by a well-fitting spinal support, or (2) to excise appropriate segments of the affected ribs. The benefit to be expected from these measures has to be balanced against the discomfort of wearing a rigid corset or the inconvenience of operation. Treatment should be advised only when the condition is the cause of quite significant disability. In the particular case mentioned it seems probable that the wisest course would be to accept the disability. Further information and reports of cases may be found in the following papers: Holmes, J. F., *Amer. J. Surg.*, 1941, **54**, 326; Ballon, H. C., and Spector, L., *Canad. med. Ass. J.*, 1938, **39**, 355; Davis-Colley, R., *British Medical Journal*, 1922, **1**, 432; Cyriax, E. F., *Practitioner*, 1919, **102**, 314.

Loss of Libido after Oophorectomy

Q.—*A married woman, aged 45, the mother of three children, has complete loss of libido and orgasm since total hysterectomy with bilateral oophorectomy for fibroids and cystic ovaries four months ago. Can any treatment be suggested?*

A.—Loss of sexual feelings does sometimes follow oophorectomy, but not inevitably. Before concluding that it is due to hypo-oestrinism in this case it will be necessary to wait longer. The woman will not have completely regained her physical and mental vigour so soon after the operation, and this alone may account for the symptoms. There may be some inhibitory factor, such as fear of disturbing the site of operation, or the patient may have been led to believe that frigidity is to be expected after such treatment. General measures, including adequate rest and patience, should be tried first, but if these fail, and provided the reason for the operation does not contraindicate it, small-dose oestrogen therapy may be tried cautiously. If it is successful the dose should be gradually reduced over the course of a few months rather than discontinued suddenly or continued indefinitely.

Local Effects of Potassium Cyanide

Q.—*Is there any method of prevention, any antidote, or any recognized treatment for the type of necrosis caused by potassium cyanide getting into cuts and abrasions on the hands? This type of lesion is seen in men at a silver-plating factory where they dip the articles to be plated in various strengths of potassium cyanide.*

A.—Potassium cyanide is the salt of a strong base, caustic potash, and a weak acid, hydrogen cyanide, hence it has a strongly alkaline reaction in aqueous solution. In the plating shop where potassium cyanide is used there is likely to be contact with other alkaline solutions, and with solutions of nickel salts which may be responsible for skin irritation. Prosser White quotes Whitfield in stating that potassium cyanide produces a very obstinate ulceration if it comes in contact with the slightest abrasion of the epidermis. Cyanide solutions, especially if alkaline, are absorbed through the skin, and the risk of poisoning should always be appreciated. The antidote is: (*a*) 158 g. of ferrous sulphate crystals; (*b*) 60 g. anhydrous sodium carbonate. Each is dissolved in one litre of water and kept ready for immediate use. The dose is equal volumes (50 ml.) of (*a*) and (*b*) taken in half a tumbler of water. This same antidote is useful, too, in washing skin contaminated with cyanide solutions.

The prevention of skin irritation from cyanide lies in the avoidance of contact by wearing rubber gloves. The treatment of cyanide dermatitis by the use of boric acid ointment or wet boric acid dressings is discussed in the *Journal of the American Medical Association* ("Queries," 1942, **118**, 935). When cyanides are present on skin surfaces the cyanide is transformed promptly to the carbonate, so that the lesion produced is an alkali burn, and there is every reason for the prompt removal of any such solution in order to avoid the action of the alkali. Boric acid serves admirably as a buffering agent, and if persistently used will maintain a *p*H ranging from 0.6 to 0.8. When deep ulcerations are produced by cyanide or, more likely, by the carbonate, with ensuing eschars, superficial débridement may be necessary. It is, of course, an important point of any treatment to avoid further contact until healing is complete.

D.O.C.A. and Ascorbic Acid in Rheumatoid Arthritis

Q.—*Suprarenal cortical hormone and ascorbic acid have been used in treating rheumatoid arthritis. What is the dosage and the technique of administration? What reactions are likely? Is it safe for an ordinary general practitioner to use in the patient's home? Which preparation is best, and how long must treatment be continued?*

A.—The suprarenal cortical hormone referred to is desoxycorticosterone acetate (D.O.C.A.), which in conjunction with ascorbic acid has been advocated recently as an ameliorative method of treatment in cases of rheumatoid arthritis. The dosage recommended is 5 mg. of D.O.C.A. and 1 g. of ascorbic acid. The former is injected subcutaneously, while the latter must be given intravenously. Although ascorbic acid can be given intramuscularly, it is extremely painful and patients generally object on this account; it is also doubtful whether it really is so effective by this route. The number of injections necessary is dictated by clinical response, in view of the fact that the effect—if any—is transient; the maximum benefit is seen generally about 30 minutes after injection. No dangerous reactions are likely as the result of one or two injections in this dosage, although it must be remembered that D.O.C.A. is a dangerous drug. From the practical point of view it is not generally expedient to give injections more often than once or twice a week. The treatment could be given by a general practitioner, as the technique is simple. Any elevation of the blood pressure, myocarditis, or nephritis are contraindications to the use of D.O.C.A. It is probable, however, that the reports on this method up to date have sounded rather too optimistic a note. A letter on the subject appears on p. 1006 in this issue of the *Journal*.

NOTES AND COMMENTS

Promoting Lactation.—Professor R. S. ILLINGWORTH writes from the Children's Hospital, Sheffield: I thought that the reply under this heading in "Any Questions?" (April 8, p. 858) was singularly unhelpful. It omits all mention of the important causes of the failure of lactation, in particular too early and unnecessary complementary feeding, failure to empty the breast after each feed when there is some deficiency of milk, and failure to treat overdistension of the breast by frequent suckling (provided the baby can get the milk), manual expression, and in severe cases stilboestrol. Such a statement as "attention to the details of technique in suckling is important" is just meaningless verbiage unless amplified and explained. There is no evidence that failure of lactation is due to an inadequate blood supply, and therefore the measures advised to promote a good supply are pointless. Furthermore, a woman with painful distended breasts two or three days after the birth of her baby would not relish "arm exercises." The evidence that thyroid extract and iodine are of value in promoting lactation is to say the least of it extremely slender. I should advise your questioner to read Dr. Charlotte Naish's book *Breast Feeding*, 1948, London, and Dr. Harold Waller's papers (*Arch. Dis. Childh.*, 1946, **21**, 1; *Lancet*, 1950, **1**, 53; *Mon. Bull. Min. Hlth.* 1947, **6**, 73).

Anal Fissure.—Dr. W. M. PENNY (Beckenham, Kent) writes: In the treatment of anal fissure described in "Any Questions?" (April 15, p. 918) I was surprised that there was no mention of stretching the anus under nitrous-oxide anaesthesia. This gives immediate relief, apart from a little local soreness, and healing of the ulcer can be expected with great confidence. That, at least, is my experience in many years of general practice.

Correction.—In our report of the inaugural meeting of the Renal Association (April 22, p. 953) we omitted to say that Dr. A. A. Osman was elected president of the association.

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