Any Questions?

We publish below a selection of those questions and answers which seem of general interest. It is regretted that it is not possible to supply answers to all questions submitted.

Poliomyelitis in Infancy

Q.—*Since poliomyelitis is said to be rare below the age of 1 year, and must be even rarer below the age of 3 months, is there any need to suspend injections of combined prophylactic during a poliomyelitis epidemic?*

A.—It is not correct to say that poliomyelitis is rare below the age of 1 year and even rarer below the age of 3 months. That no age is immune, in the sense that no age is exempt from contracting the disease, is an agreed fact: numerous cases below the age of 1 month and numerous cases above the age of 60 years have been observed. Recently the writer went over the figures of all *paralytic cases* of poliomyelitis admitted to one infectious diseases hospital during the previous 10 years. There were 314 cases, of which 22 (7%) were under 12 months, 12 under 6 months (2.3%), and 3 under 3 months (0.9%). McMath[1] has recorded recently a case of poliomyelitis with respiratory paralysis in an infant 26 days old, and has pointed out the large number of cases of paralytic poliomyelitis in infants which have been published. The incidence of poliomyelitis in infants is not negligible at present and it carries a heavy mortality (21 deaths in a series of 58).[2]

It must, however, be pointed out that a high proportion of newborn infants do have a passive immunity against all three types of poliomyelitis virus—62% according to Perkins, Yetts, and Gaisford.[3] This passive immunity is due to antibodies from the maternal blood and passes off between the 6th and 9th month. The apparent immunity which has been observed in infants is therefore limited to this group and is practically non-existent after the 9th month. It may well be that, with the present poliomyelitis vaccination campaign, the proportion of passively immune infants will be much higher in the next generation, but, until then, the risks of poliomyelitis in infants after combined prophylactics, especially the alum-containing ones, remain.

The actual number of cases of poliomyelitis in infants under 12 months after combined or alum-containing prophylactics given in the M.R.C. report[4] was 60, and under 6 months nil. But, as the authors of the report remarked, this is "largely a reflection of the small number of prophylactic inoculations given to children less than 6 months old."

REFERENCES
1 McMath, W. F. T., *Brit. med. J.*, 1959, 1, 98.
2 Bates, T., *Amer. J. Dis. Child.*, 1955, 90, 189.
3 Perkins, F. T., Yetts, R., and Gaisford, W., *Brit. med. J.*, 1958, 2, 68.
4 M.R.C. Report, *Lancet*, 1956, 2, 1223.

Sulphonamides in Pneumonia

Q.—*Have sulphonamides still a place in the treatment of pneumonia?*

A.—It is certainly reasonable to treat patients with pneumonia by means of sulphonamides. However, with the possibility of using phenoxymethyl penicillin by mouth, the sulphonamides have no longer this particular advantage. Also, if the infecting organism is a staphylococcus it will not be affected by the sulphonamides, whereas outside of hospitals it is very likely that penicillin will be effective against it. I think that on the whole the advantages of using penicillin are slightly greater than relying on the sulphonamides.

Inheritance of Myotonia Congenita

Q.—*A patient has two brothers affected with myotonia congenita. What is the likelihood of the patient having children similarly affected?*

A.—Myotonia congenita, or Thomsen's disease, is due in Dr. Thomsen's own family, in which there have now been 64 affected members, to a dominant mutant gene. In some other families, as in the patient's, only a pair of siblings were affected and the mode of inheritance is not clear.[1] No exact genetic prognosis can be given, but if the patient himself has no signs of myotonia congenita there is probably not a high risk of his children being affected.

REFERENCE
1 Thomasen, E., *Myotonia, Thomsen's Disease, Paramyotonia, Dystrophia Myotonica*, 1948. Copenhagen.

Sensitivity to Antihistamines

Q.—*Should mepyramine maleate be given by mouth to a patient who is sensitive to it when applied locally in a cream? Is there any substance in this group which it would be safe to give him?*

A.—It would certainly be risky to give mepyramine maleate by mouth to a patient who is sensitive to local application. Sensitivity to local application of antihistamine drugs is very common, and it is generally agreed that it is most unwise to use creams, etc., especially for any length of time. Oral administration is more effective for relieving itching skin conditions. Drugs similar in chemical structure to mepyramine maleate would be likely to cause sensitivity again in this patient. These are tripelennamine, methapyrilene, halopyramine, chlorpheniramine. Avoiding these, we still have a wide choice—for example, diphenylpyraline, chlorcyclizine, buclizine, triprolidine, etc.

NOTES AND COMMENTS

Ethyl Chloride, Nitrous Oxide, and Oxygen Mixture.—Dr. H. B. SANDIFORD (Southsea, Hants) writes: In the *Journal* of January 28, 1958 ("Any Questions?" p. 236) there was a question on apparatus for using ethyl chloride in an open circuit, particularly with a McKesson machine. The reply stated that there was no commercially available vaporizer to use ethyl chloride with the McKesson, Boyle, or Walton apparatus. This was not quite correct, as a reference was given to a very useful piece of apparatus designed by Dr. P. R. Bromage.[1] Some years ago I was given one of these by the McKesson Company and have used it with success ever since. One problem has been to get the necessary size of ethyl chloride container, but the British Oxygen Company has now made simple alterations to the original apparatus and any size of bottle can now be used. As stated in your answer to the original question, overdosage with ethyl chloride is a danger. If it is only given to a pink patient and in a dose of approximately 0.5 ml., which can be repeated, in my experience the risk is very small and the technique is useful from time to time, especially for dental extraction in young children.

REFERENCE
1 Bromage, P. R., *Anaesthesia*, 1950, 5, 94.

Correction.—In the letter on "Common Bile Duct after Cholecystectomy," from Mr. W. M. Capper and Mr. W. J. Gall (*Journal*, April 11, p. 973) "pre-operative" in the fourth line of the third paragraph should have read "per-operative." In the penultimate line of the letter the upper limit for the diameter of a normal duct should have been 10–11 mm. (*not* cm.).

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