patient is obese but bad if she is thin. None of these effects are reasons against trying this drug, but a watch must be kept on the patient. There is no evidence that amphetamine produces permanent effects on the central nervous system or any lowering of mental capacity.

Residual Pelvic Abscess

Q.—*About a year ago a woman of 35 was operated on for a perforated appendix; she developed a pelvic abscess a week later which burst into the rectum. After a long convalescence she is now fairly fit, but still has occasional looseness of the bowels, with discharge of pus. She was recently free from symptoms for a whole week. Is the condition likely to recover spontaneously? Is radiological investigation by barium enema free from risk? Is further surgery necessary?*

A.—A pelvic abscess discharging spontaneously into the rectum should heal automatically within a few weeks. The year that has elapsed in this case would seem to make some investigation imperative, and a barium enema should be perfectly safe. Presumably the residual abscess cavity is completely walled off by fibrous tissue. This same fact indicates the line of treatment, which should be a wider opening of the residual cavity into the rectum if the region concerned is reasonably accessible. It might be presumed that failure of resolution has been due to inadequate natural drainage and that possibly further and more adequate opening of the existing communication with the bowel may achieve the required result.

Persistent Nasal Catarrh

Q.—*For the past year a child of 6 has had moderate nasal catarrh, shown by "snorting" at intervals and by mucus being blown from one nostril perhaps two or three times a day. The child mouth-breathes by day but sleeps with the mouth closed, and there is no snoring or cough. What treatment should be given and, particularly, is adenoidectomy advisable?*

A.—The symptoms suggest chronic sinusitis, probably associated with adenoids; but it should be possible to make a definite diagnosis by skiagrams and by mirror examination of the nasopharynx. If there is sinusitis only, instillation of 0.5% solution of ephedrine in normal saline night and morning should suffice. If adenoids are present or suspected they should be removed and the antra punctured and washed out under short general anaesthesia.

Vitamin K and Menstruation

Q.—*An unmarried woman aged 37 took normal doses of vitamin K last winter for chilblains. It proved highly successful, and she is anxious to take it again this winter. Since January, however, she has had only one menstrual period—in April. There is no other apparent cause for the amenorrhoea. Is there likely to be any connexion between the vitamin K and the amenorrhoea, and, if so, is this a contraindication to its use?*

A.—In the doses in which vitamin K is used it has no effect whatsoever on the menstrual cycle. In fact large doses have been given experimentally to suppress menstruation and to treat menorrhagia, but without effect.

Treatment of Peripheral Vascular Disease

Q.—*A male aged 76 suffers from severe pain in his left leg due to atheroma of the arteries. He has no pain when in bed, but suffers acutely when sitting or walking. On rising from a chair he has to stand for a few moments before he can move. Apart from the local condition, his general health is excellent and his heart sound. Can you suggest any drug which I could prescribe?*

A.—It is not common for peripheral vascular disease to cause pain when sitting in a chair, but not when lying, unless erythromelalgia—in which pain is aggravated when the limb is dependent—is present. The medicinal treatment is twofold: by means of simple analgesics and by reputed vasodilators. The effect of the drugs of the second group is unpredictable; although usually disappointing, they should always be given a trial. Papaverine hydrochloride ½ to 1 gr. (32 to 65 mg.) subcutaneously or by mouth, acetyl-β-methylcholine 0.1 to 0.5 g. orally, theobromine sodium salicylate 10 to 15 gr. (0.65 to 1 g.), and nicotinic acid 50 mg. have all been recommended and may be used in these doses three to four times daily. Dried thyroid is sometimes useful. More patients are helped, perhaps, by physical methods such as intermittent venous occlusion.

NOTES AND COMMENTS

Lactating Baby.—Dr. J. C. VALENTINE (Lecturer in Pathology in the University of Bristol) writes: In reply to a question regarding the treatment of lactation in an infant (Oct. 23, p. 768) you suggest the administration of testosterone. While on theoretical grounds this might be of value—since it is known to be effective in inhibiting milk secretion in women—there is some evidence that it may not be effective in the newborn infant. Slobozianu[1] injected testosterone intramuscularly into male and female newborn infants and found that the incidence of enlargement and milk secretion was thereby increased. He did, however, find that with large doses there was some inhibition of milk secretion, but even with 25 mg. doses 12% of the boys secreted milk.

Another method commonly used to inhibit lactation in women is the administration of oestrogens, natural or synthetic. Dr. Margaret Robinson[2] has found that in the newborn the application to the breasts of lint soaked in a 5% solution of stilboestrol in arachis oil, followed by gentle expression of the milk, soon relieves the engorgement. On the other hand Slobozianu injected oestrone intramuscularly into newborn infants and found that this resulted in an increased incidence of mammary enlargement and milk secretion. It would be of interest to know the effect of oral or parenteral administration of stilboestrol. There is additional support for Slobozianu's work in the papers of Abraham[3] and Dobszay.[4] Abraham found that by the injection of oestrin he was able to cause mammary enlargement and secretion in the newborn to return after they had ceased; and Dobszay was able to induce mammary enlargement in the newborn by the injection of oestrin, and then, by the injection of pituitary mammotropic hormone, was able to induce colostrum secretion.

REFERENCES
1 *Schweiz. med. Wschr.*, 1946, **76**, 203.
2 *Brit. med. Bull.*, 1947, **5**, 164.
3 *Med. Klinik*, 1930, **26**, 164.
4 *Disch. med. Wschr.*, 1935, **61**, 1314.

Calcium Iodide for Cataract.—Mr. SYDNEY TIBBLES (London, W.1) writes: In "Any Questions?" (Oct. 2, p. 667) the question and answer given were pretty much the same as those to which I gave a fairly full explanation of my own experience in the *Journal* of Sept. 6, 1947 (p. 404). This provoked no protests but produced many medical men with cataract, one of whom was a well-known eye surgeon, while another, in the late forties, put the commencement of his troubles down to convulsive treatment given for some mental breakdown. In thirty-odd years of using iodides for early lens changes I can only think of four that had to be operated on in the end, and many of my cases have attended and have come back regularly, some for as long as twenty-five years. Two patients with early changes in both eyes have, as test cases, been told to use the treatment for one eye only for the past four or five years, but in each case the eye that had no treatment became worse than its fellow. In the end treatment was commenced for the second eye. This iodide treatment does not profess to cure cataract, but apparently in a very large number of early cases the degenerative changes can be controlled for a large number of years. Before July 5, 1948, a very much larger number of cataract patients in an advanced stage were seen in hospital as compared with private practice. Patients who have to travel a long way to hospital, wasting half a day off from work, often put off their troubles till one eye is blind and the other beginning to fail before they seek advice. The great advantage of eye clinics, such as those sponsored by the B.M.A. (National Eye Service prior to the new N.H.S. scheme), was that the patient could make an appointment to suit himself and seek advice somewhere near where he lived.

Correction.—Mr. E. W. RICHES (London, W.1) points out that in our report of the meeting of the Medical Society of London held on Oct. 25 (Nov. 6, p. 831) it was wrongly stated that he spoke on the use of streptomycin in tuberculous infections of the urinary tract. His paper was concerned with non-tuberculous infections.

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. Authors desiring REPRINTS should communicate with the Publishing Manager, B.M.A. House, Tavistock Square, W.C.1, on receipt of proofs.
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. EUSTON 2111. TELEGRAMS: *Medisecra Westcent, London.*
B.M.A. SCOTTISH OFFICE: 7, Drumsheugh Gardens, Edinburgh.