of 100 mg. twice a day was more effective than other measures in a series of cases recently reported.

The prognosis is bad in the sense that the condition destroys skin and hair and produces an irreversible, scarring alopecia. The disease does not affect the general health. If extensive, ulceration sometimes occurs, which generally responds to small doses of sulphonamide by mouth and locally, but this treatment must be used with care. Malignant changes are rarely seen.

Prognosis in Retinitis Pigmentosa

Q.—*What is the outlook for a boy of 10 who has retinitis pigmentosa (diagnosed by two eye specialists)? Difficulty of vision, only in the dark, was first noticed six years ago after an attack of kala azar treated by antimony. The parents have been told that the child will eventually become blind. How quickly will this happen?*

A.—The development of nightblindness in retinitis pigmentosa as early as the age of 4 is unusual; so also is a diagnostic fundus appearance at the age of 10. This in itself raises doubt whether one is dealing with the classical form of hereditary retinitis pigmentosa, though such early changes may occur in the severe, but rare, sex-linked type. A full family history is needed, and also information on whether the boy shows the characteristic field defects of retinitis pigmentosa. If the boy is actually suffering from genetically determined retinitis pigmentosa there is no treatment, and it is impossible to indicate how rapidly his vision will deteriorate. If his affection is of the sex-linked type, serious trouble is almost certain by the age of 25 years.

The history of kala azar treated by antimony may be significant. With the unusual findings in this case it is possible that the nightblindness and pigmentary changes were precipitated by either the infection or the treatment. The picture of retinitis pigmentosa has been observed in measles, after vaccination, and after quinine treatment of malaria. In these cases the tendency is for some improvement rather than deterioration.

Angina and Cold Weather

Q.—*A woman of 56, who has angina, has an opportunity to go to Ontario, where the winter climate is cold and dry. Will this be likely to precipitate her anginal attacks, which are often brought on here by cold nights?*

A.—Although Sir Thomas Lewis was unable to demonstrate that cold played any part in precipitating attacks of angina pectoris, general experience has shown that it does. There is no doubt that cold may raise the blood pressure in susceptible individuals, and this may help to provoke an attack by increasing the work of the heart. In the particular case in question it seems clear that cold is harmful, and the patient would surely be unwise to go to Ontario.

Cytochrome c and Carbon Monoxide Poisoning

Q.—*What are the functions of cytochrome c? It has been suggested that it might be a useful analeptic for cases of carbon monoxide poisoning after mining accidents. Is there a sound basis for this view?*

A.—Cytochrome *c* is a respiratory catalyst which is required for the utilization of the oxygen reaching the tissues from the blood. In carbon monoxide poisoning, less oxygen reaches the tissues because some of the haemoglobin, the respiratory carrier in the blood, is combined with carbon monoxide. The question is probably inspired by a report that cytochrome *c* is beneficial in conditions of anoxia. Exhaustive trials in many laboratories have failed to confirm this report. In any case, even if cytochrome *c* could increase the rate of utilization by the tissues of the limited amount of oxygen reaching them in carbon monoxide poisoning, this would probably be more harmful than useful, since the oxygen would be depleted more rapidly. Cytochrome *c* does not combine with carbon monoxide, so it is useless as a direct antidote.

Camphorated Oil

Q.—*Am I right in believing that rubbing the chest with olive oil or camphorated oil, or any other preparation, serves no useful purpose and may even be harmful in the treatment of an infant or child suffering from bronchitis?*

A.—Unless the rubbing is over-vigorous or prolonged or the preparation too strong, in which case dermatitis may follow, no harm is likely to result from the use of a medicated oil in cases of bronchitis. On the other hand, no great therapeutic response can be expected; the counter-irritation may be of some slight value, and in the case of an oil or ointment containing menthol or camphor some inhalation of vapour will follow, and this may be helpful in clearing the upper air-passages.

Pills for Bankrupt Smokers

Q.—*I have tried to purchase locally from many chemists some pills which are sold for the prevention of smoking, but I have been unable to buy them or find a formula for their preparation. The pills I have in mind are normally dissolved in the mouth, and, while being quite tasteless themselves, produce a very nasty taste if the subject tries to smoke a cigarette. I would be grateful if you could tell me their formula.*

A.—The formula of the pills is as follows: dried sulphate of iron, 67.85%; potash alum, 17.85%; lactose, 14.28%; acacia, 0.75%; green colouring matter and excipient, q.s. They should be kept out of the reach of children.

Speedy Hypnotic

Q.—*What sedative has the quickest and shortest action when taken orally?*

A.—The hypnotics with the quickest and most evanescent action are probably pentobarbitone sodium and sodium propylallylbarbiturate. There is not much to choose between them. The dose is from 1½ to 3 gr. (0.1 to 0.2 g.). They are effective within half an hour, and are certainly not active for longer than six hours.

Lymph Drainage of Nasal Sinuses

Q.—*What is the lymphatic drainage of the accessory air sinuses? I have been unable to find information about this in standard anatomical and surgical textbooks.*

A.—The best account may be found in *Histopathology of the Ear, Nose and Throat* by Eggston and Wolff (Williams and Wilkins, Baltimore, 1947). Quoting papers by J. M. Robison (*Tex. J. Med.*, 1944, **40**, 193; *Arch. Otolaryng., Chicago*, 1944, **40** 385), these authors state that drainage is probably to a pretubal lymph plexus, thence to lateral retropharyngeal lymph nodes, and partly to submaxillary nodes, and so to the deep cervical chain.

NOTES AND COMMENTS

Honours List: Correction.—Mr. CHARLES E. DREW, who became M.V.O. in the New Year Honours, is a member of the consultant staff of the Westminster Hospital, having been appointed as fourth assistant surgeon on April 9, 1951. We regret that this hospital appointment was incorrectly given in last week's *Journal* (January 5, p. 44).

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