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may establish himself where he chooses, it is not unknown for a new physician to solve the problem by starting practice in an adjacent location.

Many small communities formerly served by a resident doctor now receive their medical care at the hands of the physicians located in larger centres within easy reach by modern transportation. This arrangement does not entirely suit the convenience of the residents of the original community, and such bodies as women's institutes and Chambers of Commerce frequently list in placement files and in advertisements their desire to have another doctor locate there. These efforts naturally portray the need and the opportunity in favourable terms and a recent instance actually described a medical practice for sale in a village which had not had a resident doctor for several years.

To avoid publication of misleading information, all advertisers under the classification "Practices" in the *C.M.A.J.* should furnish the following information if applicable:

Population of community and surrounding territory served.

Number of doctors now practising in the community.

Location of nearest doctor (if the community has no resident physician).

Period for which the community has had no resident doctor.

Location of nearest hospital.

Description and suggested price of premises for office and residence.

Whether cash or terms are required in sale.

Whether office equipment, instruments, books, etc. are for sale.

Whether or not an introduction of at least two months' duration may be afforded to a prospective purchaser.

Name and address of vendor.

BENIGN MYALGIC ENCEPHALOMYELITIS

Since the first reports, from Iceland[1] and from Australia,[2] of atypical cases of poliomyelitis, six other outbreaks[3-8] have been reported from points as far apart as New York State[3] and Durban.[6] The recent description[9, 10] of two further epidemics in Europe focuses attention on this important diagnostic problem. Although there have been some minor variations in the clinical findings described by the various authors, there can be no doubt that a new disease entity has appeared, clearly distinguishable from poliomyelitis on the one hand and from epidemic encephalitis on the other. The outbreaks usually occur in closed communities and there is a high attack rate among contacts; four epidemics have occurred in nurses' residences and one in army barracks, and from the evidence of these it would seem that the incubation period is about four days. The onset resembles that of poliomyelitis with headaches, lassitude, neck stiffness and sore throat accompanied by pains in the limbs and back, and possibly paræsthesiæ and palsies. In contrast to poliomyelitis, however, the fever is never very high; the temperature rarely exceeds 100° F. and may persist for long periods. The clinical picture is dominated by the severe muscular pains, accompanied at first by spasms and exaggerated tendon reflexes. These pains are not transient; they often persist long after any local signs have subsided and may be accompanied by an exquisite tenderness, but at no time does any muscular wasting develop. A further distinguishing feature of the disease is the onset of behavioural changes, such as emotional lability, irritability and depression. Ramsay and O'Sullivan[9] examined five such patients by electroencephalography and obtained abnormal tracings in all of them. The abnormalities were similar in all cases and resembled those observed in patients with encephalitis lethargica. Disturbances of the cranial nerves such as diplopia and nystagmus, facial weakness, deafness or, in some cases hyperacusis, are common. A high proportion of cases show evidence of involvement of the reticuloendothelial system with enlargement of the cervical lymph nodes, particularly those in the posterior triangle, and, in some patients, hepatitis and splenomegaly.

Laboratory investigations are helpful only in that the results are consistently negative. The cerebrospinal fluid is characteristically normal and so far no causative organism has been isolated and no specific antibodies have been detected in the sera.

The disease pursues a protracted course and relapses are frequent; symptoms and signs may indeed persist for years. Sigurdsson and Gudmundsson,[11] who were among the first to report such an outbreak in Iceland in 1948-49, have just completed a re-examination of 39 of the original cases six years after the epidemic. In only 12 could they find no objective signs remaining from the disease and 7 among them complained of subjective sequelæ. In the majority nervousness and fatigue, muscle pains and muscle tenderness were the predominating complaints.

The epidemics tend to occur at much the same time as poliomyelitis, in the late summer and early autumn, and in the same age groups. It is therefore important that clinicians should be aware of the symptomatology of this new disease, not only because of its high infectivity among contacts but also because it is essentially benign. No deaths have so far occurred in any of the cases reported and a favourable prognosis as to life can therefore be given when the diagnosis is certain. The title of "benign myalgic

encephalomyelitis" is not yet official but has been suggested[12] as a more logical and helpful alternative to the names "Iceland" or "Akureyri" disease, in that it describes the essential clinical features and leaves the question of causation open.

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MARRIAGE AND MORTALITY

"A bachelor gay am I", sang the operetta hero, but he might have added that his merry life was also apt to be a short one. Statistics show clearly that the married person has a greater life expectancy than the single, widowed or divorced. Shurtleff (*J. Am. Geriat. Soc.*, 4: 654, 1956) has analyzed mortality experience in the U.S.A. for the three-year period 1949-1951, and exhibited clearly the differential in favour of the married. The differential is most marked in the case of men. For both sexes above the age of 20, the most dangerous state to be in is the divorced state. Whether it is better to be single or widowed depends on the age group, for the young widower is a poorer risk than the young bachelor or spinster, whereas the risk is reversed at higher ages.

Since there is no innate virtue in the married state which would automatically confer longer life on a man or woman immediately after the wedding ceremony, there are likely to be two main factors operating in favour of the wedded. The first is that of selection. Shurtleff suggests very reasonably that those contemplating marriage are usually the better physical specimens, although the notorious propensity of certain noble women to ally themselves to broken reeds makes one wonder about the significance of this factor. The second factor is the environmental one. Because of his responsibilities, the married man has to take more thought for his life, hence the mortality from accidents is much higher in the single than the married. Under the watchful eye of the spouse, the married man or woman is less likely to let a pathological condition develop before seeking treatment. Because of social pressures, the married are less likely than the single to die from the effects of alcohol or from syphilis. In some cases there is doubt about the cause and effect of relationship. Does the fact that more bachelors die from tuberculosis than married men mean that the married man has better care, or that the tuberculous shun marriage? The relationship of mental health to the marital state is indicated by the fact that suicide rates in husbands are half or less in every age group than those for single, widowed or divorced men. The divorced are particularly prone to suicide, as to alcoholism.

Only in one instance does the spinster score over her married sister. From middle life on she is less liable to die from diabetes mellitus than is the wife. Shurtleff suggests that this is because wives are more prone to be overnourished and overweight; for this, however, he cannot produce specific evidence. To illustrate his thesis that socio-environmental factors play a big part in this differential, Shurtleff takes the case of leukæmia which, being invariably fatal and apparently unrelated to social or environmental conditions, should kill the married and unmarried impartially. It is indeed true that this disease shows less variation in mortality by marital status than any other major causes of death.

The sceptics may of course assert that mortality figures are not the whole picture, and demand some examination of morbidity rates among the married and the single. It is, however, extremely unlikely that any statistical studies on the pathology of marriage will in any way affect the marriage rate.