College of Obstetricians and Gynaecologists.

On reading over this article it appears that I have given the impression that women doctors have had a fairly smooth path to follow, suggesting that they have progressed from none to ample opportunities without stress and strain. This is not, of course, the case; but in remembering, with gratitude, all that the pioneers have done for us, I expect it is wise to remember that all pioneers, in no matter what direction, are apt to meet with the same obstructions. They are not like us; they are 'naturally of the stuff that martyrs are made of.'

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June 29, 1951.

The Editor,
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SIR,

I was much interested in the report of clinico-pathological conference No. 14 held at the Postgraduate Medical School, Hammersmith Hospital (July 1951).

The case discussed, fulminating meningococcal septicaemia with adrenal haemorrhage contracted on the tenth day of life, may possibly be the youngest on record. Under the age of six months I know of no recovery from this syndrome.

As was pointed out, whole adrenal cortical extract in the dosage usually given is relatively inactive. Faloon, *et al.* (1951), controlled the treatment of a case, aged 17 years, by the eosinophil count and found that dosage of 20 cc. intravenously followed by 10 cc. every hour for six

hours and then three-hourly for some days was necessary to keep the eosinophil count below 15 per cmm. The suggestion that cortisone may be more effective than eucortone is a valuable one, and the drug should be made immediately available for this type of case.

Prof. Dible mentioned that he did not know whether there was specific localization of meningococci to the adrenal in this type of case. I can answer this question in the affirmative. The evidence is clear from sections prepared from a similar case (child of three years; illness 13 hours' duration) by Dr. E. H. Bailey of the Southern Group Laboratory, Park Hospital. They clearly show capillaries stuffed with meningococci among the degenerated cells of the adrenal cortex. As far as I know this evidence has not been published elsewhere than in 'Modern Practice in Infectious Fevers,' Butterworth, London, page 317, Figs. 77 and 78.

Yours sincerely,

H. STANLEY BANKS.

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