

the attacks is a temporary vascular spasm, and if, as is presumably the case, the scotoma affects only one eye, the site of the spasm is most likely to be in the retina, or possibly in the optic nerve. If, however, both eyes are affected, then the site of the lesion is likely to be in the occipital cortex. Recurrent visual disturbances may occur as a "migraine equivalent" without any accompanying headache. In such instances there is usually a family history of migraine. Another, but remote, possibility is some unusual vascular anomaly such as an angioma or small aneurysmal dilatation in the neighbourhood of the optic nerve which intermittently becomes increased in size and interferes with the blood supply of the macular fibres of the optic nerve, but by now it would almost certainly have caused some permanent defect of central vision.

Weight Changes in Menstrual Cycle

Q.—*What changes in weight are associated with the stages of the menstrual cycle?*

A.—Variations in weight owing to changes in body fluids during the menstrual cycle have long been recognized, but the first full description of "premenstrual oedema" was given by Thomas,¹ who reported weight gains of up to 14 lb. (6.4 kg.) at and during menstruation in women. Several other writers² have concluded that approximately 30% of women have weight gains associated with menstruation. In a recent investigation Chesley and Hellman³ studied 23 normal young women and found that in a third of them the weight was maximal during the premenstrual eight days—in accordance with earlier writers. Closer analysis, however, failed to substantiate the physiological basis of such weight gains, since, when they did occur, they were slight and were not repeated from one cycle to the next. It was further shown that the incidence of premenstrual weight gain was the same as would be expected on a purely random distribution of weight gains throughout the menstrual cycle. These workers also studied the salivary sodium and Na/K ratios throughout the cycle; they were unable to find any consistent pattern of variation such as would have been compatible with increased adrenal salt-retaining secretion during the premenstrual phase.

REFERENCES

- 1 Thomas, W. A., *J. Amer. med. Ass.*, 1933, 101, 1126.
- 2 Chesley, L. C., and Hellman, L. M., *Amer. J. Obstet. Gynec.*, 1957, 74, 582.

Albuminuria and Haematuria

Q.—*Does a negative albumin test render any further tests for haematuria unnecessary?*

A.—Quite simply the answer is no, and a mathematical statement will make this clear. According to Caplan and Discombe,¹ haematuria can be recognized microscopically at a concentration of 5,000 red cells per ml. Direct-vision spectroscopy, which is the least sensitive but most definite test, will show red cells present in a concentration of 2,500,000 per ml., and this indicates a clinically highly significant degree of haematuria. Taking this figure and assuming the usual values for red cells and albumin, the number of red cells in 1 ml. of urine would be contained in 0.5 c.mm. of blood. 0.5 c.mm. of blood would contain 0.02 mg. of plasma proteins and 0.07 mg. of haemoglobin, making approximately 0.1 mg. of protein in 1 ml. of urine. This would be 10 mg. of protein per 100 ml., an amount which is only just detectable by the most delicate tests and not seen in the usual boiling test. From this one can see that bleeding could easily be missed if one waited for the amount of protein arising from the blood itself to be big enough to be detected. As a corollary to this, when protein is present in easily detectable amounts, and the amount of blood present is no more than 2,500,000 R.B.C. per ml., then it is obvious that, besides blood, albumin is also being lost, and this would make it likely that the lesion involves the kidney or that there is ulceration of the epithelial surface.

REFERENCE

- 1 Caplan, H., and Discombe, G., *Brit. med. J.*, 1951, 2, 774.

Bland Lotions

Q.—*Have lotio calaminae, lotio calaminae oleos, and lotio plumbi any therapeutic value in the treatment of skin conditions, or are they merely employed as vehicles for active medicaments?*

A.—These are bland and soothing applications of value in themselves. Many applications are not bland but harmful, and patients often suffer more from the effects of local treatment than from the original complaint. The virtue of these applications is that they are harmless. They may also be employed as vehicles. It is often the patient, his body and mind, that call for active treatment rather than his skin.

Little Girls on Big Horses

Q.—*If a little girl aged about 8 rides a big horse is she likely to suffer genital damage?*

A.—The short answer to this question is in the negative. Small girls have been riding large horses for many years without any ill results being reported. It is conceivable that bruising of the external genitalia might occur, but it must be most unusual and anyway of little importance. There is no obvious way in which riding would cause injury to uterus or ovaries.

NOTES AND COMMENTS

Mild Ulcerative Colitis.—Dr. J. W. PAULLEY (Ipswich) writes: Your reply on the treatment of mild ulcerative colitis ("Any Questions?" March 8, p. 597) carries a serious omission of which the writer must surely be aware. Since Murray¹ first discovered the influence of emotional factors in this disease in 1930, this finding has been confirmed many, many times. Psychotherapy is now the most valuable medical approach to this disorder,²⁻⁷ and the majority of sufferers can be kept well by it, which is more than can be said of any other existing treatment, including steroids and short of surgery. It can be carried out by anyone willing to learn the technique and give the necessary time. Incidentally, a low-residue diet is useless; it diverts the patient's mind from the real cause of the disease, provides a dull, unappetizing fare, and adds nothing towards healing. Great are the gratitude and surprise of any patient when, after years of purées and no salads, he finds he can eat what he likes without ill effect.

REFERENCES

- 1 Murray, C. D., *Amer. J. med. Sci.*, 1930, 180, 239.
- 2 Groen, J., *Psychosom. Med.*, 1947, 9, 151.
- 3 Paulley, J. W., *Gastroenterology*, 1950, 16, 566.
- 4 Groen, J., and Bastiaans, J., *ibid.*, 1951, 17, 344.
- 5 Grace, W. J., Pinsky, R. H., and Wolff, H. G., *ibid.*, 1954, 26, 462.
- 6 Paulley, J. W., *Lancet*, 1956, 2, 215.
- 7 Groen, J., and Van der Valk, *Gastroenterologia (Basel)*, 1956, 86, 591.

Correction.—In the answer to the question on a scheme for immunization ("Any Questions?" March 22, p. 725), in the first paragraph, line 13, "acid" should be "used"; in the third paragraph, line 1, "present" should be "prevalent"; and in the first reference "London, I. S. L." should be "Loudon, I. S. L."

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