The Fatherless Child

Q.—*It is universally recognized that adopted children should be told the truth concerning their adoption, but I should be grateful for advice on what an illegitimate child should be told about his father. My maid, whose fiancé deserted her during pregnancy, has a son aged 15 months. The father of the child, who has not seen the mother since the pregnancy was discovered, is still living in the local market town, so a meeting is always possible, though unlikely; this prevents our telling the child his father is dead.*

A.—The difficulty in this case is, to a great extent, that of all mothers who have sole charge of their children, whether the absence of a father be due to death, desertion, or divorce. Fortunately, there is in the mind of the very young child no distinction between absence and death, so that the phrase "Daddy has gone away" covers all contingencies up to the age of at least 3 years. It is usually best to begin to instil this idea gently between 18 months and 2 years, so that it becomes accepted as a matter of course, thus avoiding the sudden shock of realizing the lack of a father in the home. When later there comes the inevitable question: "Is daddy coming back?" this can be answered by, "I don't think he will," and gradually explaining the truth as the child becomes old enough to understand.

Much more important than the actual telling is the manner of doing so. When a mother is the only parent known to her child, she will, if she is wise, accept a dual identity to him, since his relationship to her must be coloured by his conception of the missing father. If the latter is said to be a bad man who deserted his wife the child will also feel rejected, and will probably develop fantasies that this happened because he himself was bad. When guilt feelings so precipitated become intolerable he may well swing to the other extreme, passionately identifying himself with his father as a good figure and rejecting his mother. It may be very hard for this mother to speak of the father only with kindness and without apparent anxiety or self-pity, especially when she has to tell that they parted before her son was born, but if she can bring herself to do this she will avoid many troubles in his upbringing. Her generosity will be repaid by a secure mother–child relationship unlikely to be seriously shaken should the father meet his son in later years.

"Happy Feet"

Q.—*A patient who was a Japanese prisoner of war for 3½ years and had severe dysentery and beriberi still suffers from leg pains and the condition referred to as "happy feet." His cardiovascular system and chest are sound. Is there any specific treatment apart from aneurine for the feet? Crystalline vitamin B_1 is mentioned in the literature—what are the dose and the route, and for how long should I try it?*

A.—It is unlikely that vitamin therapy will improve the patient at this stage. Presumably he has been under treatment for some time. If deficiency of the vitamin B complex is sufficiently prolonged, irreversible changes occur in the nervous system. It is very doubtful if aneurine will have any effect. "Happy feet" has been treated by various B vitamins, including riboflavine, nicotinic acid, and vitamin B_6. The dosages of these are 5 mg., 300 mg., and 100 mg., daily, respectively. If flushing occurs with nicotinic acid, nicotinamide can be used instead. If some improvement does not occur within a week or two, either the condition is not one of deficiency disease or irreversible nerve changes have occurred.

Toxicity of the Chlorbenzenes

Q.—*What are the toxic effects of para-dichlorbenzene, which is used as an insecticide in the form of a paste pressed into tablets? I am interested in any possible toxicity conveyed to workers handling this substance during its manufacture from a grey powder into tablet form.*

A.—As a general rule the introduction of chlorine into an aliphatic compound increases its toxicity, while in the case of an aromatic compound the reverse is true. Thus, the chlorbenzenes are less toxic than benzene. There is evidence, however, to suggest that the substitution of chlorine in the benzene ring increases toxicity with each successive chlorine atom up to two, while further chlorination reduces toxicity. The structural position of the chlorine atom also influences toxicity, but there is conflicting evidence as to whether para- or ortho-dichlorbenzene is the more toxic. The more recent work seems to favour the view that the ortho preparation is more toxic than the para isomer. Some of the chlorinated benzenes are solids and insoluble in water; thus the potentialities of the solvent must be considered also. There is sufficient evidence to justify strict measures to prevent ingestion or inhalation of dust or fume of the chlorbenzenes. Headache, dizziness, and unconsciousness are the result of acute poisoning; the later manifestations of ill effects might be those associated with damage to the liver, and possibly kidneys, while the blood might show leucotoxic effects. Much of this summary of the ill effects of chlorbenzenes is based on animal experiments, and there seems no reason why work with this compound, which has been used extensively in veterinary therapeutics and as an insecticide, should not be undertaken with safety under reasonable conditions. Variations in individual susceptibility are likely.

Gangrene of Toes

Q.—*I have two patients: (a) an old man of 78 with gangrene of two toes from senile arteriosclerosis only; and (b) a man of 46 with previously undiagnosed diabetes who has moist gangrene of three toes of one foot and severe skin changes to the region of the instep. When his diabetes has settled, at what site should amputation be carried out if the dorsalis pedis is not pulsating palpably on that foot?*

A.—In both patients amputation is indicated—more urgently in the diabetic case. In this latter the diabetes must first be stabilized by insulin and a suitable diet. In both cases to wait for natural separation of the gangrenous tissue is to subject the patient to much unnecessary pain and to an unjustifiably long stay in hospital; in the diabetic case delay is definitely dangerous—the risk of infection being so great. If the dorsalis pedis artery is impalpable, the correct site for amputation is the lower third of the thigh (supracondylar femoral)—the most distal point at which the main arterial diameter is appreciably larger than that of the dorsalis pedis.

NOTES AND COMMENTS

Fissured Lip.—Dr. R. E. HADDEN (Portadown, N. Ireland) writes: Following on the "Any Questions?" note on "Fissured Lip" in your issue of July 5 (p. 40), you may think it worth while publishing the following. I have found that a satisfactory cure of fissured lip results from injections of riboflavine, 10 mg., repeated after 3 or 4 days, and continuing if necessary; but in my experience 2 or 3 doses are sufficient. Tinct. benzoin. co. is an excellent local application.

Funds for X-ray Plant.—Dr. E. S. (Hove) calls attention to the special need of a hospital in South India (Chikka Ballapura) under the care of Dr. Cecil Cutting, of the London Missionary Society. An efficient *x*-ray plant is needed, and though the building is waiting, the cost—£1,000—is not to hand. A wide area with a native population is covered, and emergency and accident cases are many. There may be some of our B.M.A. members who would like to help a fellow-member with donations towards the £1,000 needed. If so, would they communicate with Dr. Cecil Cutting through the London Missionary Society, 42, Broadway, London, S.W.? At this crisis of affairs in India the need and opportunity for continuing sympathy and help to the population is great, and the help of medical work is gratefully accepted.

Correction.—In Dr. W. Howlett Kelleher's paper on acute poliomyelitis in the *Journal* of Aug. 23 the figure "37%" in the fifth line of the second paragraph on p. 292 should read "27%."

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.
Authors desiring REPRINTS should communicate with the Publishing Manager, B.M.A. House, Tavistock Square, W.C.1, on receipt of proofs. Authors overseas should indicate on MSS. if reprints are required, as proofs are not sent abroad.
ADVERTISEMENTS should be addressed to the Advertisement Manager, B.M.A. House, Tavistock Square, London, W.C.1 (hours 9 a.m. to 5 p.m.). TELEPHONE: EUSTON 2111. TELEGRAMS: *Britmedads, Westcent, London.*
MEMBERS' SUBSCRIPTIONS should be sent to the SECRETARY of the Association. TELEPHONE: EUSTON 2111. TELEGRAMS: *Medisecra, Westcent, London.*
B.M.A. SCOTTISH OFFICE: 7, Drumsheugh Gardens, Edinburgh.