

prepared in tablets containing 250 mg. of the diphosphate. The dosage of chloroquine diphosphate for adults is 500 mg. once weekly. For children: from birth to the third birthday, 62.5 mg. once weekly; from the third to the sixth birthday, 125 mg.; over 6 years, 250 mg.; and over 10 years, the adult dose.

Alternative antimalarials are mepacrine and pyrimethamine ("daraprim"). The adult dose of mepacrine is 100 mg. daily, started a fortnight before entering the malarious area and continued for a month afterwards. Mepacrine is not as convenient as proguanil for children. Birth to second birthday: total dosage of 50 to 75 mg. in divided daily doses. From second to sixth birthday: total weekly dosage of 100 to 200 mg. in divided daily doses. From sixth to tenth birthday: total weekly dosage of 200 to 300 mg. in divided daily doses. From tenth to fifteenth birthday: total weekly dosage of 300 to 400 mg. in divided daily doses. Over 15 years, adult dose. The adult dose of pyrimethamine is 25 mg. once weekly. Half this dose has been found successful in children.

All drugs should be taken at some meal during the day with a good draught of fluid. Absorption is not affected by moderate quantities of alcohol. After cessation of suppressive therapy with any of the above drugs attacks of falciparum malaria should not develop. Vivax malaria may, however, appear and require radical therapy.

Some form of mechanical protection against insects is always desirable, even when drug suppression is successful. There are many insect-borne diseases other than malaria.

#### Artificial Materials for Hernia Repair

**Q.**—*What are the advantages and disadvantages of using materials such as nylon or wire for the repair of large hernias in place of fascia lata?*

**A.**—Those surgeons who use nylon and wire for the repair of large hernias regard the ready availability of the materials as a chief advantage. It is, however, doubtful whether a lattice or filigree of any foreign material is really as effective as a barrier of the patient's own tissues. The questioner refers to the use of fascia lata, a method introduced by the late W. E. Gallie and satisfactory in his hands. Those surgeons who object to his method have two main criticisms: first, the extra time taken in removing the fascial strip and the added risks of sepsis; and, secondly, the tendency for the inguinal ligament to be damaged by the large fascial needle, especially in patients with friable tissues. An effective barrier of the patient's own tissues can, in most cases of inguinal hernia, be provided by a rectus sheath slide operation, and many believe that this offers the advantages of a fascial repair with none of its disadvantages.

Lattices of nylon and wire all tend to fragment after a variable period of time. If the lattice is made very close critics of the method will point to the tendency for the inguinal ligament to be frayed by frequent passage of the needle. On the other hand, if the lattice is of a wide mesh, the tissues can readily bulge through the suture material. The tendency for nylon knots to slip can be irritating, and this objection is not entirely rectified by the use of braided nylon. Stainless steel wire tends to become fragmented by movement and electrolysis in the tissues, and is less in vogue than it was a few years ago. Tantalum similarly fragments on movement. Filigrees of tantalum or stainless steel also break up and tend to separate from their attachments; recurrences are therefore sometimes seen at the edge of a filigree. Silver wire is rarely used to-day: it is subject to all the objections already mentioned, with the additional one of occasionally staining the overlying skin black owing to the deposition of silver sulphide. There is some evidence to suggest that wire filigrees are more useful for difficult umbilical and incisional hernias than they are for large inguinal hernias. The critical surgeon recognizes that there is very little valid statistical evidence about the recurrence rates following different types of repair. The collection of truly comparable cases is not easy, and some

of the methods used have not been tried for long enough to enable their true worth to be assessed. It is notable that much of the earlier enthusiasm for tantalum and stainless steel wire has died down owing to appreciation of the various difficulties already mentioned. The use of relatively rigid materials in the reinforcement of mobile structures introduces inevitable complications, and many surgeons (probably a growing number) are recognizing the virtues of repair with the patient's own tissues, provided this can be effected without tension. An understanding of the fundamentals of plastic surgery is certainly an advantage in planning the repair of large and difficult ruptures.

#### Nocturnal Priapism

**Q.**—*A healthy man of 56 complains that for over 20 years he has been troubled with a full penile erection every time he sleeps. It is not associated with erotic sensations or dreams of any kind. If he partially wakes, he is conscious of the condition and its discomfort, which does not alter unless he reaches a point of wakefulness that he describes as about half-way between sleep and full consciousness, when the erection immediately ceases. If he sleeps and wakes a number of times, the condition recurs each time. Is there any special significance in his complaint? I can find no cause.*

**A.**—These cases of nocturnal priapism in an elderly or middle-aged man are exceedingly puzzling. In only a few cases does one find any physical explanation, such as an irritative lesion of the posterior urethra or an enlarged prostate. Sometimes, but not often, there is a psychological explanation, but as nothing has been said in this case to indicate that the patient is suffering from a thwarted sex life, I assume a psychological factor does not explain it.

To sum up, therefore, it is quite usual to find no explanation in these cases. They begin mysteriously and end mysteriously.

#### Nutrient Enemas

**Q.**—*Are nutrient enemas—e.g., 5% dextrose—properly absorbed?*

**A.**—A solution of 5% dextrose is absorbed when given rectally. The colon, however, can absorb only 1 to 2 litres of fluid daily, so that a total of 75 g. (300 calories) glucose is the maximum that can be administered by this route. There can be few circumstances when it is not preferable to give glucose intravenously, as there is then no doubt about the degree and speed of its absorption. Proteins, peptones, and fats are not absorbed by the colon, and their administration by this route is not only useless but may be harmful, as the putrefactive bacteria break down those substances and form toxic products which may be absorbed.

**Correction.**—The authors of the article "Cortisone and A.C.T.H. in Treatment of Non-rheumatic Conditions" (*Journal*, January 2, p. 1) regret the omission of acknowledgments to Professor R. E. Tunbridge for access to the case records of two cases of Simmonds's disease and one of adrenal virilism.

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