SOCIETIES AND LECTURES

A fee is charged or a ticket is required for attending lectures marked ●. Application should be made first to the institution concerned.

Monday

EDINBURGH UNIVERSITY.—At Physiology Class Room, June 18, 5 p.m., "*The Social Science*," by Dr. Douglas Guthrie.

LONDON UNIVERSITY.—At Westminster Medical School (Meyerstein Lecture Theatre), Horseferry Road, London, S.W., June 18, 5.30 p.m., "*Male Fertility*," Special University Lecture in Medicine by Dr. Edmond J. Farris (Philadelphia).

Tuesday

●INSTITUTE OF DERMATOLOGY, Lisle Street, Leicester Square, London, W.C.—June 19, 5 p.m., "*Cutaneous Manifestations of Visceral Malignancy*," by Dr. L. Forman.

ROYAL COLLEGE OF SURGEONS OF ENGLAND, Lincoln's Inn Fields, London, W.C.—June 19, 3.45 p.m., "*A Critique of the Present Concepts of Synovial Reactivities, with Special Reference to the So-called Synoviomata*," Arnott Demonstration by Dr. H. D. Ross. (See also June 22.)

SOUTH-WEST LONDON MEDICAL SOCIETY.—At Bolingbroke Hospital, Wandsworth Common, London, S.W., June 19, 8.30 p.m., "*The Origin, Past History, Present Position, and Future Prospects of the General Practitioner*," Bolingbroke Lecture by Mr. V. Zachary Cope, M.S., F.R.C.S.

WEST END HOSPITAL FOR NERVOUS DISEASES, 40, Marylebone Lane, London, W.—June 19, 2.30 p.m., "*Spinal Compression*," clinical demonstration in neurology by Mr. G. C. Knight.

Wednesday

●INSTITUTE OF DERMATOLOGY, Lisle Street, Leicester Square, London, W.C.—June 20, 5 p.m., "*Medical Mycology—Systemic Infections*," by Dr. R. W. Riddell.

Thursday

ROYAL SOCIETY, Burlington House, Piccadilly, London, W.—June 21, "*Reactions in Monolayers*," Bakerian Lecture by Professor E. K. Rideal, F.R.S.

ROYAL SOCIETY OF TROPICAL MEDICINE AND HYGIENE.—At 26, Portland Place, London, W., June 21, 7.30 p.m., annual general meeting, to be followed by an ordinary meeting. "*Filariasis in Fiji*," film by Sir Philip Manson-Bahr; "*Two New Cultures of Mycobacterium Leprae Hominis (Strains Chaves and Emilia) Pathogenic for Macacus Rhesus and Man*," demonstration by Dr. H. C. de Souza-Araujo.

ST. GEORGE'S HOSPITAL MEDICAL SCHOOL, Hyde Park Corner, London, S.W.—June 21, 4.30 p.m., "*Neurology*," lecture-demonstration by Dr. Denis Williams.

Friday

INSTITUTE OF DERMATOLOGY, Lisle Street, Leicester Square, London, W.C.—June 22, 5.30 p.m., clinical demonstration by Dr. F. R. Bettley.

ROYAL COLLEGE OF SURGEONS OF ENGLAND, Lincoln's Inn Fields, London, W.C.—June 22, 3.45 p.m., "*A Critique of the Present Concepts of Synovial Reactivities, with Special Reference to the So-called Synoviomata*," Arnott Demonstration by Dr. H. D. Ross. (See also June 19.)

Saturday

LONDON ASSOCIATION OF THE MEDICAL WOMEN'S FEDERATION.—June 23, 2.30 p.m., visit to St. Helier Hospital, Wrythe Lane, Carshalton, Surrey.

BIRTHS, MARRIAGES, AND DEATHS

BIRTHS

Alexander.—On June 2, 1951, to Dr. June Alexander (formerly Tyson), wife of Dr. J. Gordon Alexander, Ellerburn, Nunburnholme Avenue, North Ferriby, E. Yorks, a daughter.

MARRIAGES

Gibson—Stark.—On June 1, 1951, at Cliftonhill Parish Church, John Baird Gibson, M.B., Ch.B., D.A., Paisley, to Agnes Macfarlane Stark, M.B., Ch.B., M.R.C.O.G., Coatbridge.

Redmond-Henderson—Redmond.—On June 1, 1951, in London, Sidney Redmond-Henderson to Winifred Helen Redmond, M.R.C.S., L.R.C.P.

DEATHS

Douglas.—On June 3, 1951, at Longmore Hospital, Edinburgh, Andrew Richmond Douglas, M.B., Ch.B., aged 72.

Gray.—On June 5, 1951, in hospital, Leo Patrick Gray, M.B., Ch.B., husband of Elizabeth Gray (formerly Wheatley), M.B., Ch.B., D.P.H., of Woodford Green, Essex, formerly of 97, The Ridgeway, Chingford, London, E.

Harries-Jones.—On June 7, 1951, at the General Hospital, Northampton, Evan Harries Harries-Jones, M.D., of The Cottage, Church Brampton, aged 77.

Longstaff.—On June 7, 1951, in South Africa, Eadbert Ralph Collison Longstaff, M.R.C.S., L.R.C.P.

Pedersen.—On June 4, 1951, at 27, Macdowall Road, Edinburgh, Peder Nielsen Pedersen, M.B., F.R.C.S.Ed., aged 70.

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.

"Three Months' Colic"

Q.—*Our baby is inclined to be wakeful from the 6 p.m. feed till 8 p.m., and, as she is 3 months old, being wakeful leads to howling. I am confident there are no dietetic errors. Is it in any way harmful to put ¼ gr. (16 mg.) phenobarbitone in the 6 p.m. feed? We have found this most effective.*

A.—It sounds very much as if this is the so-called "three months' colic," which is very common in the first three months of life, usually getting better soon after the third month. The cause of this is by no means certain. Brennemann (*Practice of Pediatrics*, 1949: W. F. Prior Co., Inc., Hagerstown, Maryland) discusses it in detail, and thinks that it is due to colonic flatulence with temporary kinks in the intestine. It is also discussed in Spock's excellent little book *Baby and Child Care* (1947: American Pocket Book Series).

The colic appears characteristically between 6 p.m. and 10 p.m. It is difficult to relieve, though sucking at the breast does appear to help. I see no harm at all in giving phenobarbitone ¼ gr. if it is found to give relief, but it should be dropped off as soon as possible, so that the child does not get to need it in order to sleep. Wakefulness at this time may also be due to habit in a child who was in earlier weeks necessarily picked up a great deal in the evenings as a result of colic (Spock, B., *Pediatrics*, 1949, **4**, 89, and Illingworth, R. S., *British Medical Journal*, 1951, **1**, 722).

Trauma and Parkinsonism

Q.—*Is trauma recognized as an occasional factor in the production of parkinsonism?*

A.—References to proved cases of traumatic parkinsonism are extremely rare. On theoretical grounds it is clearly a possibility for very deep trauma to affect the basal ganglia, by either a penetrating wound or haemorrhage, but usually patients do not survive such disasters. I have personally seen two cases in which a very grave psychological disturbance without actual injury was responsible for the production of a parkinsonian disturbance within a matter of hours. In a paper by Kremer, Ritchie Russell, and Smyth (*J. Neurol. Neurosurg. Psychiat.*, 1947, **10**, 49) are described a number of cases of mid-brain disturbance with parkinsonian features, dysarthria, and cranial nerve palsies.

Abnormal Hand and Eye Dominance

Q.—*What symptoms would lead one to suspect abnormal hand and eye dominance in a child, and how is dominance effectively demonstrated?*

Is abnormal dominance likely to have an adverse effect on a child's behaviour or his progress at school, and what advice should be given to parents and teachers in these cases?

A.—In answering this question it is presumed that the term "abnormal dominance" is used by the questioner to describe left-handedness with left-eyedness, as well as uneven lateral dominance such as is demonstrated by a child who is left-handed but right-eyed or the reverse. Signs of this condition in an intelligent child may be backwardness in reading and writing, associated with the writing of letters in mirror-form and of words from right to left. Such signs, however, are no more than suggestive, and may indicate only a particular developmental stage, negativism or, in reading especially, some difficulty in auditory synthesis. Considerable research has been directed to the relationship

between educational retardation and both cross-lateral dominance and left-handedness, with inconclusive results. Both Monroe[1] and Schonell[2] found in cases of reading difficulty a higher incidence of crossed-laterals and left-handers than among controls, but their control groups proved to contain 41% and 40% respectively of children who were not both right-eyed and right-handed, findings which suggest caution in assuming that right-hand-plus-eye dominance is normal for the general population.

Testing for dominance is an expert job best carried out by an educational psychologist or by a psychiatrist who has given special attention to the problem. Rough tests would include observation of which hand is commonly preferred by a child for a wide range of activities, including writing, throwing, winding, stirring, cutting, and sorting. A useful test for eye dominance is to get the child to look through a hole in a card held about 15 in. (38 cm.) from his face at a small object, such as a sixpence, on the floor: he looks first with both eyes, then with each in turn while the other is covered, and without moving either head or card: the eye with which he can still see the object is the dominant one. The test should be repeated three times with different objects, but even then it is not infallible, though strongly indicative if the results are consistent.

Although the less usual dominances may to some extent impede educational progress, it seems probable that they do so largely by acting as the last straw when there exists already some personality stress in the child or teaching methods which discourage individuality. It is often inhibiting to be labelled an oddity.

Parents and teachers may be assured that there is nothing abnormal about the child who is not right-eyed and right-handed, and that the best way to help him is by making learning a desirable and enjoyable part of social adaptation. In addition, orientation difficulties may be diminished by the use of a pencil to guide a child's eyes from left to right in reading, and by attention being drawn to initial letters. Writing is helped by tracing in coloured pencils until a left-to-right habit is established, by the use of the "Writing Pattern Method" of Marion Richardson, which is familiar to most teachers and by children looked on as a pleasant game.

REFERENCES

1 Monroe, M. (1928). *Methods for Diagnosis and Treatment of Cases of Reading Disability*. Clark University Press, Worcester, Mass.
2 Schonell, F. J. (1942). *Backwardness in the Basic Subjects*. Oliver and Boyd, Edinburgh.

Stump Carcinoma

Q.—*Is stump carcinoma of the cervix more frequent in patients in whom ovarian tissue has been conserved at the time of the subtotal hysterectomy?*

A.—The writer does not know of any published work which allows a firm answer to this question. Moreover, considering the many issues involved, for example, the indication for the operation, and the large number of cases of subtotal hysterectomy with and without oophorectomy which would have to be followed for many years, it would probably be difficult to produce significant statistics.

The implication that ovarian function is important in the development of carcinoma of the cervix is rather refuted by the general experience that the growth is more common in post-menopausal than in pre-menopausal women. Moreover, J. McL. Morris and J. V. Meigs (*Surg. Gynec. Obstet.*, 1950, **90**, 135) record 75 cases in which the growth developed in women previously subjected to bilateral oophorectomy. Several of these are no doubt included in their 143 cases of stump carcinoma, but it is not clear how many. F. Saegesser (*Gynaecologia, Basel*, 1947, **123**, 89) goes so far as to express the opinion that removal of the ovaries at the time of subtotal hysterectomy *increases* the risk of the subsequent development of cervical carcinoma. The evidence does not yet permit a conclusion for or against this or other views, but it does indicate that it is by no means uncommon for cancer, and indeed other growths such as fibroids, to arise in a cervical stump after ablation of ovarian function.

Blood Changes during Pregnancy

Q.—*What is the normal range of E.S.R., red blood cell count, and haemoglobin level in pregnancy?*

A.—The limits of normality in respect of E.S.R., red cell counts, and haemoglobin levels in normal pregnancy are not well defined. However, most workers would probably accept the data of Bethel, Gardiner, and MacKinnon (*Ann. intern. Med.*, 1939, **13**, 91) as being approximately correct. They conclude that red cell counts of less than 3,500,000 per c.mm. and a haemoglobin content of less than 10 g. per 100 ml. indicate anaemia. They record the following data as *average* figures for the different months of pregnancy.

	4th	5th	6th	7th	8th	9th	month
R.B.C. ..	4.47	4.20	3.93	3.94	4.02	4.04	mill. per c.mm.
Hb	11.8	11.4	11.0	11.1	11.2	11.2	g. per 100 ml.

The published limits for the E.S.R. in normal pregnancy indicate a very wide range. A review of relevant literature is given by Nichols (*J. Lab. clin. Med.*, 1942, **27**, 1317).

Post-mortem Appearances in Byssinosis

Q.—*Could you tell me the post-mortem findings to be expected in a case of byssinosis?*

A.—Unlike most other industrial pulmonary diseases, byssinosis presents no distinguishing post-mortem findings. At least this is the generally accepted view at present. The findings are those of emphysema, usually with chronic bronchitis and often with those of congestive heart failure. Shaw, Dunn, and Sheehan reported necropsies on 10 cotton workers, five of whom were strippers and grinders, and four of the latter showed hypertrophy of the right ventricle which indicated the severity of the condition (*Report of the Departmental Committee on Dust in Card Rooms*. Home Office. 1932. H.M.S.O., London). They noted the following negative points: (1) By use of the polarizing microscope, no trace of cotton fibre was found in the lungs or bronchial lymphatic glands in any case. (2) No feature was detected by which the cases of chronic bronchitis and emphysema might be differentiated from other cases of the same condition that have been observed in other workers.

Cotton workers with byssinosis must have worked for long periods in card rooms, blow rooms, or cotton rooms. It is not a disease suffered by spinners or weavers. The occupational history is therefore important.

Polycythaemia and Transfusion

Q.—*I understand that the blood from patients suffering with polycythaemia vera should not be used for transfusion. What is the reason for this?*

A.—Blood from patients suffering from polycythaemia vera is used in some haematological centres for transfusion. Because of its raised red cell count, such blood offers a convenient means of introducing a high concentration of haemoglobin. On the other hand its increased viscosity and its tendency to clot make the collection difficult. A wide-bore needle, a large volume of anticoagulant, and thorough mixing of blood and anticoagulant solution help to overcome these difficulties.

Myeloid leukaemia may develop in patients suffering from polycythaemia vera. This blood should not be used for transfusion.

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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