

Management of Diverticulosis

Q.—In the case of a male patient, aged 65, with diverticulosis, what is the safest purgative to give? Liquid paraffin after meals, even in large doses, is insufficient to keep the bowels open without an occasional purgative. Since he rarely goes 48 hours without some spasmodic pain, should belladonna and hyoscyamus be kept up continuously, or only when pains appear? What articles, entering into a normal day's diet, are at least harmless as regards roughage and flatulence? Are farinaceous milk puddings, toast, and biscuits in amounts usually taken by healthy adults unsuitable in these cases? Are jams containing small seeds harmful?

A.—Any purgative is certain to increase the abdominal pain which the questioner mentions, for it can act only by increasing peristalsis. It is better to continue with liquid paraffin and make use of the glycerin suppository if the bowel habit becomes irregular. If this is not effective, a simple saline enema should be given. It is wise to prescribe antispasmodics regularly if pain occurs at all frequently, as in this particular case. In respect to diet, it is usually sufficient to avoid green vegetables and salads, cooked and raw fruit, and jams containing pips or seeds. Intestinal flatulence is commonly of carbohydrate origin and due to bread and potatoes. It can usually be controlled by reducing the quantity of these foods, substituting for them thin toast and some of the proprietary biscuits, and taking a charcoal preparation. The unsuitability of any particular food in any particular patient can be determined in the last instance only by trial and error.

Serum Sensitivity and Anaphylaxis

Q.—The first dose of a foreign protein does not usually produce a specific bodily reaction. A second injection given more than 10 days after the first may yield an anaphylactic reaction, whereas, should this second dose be given less than 10 days after the first, anaphylaxis does not occur. (a) In the latter case, will a third injection given more than 10 days after the second injection produce an anaphylactic reaction? (b) If not, could not a routine second injection of the animal serum (tetanus, diphtheria, etc.) be given five days after every first serum injection, so that the patient is freed from the danger of anaphylaxis? (c) Otherwise what methods are available to prevent anaphylaxis?

A.—The first injection of a foreign protein may or may not be followed by a reaction. If horse serum even in small quantities is injected into an allergic subject who is spontaneously sensitive to horse hair, and consequently horse serum, the initial injection is likely to be followed by an immediate severe and possibly fatal reaction. Also, if large quantities of horse serum are injected for the first time into either allergic or non-allergic persons, a proportion will develop typical symptoms of serum sickness in 8 to 12 days' time. There is no evidence that an alteration in the timing of the injections, as is suggested in this question, will prevent the development of a state of sensitivity. Immunization against tetanus and diphtheria in allergic persons is best carried out by giving injections of diphtheria and tetanus toxoids. The risks of sensitivity to serum are thus avoided. The management of a potentially horse-serum-sensitive patient was described in the answer to a question published in the *Journal* of July 2, 1949 (p. 39).

Toxins in Tuberculosis

Q.—What are the modern views on the toxins of the tubercle bacillus? Do they exist and are they important?

A.—Experimental work has failed to demonstrate that the tubercle bacillus produces either exotoxins or endotoxins. In the initial infection, before hypersensitivity has developed, the normal tissue cells live and grow without hindrance in the presence of large numbers of tubercle bacilli. If toxins do exist, they require more delicate methods for their detection than are at present available.

Benedict's Solution

Q.—What substance in urine, possibly a drug, turns Benedict's solution (qualitative) black but does not reduce it on boiling?

A.—This question could be answered with accuracy only if the particular specimen of urine was available for examination; there are a variety of substances which might possibly have this effect. Some, but not all, polyphenols would do this, and they might be derived from some drug or from melanogens which might appear in the urine in the case of a melanotic sarcoma. In the latter case one would expect some slight reduction of Benedict's solution on boiling. Sulphides in the urine would also turn Benedict's solution black, but it is difficult to see how they would get into the urine unless the patient was suffering from sulphhaemoglobinaemia. A black coloration might also be produced if the patient was taking a dye in some medicine. Lastly, homogentisic acid, which is excreted in alkaptonuria, a rare inborn error of metabolism, turns the urine black on standing, and if Benedict's solution had been added it would no doubt go black, too.

Mouth-wash for Cigarette Smokers

Q.—What is the inorganic chemical which can be used as a mouth-wash and which has the effect for some time afterwards of rendering the taste of a cigarette nauseating, if not emetic?

A.—A very weak solution of copper sulphate.

NOTES AND COMMENTS

Infant Feeding.—The Director of Public Relations, Ministry of Food, writes: In his article on infant feeding which appeared in the *British Medical Journal* on May 13 (p. 1128), Dr. Philip Evans states that "evaporated (unsweetened condensed) milk is nearly unobtainable in Britain at present." There is some misunderstanding here. There are good supplies in the shops, and for this reason evaporated milk was taken off the points rationing system on April 23 last.

Nasal Folliculitis.—Dr. GEORGE GRAHAM (London, W.1) writes: In the answer to a question on this subject (June 17, p. 1446) it is suggested that "in view of a renal glycosuria the diet should be regulated." If it has been shown by a sugar tolerance test that the patient has in fact got a renal glycosuria there is no need whatsoever to do any dieting, as the condition is harmless.

Corrections

In our review (June 3, p. 1304) of *The Parathyroid Glands and Metabolic Bone Disease*, by Fuller Albright, M.D., and Edward C. Reifenstein, M.D., the price was given as £2 4s. Owing to devaluation it is now £3 1s. 6d.

Our attention has been drawn to certain inaccuracies appearing in the report in the *Supplement* of June 3 (p. 247) of the consideration by the General Medical Council of the case of Dr. A. P. Abraham, and we are asked to publish the following corrections: First, Mr. James Johnson did not say in evidence, as was stated in our report, that Dr. Abraham had told him that he was opening a surgery in Eccles New Road and would expect to get his and his family's cards. Secondly, Mrs. Glencross in cross-examination said that she never saw Dr. Abraham again after the occasion when he had offered her a lift in his car. Thirdly, the meetings referred to by Mr. James Dixon were alleged to have taken place in early September, 1949.

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