

artery owing to atherosclerosis; here only the treatment of patients suffering from intermittent claudication due to this disease will be discussed.

Atherosclerosis is a general disease, and it is important to realize that intermittent claudication is only a local manifestation of a general abnormality. Treatment may be medical or surgical. Medical measures include correction of anaemia, reduction of weight, stopping tobacco-smoking, and the use of vasodilator drugs. Surgical measures include sympathectomy and arterial reconstruction operations.

In many patients it is a mistake to treat intermittent claudication too actively. For example, a successful arterial reconstruction operation may cure this symptom, only for the patient to be stopped by the worse pain of angina pectoris after he has walked a little further than he did before the operation. However, for those patients with severe symptoms and particularly those who cannot work, active measures are desirable. A bypass type of arterial reconstruction operation is the best method of surgical treatment, and, if successful, results in complete relief.

Hyperpyrexia and Survival

Q.—*What are the highest temperatures in children compatible with survival?*

A.—Children are apt to run higher temperatures than adults, but there is no good reason to believe that extreme hyperpyrexia is tolerated better or worse in children than in adults. In adults, Rogers¹ studied the mortality of heat stroke and found it, in two series of cases, to be 8.3% when the body temperature was less than 107° F. (41.7° C.), 29.2% when the temperature was between 107° and 109° F. (41.7–42.8° C.), and 69.2% when the body temperature exceeded 109° F. (42.8° C.). Body temperatures of 112° F. (44.4° C.) with survival have been quoted in the literature.² The same degree of fever is recorded in children.³ A case of hyperpyrexia following a Turkish bath in an adult was reported in last week's *Journal* (p. 443).

REFERENCES

- ¹ Rogers, L., quoted in *Tropical Medicine*, by Rogers, L., Megaw, J. D. W., and McRobert, G. R., 1952. Churchill, London.
- ² Marsh, F., *Lancet*, 1930, 2, 904.
- ³ Héritier, P., *Arch. de Méd. d. enf.*, 1930, 33, 29.

Amoebic Cysts in Drinking-water

Q.—*Is chlorination of drinking-water an adequate safeguard against amoebic cysts?*

A.—Chlorination of drinking-water is not an adequate safeguard against amoebic cysts, and no satisfactory chemical method of eradicating them from drinking-water has yet been devised and proved. Boiling the water remains the only completely satisfactory procedure, but the use of well-maintained Berkefeld filters will also eliminate cysts. It is essential that the filters should be thoroughly cleaned every two to three days, for otherwise there is grave risk of bacterial and other infection of the water which has passed through them.

Antiseptic Powder for Minor Wounds

Q.—*Sensitization to penicillin may follow the use of penicillin and sulphathiazole powder in treating minor wounds. What other antiseptic powder may be used?*

A.—If a powder is insisted on, and assuming that possible sensitization to sulphathiazole is not regarded in the same light as sensitization to penicillin, an effective substitute would be a powder containing 1 part of proflavine hemisulphate in 99 parts of sulphathiazole. This was extensively used before penicillin became available, and its efficacy in preventing sepsis has been proved.

There are many alternatives for the antiseptic treatment of minor injuries apart from the use of a powder. It may often be considered enough to swab out the lesion with a solution of a quaternary ammonium compound such as 1% cetrimide; this has an excellent cleansing action as well as some antiseptic effect. A more powerful antiseptic suitable for this kind of use is hibitane, which may be applied as

a 2.5% aqueous solution, as a 1% cream, or in a lower concentration in a solution combined with cetrimide. Either a powder or a cream has a much more lasting effect than swabbing or irrigating with a solution, and may be preferred when there is any actual reason for suspecting contamination by pyogenic bacteria.

Laying Out the Dead

Q.—*Why do nurses occlude all orifices with cotton-wool when laying out the dead?*

A.—After death a body is carefully washed and wrapped in a clean covering. The orifices are stopped up to avoid the escape of discharges, which otherwise might befoul the clean covering and in some cases might even spread infection. This simple act is therefore a useful sanitary precaution.

Thyroid Treatment for Otosclerosis

Q.—*Is thyroid extract or oral iodine of value in the treatment of otosclerosis?*

A.—Some years ago there was a fashion for injecting thyroxine into the tympanum in cases of deafness due to otosclerosis, the idea being to cause dilatation of the blood vessels in the bony capsule of the labyrinth. The results of this medication were not sufficiently encouraging to keep it from falling into disuse. Thyroid gland extract by mouth and iodine by mouth have been used for otosclerosis, but again the results have been in some doubt and these drugs are not now regularly used.

Otosclerosis is a disease of bone, and the otosclerotic patch of bone appears on the bony capsule of the labyrinth. The favourite site is the small fissure just in front of the oval window, which is often filled with cartilage. It is thought that as the bony labyrinth is fully developed at birth the otosclerotic bone is an attempt on the part of nature to turn any little patches of cartilage into bone, and this is brought about by bone-growth-promoting substances circulating in the blood. During adolescence or during the last two months of pregnancy are favourite times for otosclerosis to begin or get worse, and it is at just these times that cartilage is being turned into bone. It is possible that in some cases iodine or thyroid might interfere with this growth of bone mechanism, in which case a regression of the deafness can be explained.

NOTES AND COMMENTS

Corrections.—In the leading article on acute otitis media (*Journal*, February 8, p. 328) it was said that among J. A. H. Lee's cases of candidates for National Service rejected because of ear discharge a "high proportion" had cholesteatosis. This was incorrect, and in fact he found the condition to be rare.

The peak-flow meter referred to by Dr. J. L. Livingstone (*Journal*, February 22, p. 454) should have been described as designed by Dr. B. M. Wright.

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