

the mildest cases of haemolytic disease received a replacement transfusion of one pint of compatible blood within a few hours of birth. The indications for replacement transfusion cannot as yet be laid down clearly, but as a general rule any child with a positive direct Coombs test and a cord haemoglobin level of under $15\frac{1}{2}$ g. per 100 ml. should receive one. Although the series quoted is small, it shows that the prognosis for such a pregnancy is not hopeless.

| | Stillborn | Neonatal Death | Survived |
|---|-----------|----------------|----------|
| Results of latest pregnancies of 19 mothers whose previous affected infant was stillborn | 5 | 5 | 9* |
| Results of latest pregnancies of 27 mothers whose previous affected infant was born alive | 5 | 5 | 17 |

* Includes one case of kernicterus

The problem of allowing further pregnancies is one for the parents to consider after they have been informed of the probable risk. If, as is generally the case, they decide that a further pregnancy is undesirable, then advice on contraception should be given. In the uncomplicated case there are no grounds for advising either sterilization or termination of pregnancy.

Dupuytren's Contracture

Q.—How should Dupuytren's contracture be treated? Is vitamin E of value in this condition?

A.—The treatment of Dupuytren's contracture is still entirely an operative one. The classical methods of subcutaneous fasciotomy and excision of the affected fascia are still the two basic procedures. In the past it was customary to use fasciotomy for the mild cases and excision of the fascia for the severe cases. The present attitude is the reverse. The mild or moderate cases are those best suited to excision of the fascia, and in these an excellent result can be expected. In the severely contracted cases fasciotomy is performed to explore the possibility of treatment by excision. In most of them excision is of no value, as the joints of the finger are commonly stiff or subluxated. If a tentative fasciotomy shows this to be the case no operative treatment other than amputation is to be advised. In the operative excision of the fascia it is imperative to remove all skin which is involved in the Dupuytren process. Closure of the skin by means of a Z-plasty is a very valuable adjunct to the operation.

It is almost certain that vitamin E is valueless in this condition. Various writers have reported success with heavy doses of this vitamin (see *British Medical Journal*, 1949, 2, 1399), while others (for example, A. R. King, *J. Bone Jt Surg.*, 1949, 31 B, 443) have reported equal failure. Many of the improvements were of subjective type, the patients saying that the hands felt softer or the fingers felt straighter, and that the aching pain had gone. Some observers have reported objective improvement in the extension of the fingers, others have reported failure of improvement in objective signs. One writer comments that in 12 cases out of 13 no value was seen with treatment at full dosage for six to eight weeks at a cost of approximately £5 per week.

Adiposis Dolorosa

Q.—Is anything known of the aetiology and treatment of adiposis dolorosa?

A.—There is no pathological basis for the differentiation of adiposis dolorosa from other forms of adiposity, although clinically the name is used if the adipose deposits tend to be painful and the patient depressed or melancholic.

The question therefore involves discussion of the whole complex problem of adiposity. This also applies to treatment, which has been dealt with many times in these

columns, and broadly speaking involves three lines of approach: dieting, and the use of appetite depressors and diuretics. Thyroid is of limited value, and there is no hormone known which specifically catabolizes fat.

Urticaria in 8-week-old Twin

Q.—I have under my care a baby of 8 weeks, one of identical twins. He was quite well until two weeks ago, when an urticarial rash developed and he began vomiting; he was also constipated. Examination showed that the colon was loaded with hard faeces, and treatment of the constipation cured the vomiting. However, the urticaria has continued, the hands have been grossly swollen, and huge weals have appeared on the face and trunk. On the assumption that the urticaria might be due to woollen clothes or to the detergent these were washed in, the child was given cotton underclothes washed in soapflakes only. In spite of this the condition has persisted, and now one leg is grossly swollen. The other twin, although having the same food (national dried milk) and living in the same environment, is quite well and is now two pounds heavier than his brother. Can you tell me: (1) What is the youngest age at which urticaria occurs? (2) Does the fact that one twin has reacted differently to the same condition prove that the twins are not identical? (3) Is it safe to give antihistamine drugs to children of 8 weeks, and, if so, what is the dosage?

A.—The answers to the three questions are: (1) Urticaria may appear at any age, and has been reported in the newborn. (2) A different reaction to the same condition in twins does not prove that they are not identical, because other factors may not be the same, but in general one would expect identical twins to react in the same way. (3) The antihistamine drugs at present on the market can safely be given to infants, who seem to tolerate them better than most adults. The dose varies according to the drug used, but those for which a single adult dose is 25 mg. can be given in 10-mg. doses up to a total daily maximum equal to about 3 mg. per pound (0.45 kg.) of body weight.

It is rather unusual for an allergic reaction to cause such persistent swelling of the limbs. Is it possible that some other condition is present as well as an allergic reaction with urticaria? Vomiting and urticaria in a bottle-fed baby suggest a milk allergy, although colic and loose, fatty, or undigested stools would be expected rather than constipation. It is important to find the allergen before exhibiting antihistamine drugs, and it would be best to place the child on a boiled water, or glucose-water, diet for a couple of days to see if the symptoms disappear. If they do, then it would be wise to feed the child upon a soya-bean preparation before attempting to desensitize him to cow's milk. The delay in the appearance of symptoms does not rule out the possibility of sensitivity to cow's milk.

NOTES AND COMMENTS

Correction.—In the obituary notice of Sir Leonard Parsons, which was published in the *Journal* of December 30, 1950, it was wrongly stated that Sir Gilbert Barling was co-editor with Sir Leonard Parsons of *Disease in Infancy and Childhood*. It was Mr. Seymour Barling who was co-editor of this textbook.

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