Amenorrhoea or infrequent menstruation is also to be expected; a scanty regular loss is not necessarily indicative of hypoplasia.

However, even if uterine hypoplasia is proved to exist, there is no evidence that the condition *per se* lowers fertility, despite the general statements to the contrary which are found in most gynaecological textbooks and in monographs on infertility. Why should it? A small cavity with ill-prepared walls does not prevent conception, as the frequent occurrence of tubal pregnancy proves. It might, however, favour abortion. The only circumstance in which uterine hypoplasia is *associated* with infertility is when it is the result of inadequate ovarian function. In such case the uterus can be made to grow to normal size with oestrogen, but this does not raise fertility and the effect is only temporary. For the real cause of the sterility is failure of the ovary to produce ova, so treatment should be directed to the establishment of ovulation, even though the results are generally unsatisfactory. If uterine hypoplasia occurs despite normal ovarian function, then it is presumably because the uterus is unresponsive to ovarian hormones. It is the target organ which is at fault, the fault being unknown but allegedly inherent. In that case treatment with oestrogens is not likely to affect the uterus at all.

A critical, some may say hypercritical, outlook leads to the conclusion that uterine hypoplasia is more often a convenient label than a proved state; and that when it is present its treatment is either unnecessary or is doomed to failure unless its cause can be traced and corrected.

Methylpentynol in Pregnancy

Q.—*I should be glad to know whether there is any danger in expectant mothers taking methylpentynol before visiting the dentist, especially when they are going to have gas.*

A.—There are no reports in the literature to suggest that methylpentynol is dangerous for expectant mothers. It is destroyed in the body very much like ordinary alcohol, and the ill effects of too much methylpentynol resemble the effects of too much alcohol.

Treatment of Bee Stings

Q.—*What is the best treatment for bee stings? I am a member of a bee club and have been asked for advice.*

A.—Bee stings may result in a local reaction due to the injected bee-venom, a more generalized allergic reaction, or both.

The sting should be gently removed. Local therapy consists in the application of an antihistaminic ointment: various alkali solutions are also of help—for example, soap, sodium bicarbonate, methylene blue, weak ammonia, or calamine. For the milder urticarial reactions an antihistaminic drug, preferably one that does not cause drowsiness, ephedrine, or a combination of these two should be given. For the severe allergic reactions, angioneurotic oedema, severe dyspnoea, collapse, or unconsciousness, 1:1,000 adrenaline should be given in doses of 5–10 min. (0.3–0.6 ml.) and repeated as necessary. Some sensitized bee-keepers have found taking a small dose of ephedrine prior to handling the bees a means of reducing the severity of their reactions. All might well be advised to carry with them ephedrine and an antihistaminic to take as soon as they are stung, while the more severely affected should carry isoprenaline.

"Desensitization" or hyposensitization presents a series of difficult problems which are well discussed by Mueller and Hill, of Boston.[1] Isolated successful cases have been recorded, but it is not known for a series of patients what proportion would be adequately protected nor for how long the protection is likely to last once the injections are stopped. Bee-venom antigen is available from commercial firms, but skin testing and hyposensitization should be advised and carried out by an expert, for the antigen is a potent one. As in the treatment of hay fever, the dosage depends on the degree of sensitivity and even in skilled hands carries some risk of untoward reactions occurring. One might expect the results to be similar to those of hyposensitization to hay fever and other immediate wealing allergies. The writer hesitates to advise hyposensitization except in individual cases and only when undertaken by experts.

REFERENCE

1 Mueller, H. L., and Hill, L. W. (1953). *New Engl. J. Med.*, **249**, 726.

Sparks from a Silk Shirt

Q.—*When I wear a leather corset and an artificial silk shirt the crepitations and sparks of static electricity are observed on removal of the shirt. Are such sparks sufficient to ignite ether or petrol?*

A.—The only safe answer is yes, though the risk of ignition of dangerous vapours by the crepitations and sparks alone is probably small and would require the co-existence of various other favourable factors. Nevertheless, in these kind of circumstances no avoidable risk, however slight, should ever be incurred. The conditions described in the question are particularly favourable to the development of static charges of high potential.

It has long been known that the ordinary movements of an anaesthetist, or other person in an operating theatre, can build up in himself a high charge of static electricity. Should he then approach or handle an object of lesser electric potential a spark will be formed sufficient to ignite or explode any dangerous vapour in the vicinity. This is known to be the explanation of many disasters that have occurred. If ordinary movements can do this, how much more so will the relatively violent ones described in the question? Silk is considered to be specially dangerous, and other fabrics may be little less dangerous. The risk of such accidents is much accentuated by the use of footgear made of ordinary non-conductive rubber or other similar material and also by furnishing operating rooms with non-conducting floor coverings such as linoleum.

Specific Desensitization to Foods

Q.—*An asthmatic child has been advised to avoid milk, fish, eggs, cheese, chocolate, and nuts. As it will be difficult to provide such a diet, can you please advise me whether it would be worth undertaking specific desensitization, and, if so, how should it be done?*

A.—Specific desensitization to foods is not advised. Neither oral nor parenteral "hyposensitization" have been proved to be effective, and both methods are considered by most authorities to be ineffective. Complete elimination from the diet and re-testing by ingestion every six months or so is the accepted treatment of proved food allergies.

The writer, however, would emphasize the great importance of not eliminating from the diet of any asthmatic (child or adult) any food unless it has been shown beyond doubt that its ingestion, even when introduced into the diet in a hidden or unsuspected form, repeatedly precipitates asthma.

Correction.—In the Parliamentary report on the consumption of welfare foods (*Journal*, May 14, p. 1228) the word "tons" (of dried milk) should read "tins."

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