

meals dry and to avoid hypertonc drinks of glucose or milk. Sometimes sodium bicarbonate before a meal will help, and in other cases hexamethonium in small doses is helpful. Meat at the beginning of the meal may ward off the symptoms, or sometimes lying down immediately after the main meal of the day may be sufficient. It is only in the most severe and crippling cases that further operation is necessary. If this becomes imperative, it is best to convert the Polya to a Billroth I anastomosis, or else to support the lesser curve of the stomach and the afferent loop very firmly to the remains of the gastro-hepatic omentum. In some cases patients who have had indigestion for years will say that a bit of dizziness after meals, and lassitude, with occasional biliary vomiting, is a small price to pay for the complete freedom from pain they have after operation.

The late syndrome comes on about two and a half hours after a meal, and is entirely due to a low blood sugar. The common symptoms are tremor of the limbs, giddiness, and profuse perspiration. For some as yet unexplained reason the blood sugar is low at this stage of digestion and the symptoms respond rapidly to some sugar by mouth or to two-hourly feeding. As soon as the blood sugar rises, the symptoms disappear. It can easily be distinguished from the early syndrome by its time of onset and its response to more food. No special treatment is necessary in this condition, as it always disappears after two or three years. It must be emphasized that these post-gastrectomy syndromes are not common, and usually do not cause any serious inconvenience.

Antituberculosis Drugs and the Heart

Q.—*Is there any evidence to suggest that anti-tuberculosis drugs such as streptomycin, P.A.S., or isoniazid are harmful to the heart in any way? I have had a patient with a history of previous coronary infarction who developed auricular fibrillation after streptomycin, which reverted to normal rhythm on digoxin, but later when given P.A.S., streptomycin, and isoniazid again developed a cardiac arrhythmia and died suddenly.*

A.—The only drug used which might have had an effect on the heart is P.A.S. (*para*-aminosalicylic acid). Potassium deficiency, with weakness and cardiac irregularity, has been described in patients treated with P.A.S.,^{1,2} though there is evidence that the liquorice sometimes used as a flavouring agent may be the important factor.³ Streptomycin and P.A.S. are more apt to delay blood clotting than induce thrombosis, though the concentrations necessary for this effect are unlikely to be reached with the usual clinical doses.⁴

REFERENCES

- 1 Cayley, F. E. de W. (1950). *Lancet*, **1**, 447.
- 2 Heard, K. H., et al. (1950). *Med. J. Aust.*, **2**, 606.
- 3 Strong, J. A. (1951). *British Medical Journal*, **2**, 998.
- 4 Walther, G., and Winter, K-A. (1952). *Klin. Wschr.*, **30**, 25.

Iron in the Water Supply

Q.—*Chemical analysis of a sample of water from a bore-hole shows that iron is present to the extent of 0.25 part per 100,000. As the permissible limit for this metal is usually given as 0.05, what ill effects would result from the continued use of this water for human consumption? Should this water be condemned despite the fact that the chemical analysis is satisfactory in all other respects?*

A.—Quite small concentrations of iron in water preclude its use by reason of an unpleasant inky taste and of undesirable staining effects when the water is used for laundering and other purposes. In addition, iron-bearing waters are prone to the development of crenothrix and other growths in the distribution system. The concentrations of iron which condemn a water on such grounds are, moreover, but a very small fraction of those at which its wholesomeness would be impaired. The limit is thus one set by suitability and not by considerations of health.

It may be taken in general that a supply should not contain more than 0.03 part per 100,000 of iron. If this figure is appreciably exceeded, even though the water be clear at

its source, discoloration or even deposition of a reddish deposit of iron oxide may occur subsequently. Fortunately the removal of iron from water is not often difficult and a process involving aeration followed by filtration or sedimentation is usually sufficient to remove all but the merest trace. If, as the inquirer states, the supply is satisfactory in all other respects, an approach might be made to the makers of equipment for water treatment who would suggest measures appropriate to the supply in question.

Local Analgesics for Scalds

Q.—*Is there any local analgesic which is effective when applied to the unbroken skin? I have in mind the relief of pain due to burns and scalds.*

A.—I do not know of any such. There are various creams and ointments on the market which are reputedly analgesic, but a few months ago I and my staff tried them all out; we rubbed ourselves diligently but produced no anaesthesia of the skin.

NOTES AND COMMENTS

Post-vaccinal Encephalitis.—In a leading article on encephalitis in childhood (June 5, p. 1312) it was stated that post-vaccinal encephalitis "is almost never seen when primary vaccination is undertaken in the first year of life." We understand from the General Register Office that between the years 1936 and 1952 there were 26 deaths from post-vaccinal encephalitis in children under 1 year of age in England and Wales. These represent about two-fifths of the total mortality from post-vaccinal encephalitis during this period.

Corrections

In our account (July 24, p. 229) of the meeting of the Sections of Occupational Health and Ophthalmology during the Annual Meeting at Glasgow, Mr. E. Gordon Mackie is reported to have said that "those who became partially sighted did so usually as a result of sudden visual loss. . . ." What Mr. Mackie actually said was: "The partially sighted children are already cared for under the school ophthalmic service and progress naturally through education to suitable employment. Our special problem in this discussion is the adult who becomes partially sighted by sudden visual loss."

On p. 312 of our issue of July 31 Professor John Fulton was wrongly described as of Harvard. He is, of course, Sterling Professor of the History of Medicine at Yale.

Professor DOUGLAS KERR writes: "You report me as saying at the meeting of the Section of Forensic Medicine at Glasgow (July 24, p. 226) that alcohol had been exaggerated as a cause of road accidents and only five per thousand could be attributed to that cause. This suggests that I think alcohol is only a minor cause of road accidents, which is just the reverse of what I actually said. These remarks apply to drivers certified as being drunk, and I went on to state that a much larger and much more dangerous category of drivers was the driver who had been drinking to excess but who was not drunk. The whole point of this part of my address was to emphasize that people only thought about the drunken driver, whereas a much more dangerous and more numerous class was the driver who was not quite drunk, and I made a plea for fresh legislation to bring these dangerous drivers within the law."

It was Sir Francis Walshe, not Sir William Gilliatt, who conferred the honorary Fellowships of the Royal Society of Medicine reported in the *Journal* of July 31, p. 312.

The second paragraph under the heading "Royal College of Physicians of Edinburgh" in the *Journal* of July 31 (p. 310) should have been headed "Royal College of Surgeons of Edinburgh." It reported a meeting of that College held on May 26.

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