Any Questions?

Correspondents should give their names and addresses (not for publication) and include all relevant details in their questions, which should be typed. We publish here a selection of those questions and answers which seem to be of general interest.

Tetanus Toxoid after Allergy to A.T.S.

Q.—Is there any danger in giving tetanus toxoid to a child who has had an allergic reaction to antitoxin serum in the past?

A.—While no injection should be regarded as completely devoid of risk, the likelihood of reaction in an allergic child is very much less after tetanus toxoid than antitoxic serum. Active immunization is therefore indicated; a cautious course of injections of toxoid should obviate the emergency use of antitoxic serum. It is suggested that a small dose of 0.1 ml. of toxoid should be given deep subcutaneously or intramuscularly, followed by 0.5 or 1.0 ml. about two days later, if the “detector” injection has been trouble-free. With such a mild prophylactic as tetanus toxoid, the remainder of the course can usually follow the accepted regimen—namely, a second full dose after an interval of six weeks, and a third after six to twelve months. Thereafter, periodic boosting is probably necessary for three to five years. When the injections are given, a syringe and adrenaline 1:1000 must be kept in readiness for the prompt control of any allergic symptoms which may develop. The use of an antihistamine drug may also be considered.

Allergic children should be actively immunized against diphtheria as well as tetanus. Ideally, a duplicate record card should be given to parents, with instructions that it must be readily available when required.

Impotence in Diabetes

Q.—Can you tell me what are the aetiology and treatment of impotence in the diabetic?

A.—Impotence in the male diabetic may occur in the early untreated patient, in which case it is usually temporary and disappears with proper control of the diabetes. Impotence occurring in the treated diabetic tends to be gradual in onset and does not respond to any form of treatment. Its cause is unknown, but it has been suggested that it may be neuro-pathic or possibly due to local vascular disease; the former seems more probable, as the bulb-cavernous reflex is often absent.

Testosterone by injection in large doses may have some slight effect in the early stages, but fails to produce any improvement when impotence is fully established; this condition is therefore not due to lack of male hormone, and the results of testicular biopsy support this view.

Anatomy of Leucotomy

Q.—Please describe the anatomical extent of the original leucotomy, and the present-day modified leucotomies. What tracts are interrupted?

A.—In the standard prefrontal leucotomy an incision is made in the white matter of the frontal lobe in the plane of the coronal suture. It is carried inferiorly to the floor of the anterior cranial fossa, superolaterally to the cortex of the convexity, and medially to 1 cm. lateral to the midline. The incision divides the nerve fibres connecting all parts of the frontal cortex anterior to it with the medial nucleus of the thalamus. The effects of the operation are decreased by advancement of the incision and increased by its posterior placement, the latter carrying the additional risks of motor and trophic disturbances as well as areumae.

In an attempt to obtain the desired therapeutic effect and limit post-operative personality alteration various modifica-