

Saturday

- **INSTITUTE OF ACCIDENT SURGERY, BIRMINGHAM.**—At Birmingham Accident Hospital, Bath Row, Birmingham, April 21, 9 a.m., "Traumatic Surgery: Lower Limb and Trunk," week-end course. (See also April 20 and 22; also Coming Events, p. 830.)
- SOUTH-EAST METROPOLITAN REGIONAL TUBERCULOSIS SOCIETY.**—At Lenham Sanatorium, Lenham, April 21, 10.30 for 11 a.m., "Clinical Aspects of Thiosemicarbazone in Pulmonary Tuberculosis," by Dr. R. Livingstone; "Biochemical Aspects of Thiosemicarbazone in Pulmonary Tuberculosis," by Dr. E. R. Jones; "Primary Lesions," by Dr. Ruth Dingley.

Sunday

- **INSTITUTE OF ACCIDENT SURGERY, BIRMINGHAM.**—At Birmingham Accident Hospital, Bath Row, Birmingham, April 22, 9.30 a.m., "Traumatic Surgery: Open Wounds," week-end course. (See also April 20 and 21; also Coming Events, p. 830.)

APPOINTMENTS

- APSEY, G. R. M., M.D., D.P.H., Regional Medical Health Officer, Health Region No. 3, Saskatchewan, Canada.
- CRICHTON ROYAL, Dumfries.—Crichton Fellowships: P. Rowsell, M.B., B.Chir., M.R.C.P.; J. Harrington, M.D., D.P.H., D.I.H.
- CROSS, RAYMOND GERARD, M.D., M.A.O., D.P.H., M.R.C.O.G., F.R.C.P.I., Assistant Gynaecologist, Meath Hospital and County Infirmary, Dublin.
- CURRAN, ANDREW P., M.B., Ch.B., D.P.H., Deputy Medical Officer of Health and Deputy School Medical Officer, Borough of Luton.
- DOYLE, JOSEPH IGNATIUS, M.B., B.Ch., Medical Officer, Coolatlin Dispensary District, Co. Wicklow, Eire.
- DUNCAN, ERIC H. WEIR, M.B., Ch.B., D.P.H., Medical Officer of Health, Greenock.
- FOREMAN, H. M., M.B.E., M.B., Ch.B., M.R.C.P., Physician-Superintendent (Consultant), Sully Hospital, Welsh Regional Hospital Board.
- HASTILOW, IRENE M. D. F. C., M.B., Ch.B., D.P.H., D.C.H., D.Obst.-R.C.O.G., Medical Officer of Health for Saffron Walden Borough and Saffron Walden Rural District, and Assistant County Medical Officer for Essex.
- HORTON, E. H., M.B., B.Ch., Assistant Chest Physician (S.H.M.O.), Brecon and Radnorshire Area.
- HOSPITAL FOR SICK CHILDREN, Great Ormond Street, London, W.C.—Assistant Medical Registrars (Registrar Grade), P. J. N. Cox, B.M., M.R.C.P., D.C.H., D. H. Garrow, B.M., M.R.C.P., J. Luder, M.D., M.R.C.P., D.C.H., R. G. Welch, M.D., M.R.C.P. Part-time Surgical Registrars (Senior Registrar Grade), T. Rowntree, M.S., F.R.C.S., I. F. Rose, F.R.C.S.
- JEFFERY, C. C., F.R.C.S., Consultant Orthopaedic Surgeon in Exeter Clinical Area, South-western Regional Hospital Board.
- PARKER, WILLIAM SHEPHERD, M.B., Ch.B., D.P.H., D.I.H., Medical Officer of Health, Brighton County Borough.
- ROGAN, JOHN M., M.D., F.R.C.P.Ed., D.P.H., Chief Medical Officer, National Coal Board.
- ROSS, HENRY A., M.B., Ch.B., D.P.H., Physician-Superintendent, South Wales Sanatorium, Talgarth, Breconshire.
- SAMBROOK, D. K., M.B., B.S., F.R.C.S., D.M.R.T., Consultant Radiotherapist, Glantawe Hospital Management Committee Group, Swansea.
- SOUTH-WESTERN REGIONAL HOSPITAL BOARD.—Consultant Radiologist in South Somerset Clinical Area, John Winter, M.B., Ch.B., M.Rad., D.M.R.D. Senior Surgical Registrar in West Cornwall Clinical Area, C. B. O'Carroll, M.B., B.S., F.R.C.S.Ed.
- STEWART, JOHN BERKLEY, M.B., Ch.B., D.Phys.Med., Consultant in Physical Medicine, Cirencester, Swindon, and Pewsey Hospital Management Committees.

BIRTHS, MARRIAGES, AND DEATHS

BIRTHS

- Howat.**—On April 2, 1951, to Margaret (formerly Harker), wife of Dr. James Howat, 3, Tankerville Terrace, Newcastle-upon-Tyne, a daughter.
- Mann.**—On March 15, 1951, at Aberdeen Maternity Hospital, to Dr. and Mrs. A. B. Mann (Irene Menzies), "Lochnagar," Cults, Aberdeenshire, a son.
- Raper.**—On March 31, 1951, at Kampala, Uganda, to Doris, wife of Dr. Alan Raper, a son.
- Stuart-Harris.**—On March 28, 1951, at the Hammersmith Hospital, to Marjorie, wife of Professor C. H. Stuart-Harris, M.D., F.R.C.P., a son.

MARRIAGES

- Beveridge—Pinney.**—On March 29, 1951, at the Parish Church, Sidmouth, Devon. Dr. T. S. Beveridge to Miss Cynthia Pinney, S.R.N.

DEATHS

- Craig.**—On March 24, 1951, at Roseville, Gatehouse-of-Fleet, Kirkcudbrightshire, Alexander Currie Carruthers Craig, M.B., Ch.B., aged 56.
- Farquharson.**—On March 25, 1951, at The Grange, Wetheral, Carlisle, William Frederick Farquharson, M.D., aged 84.
- Furness.**—On March 24, 1951, at Clarehaven, Melton Mowbray, Harold Sydney Furness, M.D., aged 67.
- Liddell.**—On March 22, 1951, at 30, Greenbank Drive, Edinburgh, John Liddell, M.B., C.M., late of Errol, Perthshire.
- McDougall.**—On March 24, 1951, at a Bournemouth nursing-home, John Tiley Montgomery McDougall, 8, Dunkeld Road, Bournemouth, aged 75.
- Messiter.**—On March 26, 1951, at 3, Ednam Road, Dudley, Worcs, Cyril Cassan Messiter, M.R.C.S., L.R.C.P.
- Owles.**—On March 20, 1951, at his home, 14, Whitehall Road, Rhos-on-Sea, Colwyn Bay, Wilfred Harding Owles, D.M., M.R.C.P.
- Sprague.**—On March 21, 1951, at his home, 4, Clarence Street, Gloucester, Francis Henry Sprague, M.R.C.S., L.R.C.P.
- Symes.**—On March 25, 1951, at 6, Pembroke Vale, Clifton, Bristol, John Odery Symes, M.D., D.P.H., aged 83.
- Wigham.**—On March 22, 1951, at Dublin, Joseph Theodore Wigham, M.D., F.R.C.P.I., of Edenvale, Conyngham Road, Dublin, aged 76.

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.

Foetal Damage from X Rays

Q.—(1) What is the mechanism of irradiation damage to the foetus? (2) Should a woman be allowed to have children after she has had therapeutic irradiation to the abdomen or pelvis? If so, what criteria of dosage, site, etc., should be applied in deciding in a particular case?

A.—(1) If a woman is irradiated during pregnancy damage to the foetus will depend on whether the foetus receives either direct or scattered radiation; if it does, the effects will be those following irradiation of any young growing tissues. There is at present no evidence that chemical substances produced by irradiation of maternal tissues reach and damage the foetus.

(2) If a woman has had therapeutic irradiation for a malignant tumour in the abdomen or pelvis it is most unlikely that she will have children. If she has had small doses of irradiation for a benign condition there is little evidence that such treatment results in a real increase in the proportion of abnormal pregnancies, but the possibility of genetic changes due to irradiation of the ova cannot be ignored.

Sulphones in Leprosy

Q.—How effective are sulphones in the treatment of leprosy? How are they given?

A.—A number of sulphone derivatives (e.g., "promanide" intravenously; "diasone," "promizole," "sulphetrone" orally) have been used in the treatment of lepromatous leprosy. These drugs almost invariably arrest the progress of the lepromatous lesions and prevent the development of new lesions; in most cases they cause retrogression and even disappearance of the lepromatous lesions, with diminution of the numbers of bacilli in them sometimes to such an extent that the bacilli can no longer be recovered. Apparent "cure" has therefore been reported in a number of cases; but in an extremely chronic infection of this type, where evidence of the presence of the causative organisms rests solely on their recognition on microscopical search, it is very difficult to say when sterilization of the infection has been achieved. Claim to "complete success as a cure" is therefore not warrantable at least until many years of close study and repeated examination support it.

It has always seemed probable that the derivatives of diamino-diphenylsulphone (D.D.S.) are not active as such but that they owe their activity to hydrolysis with liberation of the parent substance. D.D.S. was stated initially to be too toxic for use in man; with suitable modification in dosage it now is used by many workers; the results of treatment with it appear to be at least as good as those obtained with the more expensive and complicated compounds. The maximum tolerated dose of D.D.S. by mouth is stated to range from 100 to 300 mg. a day. A dose of 30 to 50 mg. of D.D.S. a day is said to be effective; for mass treatment in Nigeria up to 400 mg. are given twice a week.

Diasone is given orally in doses of up to 2 g. daily; promizole or sulphetrone orally in doses up to 6 or 8 g. daily, though 2 to 4 g. daily have given good therapeutic results. In every case the initial dosage of D.D.S., or its derivatives, must be very small; it is gradually increased, with caution, to the full dosage over a period of not less than about three months. Precipitate increase in dosage may cause lepra fever and a flare-up of the disease; the serious toxic effects of the drug include the development of a severe anaemia; this must constantly be watched for. Reduction

in the dosage of the drug, or even its suspension, may be necessary in these events. As habituation is established the risk of toxicity diminishes. Treatment should continue over many months, or even many years, with or without intermissions of a week or two from time to time, as appears necessary in the individual case.

Arm Girth and Blood-pressure Readings

Q.—Does excessive girth in the arm affect the accuracy of blood-pressure readings; if so, in which direction and to what extent?

A.—Using a standard blood-pressure cuff (9×5 in.—23.9×12.7 cm.) excessive girth of the arm is likely to result in a reading that is too high. This general principle is well illustrated by the use of the standard cuff on the thigh when attempting to take blood-pressure readings in the legs. These are invariably too high when compared with direct intra-arterial records. To a certain extent the difficulty can be overcome by using a larger cuff. When a larger cuff is used on a normal arm the reading obtained is likely to be too low. Similarly, the standard cuff used on the thin arm of a child also tends to give readings that are too low. Unfortunately it is very difficult to correct these errors by using suitable cuffs for each patient, because without experiment it is almost impossible to know what size cuff in any individual will give the most accurate reading. It is not a bad policy, however, to carry three sizes of cuff, large, standard, and small. Alternatively, one can simply bear the principle in mind. If one is aware of a likely error there is less chance of being seriously misled.

Nutritional Value of Gelatin

Q.—After ox bones, etc., have been boiled in water for some hours the whole, on cooling, sets in a firm jelly, and presumably this is due to osseous gelatin. What value is this jelly to starved persons or patients suffering from protein depletion?

A.—Gelatin from any source is deficient in the amino-acids tryptophan and tyrosine, and was at one time considered to be of little nutritional value. Rats are quite unable to grow when given gelatin as their sole source of protein. Experiments by Chick, however, have shown that when two defective proteins are eaten together one may often make good the deficiency of the other. Thus she has clearly demonstrated that the gelatin of beef tea and protein of bread have a much greater nutritional value when taken together than when consumed separately. The jelly from bones should therefore be of considerable value to starved or protein-deficient persons if received in adequate quantities in conjunction with a vegetable protein capable of compensating for its defects. As a source of protein the combination would still not equal milk or meat, but ease of digestion might well outweigh this defect in the first stages of the rehabilitation after starvation.

Acute Thyroiditis and Influenza

Q.—I have seen a case of acute thyroiditis following influenza in the recent epidemic. Is this a recognized complication of influenza, and, if so, how frequent is it? How is it caused, and what is the prognosis?

A.—Acute thyroiditis is a very rare condition. It has been recorded in influenza, but so infrequently that it could scarcely be regarded as a recognized complication. It has also been described in scarlet fever, typhoid fever, malaria, and septicaemia; it may result by extension from an infected wound of the neck or from adjacent cellulitis or abscess. In typhoid fever, the typhoid bacillus has been cultured from the pus, with or without other pyogenic organisms, suggesting that the infection is blood-borne. In influenza, the cause would most probably be one of the secondary

invaders and not the influenza virus. According to most writers the condition usually resolves, but it may go on to pus formation, and there is then danger of invasion of the cellular planes of the neck. Modern chemotherapy should control the condition.

Pethidine Addiction in Gout

Q.—A man of 38 who has gout insists on 200 mg. pethidine daily to control the pain. Is this a case of pethidine addiction, and, if so, what should be done about it?

A.—Certainly this is a case of pethidine addiction. Gout never justifies daily administration of powerful analgesics. No addict can be treated satisfactorily at home. You should insist on his entering a hospital or nursing-home. The drug should then be fully withdrawn within three days and the patient kept under observation in the institution for a month. No details are given in respect of the gout, and therefore this aspect of the case cannot be dealt with.

Dipsomania in the Aged

Q.—What is considered the best method of treating a dipsomaniac man aged 78 at home? Would "antabuse" be any good?

A.—Surely the point here is that either the dipsomaniac tendencies create a social problem or they do not. If they do, is it right and proper that the patient should go on being treated at home? If there is a real problem he would best be put in a home for the aged, where he could be adequately supervised; or if he is a well-off man he could be cared for by having a male nurse in personal attendance. I would certainly not suggest "antabuse" in this case. The treatment is physiologically depressing and would not be tolerated by a man of this age.

Syphilis in Women

Q.—Syphilis is said to be a milder disease in women than in men. Is this true, and, if so, why?

A.—All observers are agreed that syphilis is a much milder disease in the female than in the male, the routine blood test often being the only method of diagnosis even in women who have infected their sexual partners or offspring. Acute manifestations are, of course, sometimes seen in women, especially before puberty or after the climacteric, more rarely during the reproductive period. It will also be found that females, much more frequently than males, suffering from latent syphilis or late manifestations (cardiovascular or nervous) give no history of signs of primary or secondary stages.

The benign course of syphilis in the female has been attributed to the beneficial effects of pregnancy, but, as Moore states, "recent experimental studies have shown that the female sex hormones are probably equally responsible." The biochemistry in both pregnancy and menstruation may, as suggested by some workers, cause reactions similar to those following non-specific shock therapy.

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: *Aitology, 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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