Thursday

EDINBURGH UNIVERSITY.—At Anatomy Theatre, University New Buildings, Teviot Place, April 28, 5 p.m., "*A Workshop for Severely Disabled Men*," Honyman Gillespie Lecture by Professor T. Ferguson.

FACULTY OF RADIOLOGISTS: THERAPY SECTION.—At British Institute of Radiology, 32, Welbeck Street, London, W., April 28, 8.15 p.m., Sylvanus Thompson Lecture by Dr. F. Gordon Spear.

MEDICO-LEGAL SOCIETY.—At 26, Portland Place, London, W., April 28, 8.15 p.m., "*Medico-Legal Aspects of the Problems of Everyday Dental Practice*," joint paper by Surgeon Lieutenant-Commander John Bunyan, R.N.V.R., and Mr. C. W. Stidson Broadbent.

ROYAL COLLEGE OF SURGEONS OF ENGLAND, Lincoln's Inn Fields, London, W.C.—April 28, 5 p.m., "*Stomatodaeal Ruminations, Clinical and Non-clinical*," Hunterian Lecture by Professor Charles F. M. Saint (late Professor of Surgery in the University of Capetown).

Friday

FACULTY OF RADIOLOGISTS: THERAPY SECTION.—April 29, joint meeting with Section of Radiology, Royal Society of Medicine. Discussion: "*The Method of Presentation of Results in the Treatment of Cancer*." (1) At Royal College of Surgeons of England, Lincoln's Inn Fields, London, W.C., 2.15 p.m., to be opened by Professor B. W. Windeyer and Drs. J. S. Fulton and Percy Stocks. (2) At Royal Society of Medicine, 1, Wimpole Street, London, W., 8.15 p.m., to be delivered by Dr. Ralston Paterson, Miss M. C. Tod, and Professor R. McWhirter.

KENT AND CANTERBURY HOSPITAL, Canterbury.—April 29, 5 p.m. to 7 p.m., clinical meeting.

MEDICAL SOCIETY FOR THE STUDY OF VENEREAL DISEASES, 11, Chandos Street, London, W.—April 29, 8 p.m., "*Reiter's Disease*," by Dr. A. H. Harkness.

ROYAL COLLEGE OF SURGEONS OF ENGLAND, Lincoln's Inn Fields, London, W.C.—April 29, 5 p.m., "*Spondylolisthesis*," Hunterian Lecture by Professor R. I. Harris, Professor of Orthopaedic Surgery in the University of Toronto.

ROYAL INSTITUTE OF PHILOSOPHY.—At University Hall, 14, Gordon Square, London, W.C., April 29, 5.15 p.m., "*The Relevance of Psychical Research to Philosophy*," by Professor C. D. Broad.

APPOINTMENTS

Mr. J. L. B. Ansell has been appointed Surgeon-Apothecary to his Majesty's Household at Sandringham in succession to Sir Frederic J. Willans, K.C.V.O., deceased.

DONOVAN, W. T., M.B., Ch.B., D.P.H., Medical Officer of Health, Metropolitan Boroughs of Bethnal Green and Poplar.

EAST ANGLIAN REGIONAL HOSPITAL BOARD.—*Chest Physician, Peterborough Area*: G. B. Royce, M.B., Ch.B. *Medical Superintendent, Hellesdon Hospital*: F. J. Napier, M.B., B.S., D.P.M. *Ophthalmic Surgeon, Peterborough Area*: G. M. Barling, M.B., Ch.B., D.O.M.S. *Specialist Obstetrician, Peterborough Area*: Norman Kimbell, M.B., Ch.B., M.R.C.O.G. (*Corrected announcement*).

HOSPITAL FOR SICK CHILDREN, Great Ormond Street, London, W.C.—*House-physicians*, H. G. Dunn, M.B., B.Ch., M.R.C.P., O. D. Fisher, M.B., B.S., M.R.C.P., D.C.H. *House-surgeon*, Mrs. Christine B. A. John, M.B., Ch.B. *Assistant Resident Medical Officer* (*Tadworth Court*), Joan P. D'Arcy, M.B., B.Ch.

LEES, DAVID HUGH, M.B., Ch.B., F.R.C.S.Ed., M.R.C.O.G., Assistant Surgeon, Jessop Hospital for Women, Sheffield.

LOGAN, DANIEL CRAWFORD, M.B., Ch.B., D.P.H., Medical Officer of Health, Whittlesey, Cambridgeshire.

BIRTHS, MARRIAGES, AND DEATHS

BIRTHS

Halle.—On March 21, 1949, at Sheffield, to Frances and Hugh, a daughter—Elizabeth Anne.

Hulbert.—On April 5, 1949, at West Hill Hospital, Dartford, to Elizabeth, wife of K. F. Hulbert, F.R.C.S., a daughter.

O'Sullivan.—On April 11, 1949, Una (née O'Leary), wife of Dr. J. G. O'Sullivan, Manchester, a daughter.

Pooler.—On April 10, 1949, at Easterholme, Stretton, Derbyshire, to Pamela (née Relton), wife of H. E. Pooler, M.B., D.A., a brother for Rosamund.

Taylor.—On April 11, 1949, in Edinburgh, to Helena (née Lauder Thomson, M.B., Ch.B., D.P.H.), wife of Dr. A. W. O. Taylor, M.R.C.P.Ed., 9, Frogston Road East, Edinburgh, a son.

Whalley.—On March 10, 1949, to Joy (née Brooks), wife of Dr. G. Hamilton Whalley, Newcastle, a son.

DEATHS

Burn.—On April 10, 1949, at Bryansburn House, Bangor, Co. Down, Mrs. Alice M. Burn, M.B., Ch.B.Ed., D.P.H.

Cuthbert.—On April 7, 1949, at a nursing-home, Glasgow, Charles Campbell Cuthbert, M.D., M.B., Ch.B., formerly of 3, Buckingham Terrace, Glasgow, W.2, and his wife Jean Copeland.

Davies.—On April 6, 1949, after a short illness, John Christopher Davies, M.B., B.Ch.

D'Esterre.—On April 12, 1949, at Westwinds, 31, Alleyn Park, West Dulwich, S.E.21, William Henry Daniel Patrick D'Esterre, M.D., B.S., M.R.C.S., L.R.C.P., aged 79

Groome.—On April 10, 1949, at Canterbury, Walter Groome, M.B.E., M.B., C.M., aged 81.

Mackay.—On April 12, 1949, at Rockbank, Campbeltown, Argyll, Duncan Matheson Mackay, M.D.Ed., aged 79.

Neill.—On April 9, 1949, at Coonoor, South India, the Rev. Charles Neill, M.A. M.B., formerly of Craigavad, Co. Down, aged 80.

Sorsby.—On April 6, 1949, at Los Angeles, Maurice Sorsby, M.D., F.R.C.S.Ed.

Wacher.—On April 11, 1949, peacefully after a long illness, Harold Wacher, M.D.

Any Questions?

Correspondents should give their names and addresses (not for publication) and include all relevant details in their questions, which should be typed. We publish here a selection of those questions and answers which seem to be of general interest.

Penicillin–Phthalylsulphathiazole Antagonism

Q.—*The National Formulary, 1949, on page 13 states that "there is evidence that it [phthalylsulphathiazole] should not be given with penicillin." Would you please quote the evidence?*

A.—Poth, Wise, and Slattery (*Surgery*, 1946, **20**, 147) gave phthalylsulphathiazole to six patients and succinyl sulphathiazole to five patients to reduce the coliform organisms in the large bowel. Penicillin was then given intramuscularly (20,000 units at two-hourly intervals) while the administration of the sulphonamide was continued. There was no demonstrable effect on the reduced flora induced by succinylsulphathiazole, but there was an abrupt and significant increase in the coliform flora in all the cases treated with phthalylsulphathiazole. The phenomenon could not be explained. The authors recommend that penicillin should not be administered simultaneously with phthalylsulphathiazole if it is important to maintain a reduction in the coliform flora of the bowel, as in the treatment of chronic coliform infections of the urinary tract or ulcerative colitis.

Streicher (*J. Amer. med. Ass.*, 1947, **134**, 339) in an investigation on the effect of orally administered penicillin in chronic ulcerative colitis found that the antibacterial effect of penicillin was impeded by the administration of phthalylsulphathiazole. The organisms studied were *Bacterium coli, Staphylococcus albus,* and streptococci of gamma type. When 3 g. of phthalylsulphathiazole was given in addition to 225,000 units of penicillin by mouth, 300 units of penicillin was needed to inhibit the *Bact. coli in vitro* as compared with 20 units when the penicillin was given alone. Nevertheless, Streicher considers that in practice oral penicillin and phthalylsulphathiazole may be combined with advantage. More recently Stewart and Jones (*Ann. trop. Med. Parasit.*, 1948, **42**, 33) have studied the effects of combining penicillin and phthalylsulphathiazole in the treatment of experimental amoebic infection in the rat. Both drugs were effective prophylactically, with a possible additive effect. Therapeutically, phthalylsulphathiazole enhanced the action of penicillin without itself having any effect on the established infection.

There is thus no definite confirmation of the observations reported by Poth and his co-workers suggesting that the combined use of penicillin and phthalylsulphathiazole is undesirable in clinical practice, but until further evidence is available succinyl sulphathiazole would appear to be a wiser choice in combined therapy.

Xanthomatous Biliary Cirrhosis

Q.—*What are the features of the condition known as "primary biliary xanthomatosis"?*

A.—"Primary biliary xanthomatosis" is more often termed "xanthomatous biliary cirrhosis." It is a disorder in which chronic obstructive jaundice and hepato-splenomegaly are associated with cutaneous xanthomata (plana or tuberosa), and less frequently with xanthomata in the tendons, bones, or coronary arteries. The serum cholesterol level is greatly raised, owing mainly to an increase in the quantity of cholesterol ester. This uncommon condition is placed by Thannhauser in the group of hypercholesterolaemic primary essential xanthomatoses. This author's monograph (*Lipidosis: Diseases of the Cellular Lipid Metabolism*, 1940, Oxford University Press) contains a full bibliography and should be consulted.

Petroleum Products and the Skin

Q.—*Can you give any information on the reactions which may occur when one of the following is applied to the skin: (a) light liquid paraffin. (b) liquid paraffin B.P., and (c) soft paraffin (yellow or white)?*

A.—Light liquid paraffin, liquid paraffin *B.P.*, and soft paraffin (yellow or white) do not usually give rise to any

reaction when applied to intact skin, even for prolonged periods. These oils collect in the mouths of the hair follicles, and, when their use in association with cosmetics is accompanied by insufficient attention to skin cleansing, aggregates of oil and particulate matter may give rise to mechanical plugging of the follicle opening. The occurrence of follicular hyperkeratosis, comedones, and sometimes pustular eruptions has been recorded following the use of impure paraffin oils in hair oil (*Year Book of Dermatology and Syphilology*, 1946, p. 277) and also as a result of the application of impure petroleum jelly (yellow soft paraffin). It is likely that the hyperkeratotic reaction in such instances is due to the presence of aromatic hydrocarbons which the refining process has failed to remove. This defect should not occur in medicinal preparations. The introduction of even highly refined paraffins into the subcutaneous tissues gives rise to an oleogranuloma, and consequently this must be borne in mind when application of these oils to damaged skin is considered. The ill effects of paraffin oils on damaged or diseased skin are otherwise due to their physical properties. In general it is undesirable to apply paraffin oils to skin which is inflamed or weeping, as they retain the heat, fail to mop up the exudate, and thus render the skin moist and soggy—a condition in which it is especially liable to infection.

Safe Dose of Acetylsalicylic Acid

Q.—*What is the largest dose of acetylsalicylic acid that can be taken within twelve hours without endangering health?*

A.—The amount of acetylsalicylic acid which can be taken with safety varies for different people. Single doses of 20 g. (300 gr.) have been fatal, and some susceptible persons have had a severe allergic reaction after 0.6 g. (10 gr.). The principal danger is from haemorrhage, owing to a fall in the blood prothrombin level. If this is counteracted by giving menaphthone beforehand it is probably safe to take from 5 to 10 g. (75 to 150 gr.) in 12 hours.

Dyspareunia

Q.—*A woman aged 28 has always had severe pain on intercourse. She is normally developed, and no structural abnormality of uterus, ovaries, or parametrium can be felt. Endometrial biopsy also shows no abnormality. The pain can be elicited only by moving the cervix, but is not felt when the uterus is squeezed without being moved. The patient also complains of frequency of micturition, and has had bouts of mild pyrexia. A recent abortion has not altered the pain. Any advice on this problem would be welcome.*

A.—Tenderness of the cervix and the production of pain on moving that organ strongly suggest the presence of disease in the cervix or neighbouring tissue. The other clinical features of this case also point to a diagnosis of chronic cervicitis. If this is deep-seated in the glands, and there is no superficial evidence of it, it may be difficult to exclude. The presence or absence of intermenstrual discharge should help. If chronic cervicitis is present, treatment with surgical diathermy or a graduated course of medical diathermy should be tried. Another possibility is endometriosis in the pouch of Douglas or utero-sacral ligaments; even intermittent pyrexia can be associated with this. For this condition another pregnancy should be encouraged, and if it progresses satisfactorily spontaneous retrogression of the endometriosis might occur. In either of the above conditions, if the pain proves intractable, injection of the paracervical ganglia with a local analgesic is sometimes useful. If no organic disease is present the discomfort might be explained by a congenitally short vagina which exposes the vault and the cervix to an unusual degree of trauma during coitus, or by an inherent hypersensitivity of the cervix. There might also be a psychogenic basis leading to aversion to coitus.

Pig as Vector of Ascaris

Q.—*Is there a greater risk of human infection with roundworm from vegetables grown in soil containing pig manure as compared with other manures? How long do the ova remain viable in manure, and is there any means of destroying them?*

A.—In spite of the fact that the roundworm (*Ascaris suis*) occurring in the pig is morphologically indistinguishable from the roundworm (*Ascaris lumbricoides*) occurring in man, it does not normally develop to maturity in the human host, although it has been shown that *A. lumbricoides* may reach maturity in the pig if the animal is placed on a vitamin-deficient diet. The pig cannot therefore be regarded as a reservoir for human ascariasis, but it is believed that pigs play a part in the dissemination of eggs of *A. lumbricoides* which have been ingested previously with human faeces. The ova of *Ascaris* commonly remain viable in buried manure for at least a year, although much longer periods have been recorded. During this resting period they are very resistant to chemicals, but may be destroyed by drying, and perish almost immediately if heated to 55° C.

Thickening of Palmar Skin

Q.—*An unmarried female aged 49, well developed and active, is greatly distressed by the formation on both palms of thickened, dry, rough skin with a tendency to crack and fissure. The condition appears to be hyperkeratosis. What is the treatment?*

A.—A diagnosis is necessary before suggesting treatment in this case, and cannot be made without more knowledge of the patient's general condition, menstrual history, past medical and dermatological history, and family history. The condition might be psoriasis, lichen simplex, constitutional eczema, lichen planus, or keratodermia climactericum, among other things. A patchy hyperkeratosis of palms and soles is occasionally associated with the climacteric and is responsive to oestrogen therapy. Treatment should be undertaken with care, starting probably with 0.5 mg. of stilboestrol daily. It should not be carried to the point of provoking uterine haemorrhage if the periods have stopped. It would, perhaps, be advisable to submit the case to a dermatologist for clinical review before undertaking treatment.

Intravenous Calcium Chloride and Gluconate

Q.—(*a*) *I understand that intravenous calcium chloride is dangerous to the digitalis-controlled heart. Does this apply to the rapid intravenous injection of calcium gluconate to determine the circulation time?* (*b*) *Have fatalities been recorded with this drug, or with ether, saccharin, dehydrocholic acid ("decholin"), or magnesium sulphate?* (*c*) *Which is the safest?*

A.—(*a*) There are numerous reports, both clinical and experimental, on the synergic effects of calcium chloride with digitalis and fatalities have been recorded in animals and in human beings. On the other hand, many observers have used calcium gluconate without any fatal result in large numbers of patients suffering from serious cardiovascular disease which was fully controlled by digitalis (Goldberg, *Amer. J. med. Sci.*, 1936, **192**, 36; Baer and Slipakoff, *Amer. Heart J.*, 1938, **16**, 29; Berliner, *Amer. J. med. Sci.*, 1936, **191**, 117). H. C. Wall (*Amer. Heart J.*, 1939, **18**, 228) pointed out that calcium chloride contained three times as much calcium, weight for weight, as calcium gluconate; and in the former ionization was much greater. The rare fatalities in human beings occurred in extremely ill patients with advanced heart disease. In heart failure the blood volume is greatly increased and the circulation time slowed, these factors acting as safety-valves to the sudden rise of calcium concentration in the chambers of the heart, which apparently causes the fatal outcome (Mcguigan and Higgins, *J. Lab. clin. Med.*, 1938, **23**, 839). These factors, however, also tend to prevent a precise end-point being attained, and in patients with slow circulation time and taking less than 5 ml. of calcium gluconate, no subjective sensation may be noticed. Thus, to be safe, intravenous calcium should be given slowly, but this would vitiate the result. Bernstein and Simpkins (*Amer. Heart J.*, 1939, **17**, 219) showed that magnesium sulphate had none of the dangers incidental to the use of calcium salts, and gave more exact readings at the slower circulation rates.

(*b*) No fatalities have been reported following the use of saccharin, dehydrocholic acid, or magnesium sulphate. Leinhoff (*J. Amer. med. Ass.*, 1935, **105**, 1759) reported a fatality accompanying the injection of 2.5 ml. of 10% ether in saline in a case of bronchial asthma. He doubted whether this was alone the cause of death, but felt that it was a precipitating factor. Hitzig advises against the injection of saccharin and ether into the same vein, because it may give rise to thrombosis and local pain. If the substances are injected outside the vein severe local reactions occur. The only, untoward

effects reported after the use of dehydrocholic acid were in allergic or asthmatic patients. K. J. Norman (*Amer. Heart J.*, 1947, **34**, 740) mentioned three such cases, in one of which sensitization to the drug itself was acquired.

(*c*) Dehydrocholic acid, magnesium sulphate, and saccharin are safe, provided allergy is excluded in the case of the first named.

Arcus Senilis

Q.—*What significance should be attached to the presence of a well-developed arcus senilis in a man aged 37, with normal blood pressure and without signs or symptoms of cardiovascular disease?*

A.—No significance should be attached to this. The writer has under his care one of a family in the members of which a definite arcus senilis develops at about the age of 16 years. The differential diagnosis is from the Kayser-Fleischer ring, which is coloured and is associated with hepatolenticular degeneration (pseudo-sclerosis and Wilson's disease).

Oestrogen Therapy of Menorrhagia

Q.—*In the article on sex hormones in therapeutics (B.M.J., Jan. 29, p. 165) it is stated that intensive oestrogen therapy will control heavy and prolonged menstrual bleeding. What would be the most appropriate synthetic drug to use orally, and in what dosage?*

A.—The statement was made in reference to so-called functional uterine haemorrhage. Stilboestrol 1 mg., or ethinyl oestradiol 0.05 mg., orally every four hours, might be used. It is emergency treatment in that it controls the bleeding by raising the oestrogen level above the bleeding threshold. There is still the problem of preventing or controlling oestrogen-withdrawal haemorrhage, which is likely to occur when treatment is suspended.

Ptyalism in Pregnancy

Q.—*A patient had excessive salivation all through her first pregnancy; she could not swallow the saliva but had to spit. Belladonna or sedatives failed to relieve the condition. She is now pregnant again and the salivation is returning. What treatment do you suggest?*

A.—The treatment of ptyalism in pregnancy is difficult because the aetiology is unknown. There is often, however, as in hyperemesis, a psychological underlay which manifests itself by the constant spitting—a conscious or subconscious dislike or fear of pregnancy. Usually the condition clears up by the time quickening is first felt, and this should be impressed on the patient. Calcium gluconate (10 ml. of 10% solution daily) has been given intravenously with good results in some cases. After a similar query was answered some years ago (April 14, 1945, p. 543) one correspondent advised putting very thin slices of lemon between the cheeks and the teeth. Another reported having successfully treated a patient with 20 drops of 25% benzyl benzoate in 90% alcohol taken in water every four hours.

Treatment of Asthma

Q.—*A female patient of 43 has been subject to acute attacks of hay-fever from the age of 8. Six years ago she developed sharp attacks of asthma lasting several days, usually followed by bronchitis. The asthma has been successfully treated with subcutaneous adrenaline. Unfortunately, however, owing to the frequency of nocturnal mild attacks, I have for many months had to use maintenance doses as a suppressive, and in consequence the patient has become adrenaline-fast. She now complains of palpitation and cardiac pain, both during the severe attacks and for some weeks afterwards, despite prolonged rest in bed. A recent blood count showed R.B.C. 3,500,000 and W.B.C. 16,000 per c.mm., with a haemoglobin value of 75%. I am treating the anaemia with intramuscular injections of "anahaemin." Can you make any alternative suggestions for prophylaxis of the mild nocturnal attacks, and what treatment do you recommend during the violent attacks?*

A.—For the periodic violent attacks, when adrenaline fails, intravenous aminophylline, 0.48 g. in 20 ml., is usually effective. For alternative nightly prophylaxis one might suggest aminophylline 0.2 to 0.4 g. with or without phenobarbitone gr. ½ (32 mg.); if there is gastric irritation after aminophylline, enteric-coated aminophylline or glucophylline in similar doses might be tried, or the aminophylline could be given per rectum, 0.5 g. in 10 ml. of water, with a syringe and catheter; alternatively, "franol" (theophylline, ephedrine, and phenobarbitone), 1 or 2 tablets, might be tried, and a favourite prescription in such cases is "caffneine" 1 drachm (3.5 ml.) in water three times a day. This preparation is made up as follows:

℞	Caffeine sod. iodid.	5 gr. (0·32 g.)
	Sod. iodid.	5 gr. (0·32 g.)
	Dilute hydriodic acid	5 m. (0·3 ml.)
	Decoction of coffee	40 m. (2·4 ml.)
	Water to	1 fl. dr. (3·5 ml.)

The history and leucocytosis suggest the presence of infection. Is there infection in her sinuses?

Washing-soda in Tea

Q.—*A patient who works in a buffet informs me that it is a widespread practice to put a handful of washing-soda in the tea urn at each filling to make the tea darker than the strength of the brew would warrant. Would the constant drinking of tea so treated be harmful?*

A.—It is not likely that any harm would come of the use of washing-soda in tea. But, as with other methods for making tea go further, the resulting drink is not nearly so good as it should be.

NOTES AND COMMENTS

Lactation.—Dr. ARMIN RUTISHAUSER (Dessie, Wollo Province, Ethiopia) writes: In a question about lactation in virgins ("Any Questions?" Nov. 20, 1948, p. 925) it is stated that Margaret Mead describes how one of the savage tribes in New Guinea adopts babies who are then breast-fed by women who have never had children of their own. Before the war I spent two years at the hospital of Dr. Albert Schweitzer, French Equatorial Africa, where I saw the following two cases in the obstetrical department. There was one woman who gave birth to a child, but after a few days breast-feeding was impossible, as the breast did not produce any milk, though we had the baby suckling. All the treatment we undertook had negative results. Then I was asked permission to take mother and child away, as the family wanted to consult a sorcerer. I agreed, seeing that we were at a standstill. After some weeks the family came back—baby all right and mother producing a lot of milk. Another mother died, and her mother, a very old-looking woman with breasts like paper, started to feed the baby after having disappeared for a short time in the jungle. After those experiences my curiosity was aroused, and I found out that the women underwent treatment with the result that inactive breasts started to produce milk. During the following year we tried hard to find out what kind of plants were used for this special treatment, but it was quite impossible to get information, as the sorcerers are very anxious to keep their knowledge for themselves. In any case, it would be very interesting to learn more of all the drugs used in Africa, as I am quite sure that there are a great number of very important ones.

Late Menopause.—Dr. HILDA M. DENHOLM-YOUNG (Farningham, Kent) writes: Regarding menstruation at age 56 ("Any Questions?" April 2, p. 602), the question does not state if the woman was from Shetland or Orkney, where menstruation finishes normally at about 60 and where children are sometimes borne at that age.

Disclaimer.—Mr. HAROLD DODD (London, W.1) writes: During the past week there have been several announcements in the public press with regard to my connexion with the Fife-Openshaw Nursing Home. These have been made in spite of my urgent requests. I begged the Press to confine their statement to the announcement made by Princess Arthur "that she was giving up her connexion with it." My wishes were ignored. Therefore I should be grateful if you would kindly insert this disclaimer.

All communications with regard to editorial business should be addressed to THE EDITOR, BRITISH MEDICAL JOURNAL, B.M.A. HOUSE, TAVISTOCK SQUARE, LONDON, W.C.1. TELEPHONE: EUSTON 2111. TELEGRAMS: *Aitiology, Westcent, London.* ORIGINAL ARTICLES AND LETTERS forwarded for publication are understood to be offered to the *British Medical Journal* alone unless the contrary be stated.

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