

sexual tension herself than to live in continual frustration. It is important, however, for the medical attendant to make sure that a common source of confusion is not being overlooked—that is, that the woman is not just suffering from vaginal anaesthesia and would be able to get clitoral orgasm by digital stimulation, were this not, for some reason, being withheld. If such should be the case, her husband must be instructed how to provide this so that she can achieve orgasm either before coitus or after, whichever suits the couple best.

Sterility of Mucous Membranes at Birth

Q.—*Are the mucous membranes of the nose and throat of a newborn baby sterile? If organisms are present, how did they establish themselves in a sterile amniotic cavity?*

A.—The nasopharyngeal mucous membrane of the newborn baby is sterile if delivery occurs soon after the membranes are ruptured—that is to say, before the liquor has had time to become infected. If, on the other hand, delivery is delayed a considerable time and the liquor does become infected, then inevitably the mucous membranes of the nose and throat of the baby are contaminated with the organisms infecting the liquor.

These organisms are a mixed flora and vary considerably. The commonest to be recovered from the baby's throat are coliforms (including *Proteus*), diphtheroids, staphylococci, and streptococci (both anaerobic and aerobic).

Scarring from Boils

Q.—*What can be done to improve the appearance of the back of a neck badly disfigured by pitting and scarring due to chronic furunculosis? The condition is now inactive, although the patient received a single course of superficial x rays for it about six months ago.*

A.—This is one of the most difficult conditions to treat. In the chronic stage, when it is often due to acne as well as to hair follicle infection—and as a rule evidence of infected hair follicles can be seen throughout the scarred surface—epilation by tweezer is a satisfactory method of keeping the infection down and allowing healing to become complete. Only after healing is complete should any surgical means be adopted, and even then it is only too often true that in many cases the scarring must be accepted. In particularly bad cases excision of the entire area and free grafting is the only alternative, but it should be a last resort, for the graft is certain to make a prominent white patch on the back of the neck.

Treatment of Leukoplakia of the Tongue

Q.—*I have a case of leukoplakia of the tongue which has been present for the past nine months. It started as quite a small area and is now almost the size of a halfpenny. It is quite superficial, and the Wassermann reaction and Kahn test are negative. I have given the patient large doses of vitamin A, and bland mouth-washes. In my student days the recommended treatment was excision. Will you please tell me the latest views on this condition and its treatment?*

A.—There has not been much change in our views on the treatment of leukoplakia of the tongue. Some surgeons have always been inclined to more radical measures than others. It is certain, however, that many cases of leukoplakia persist for years without showing any tendency to malignant change. In the present case, with a negative Wassermann reaction, the correct attitude is probably an expectant one.

All sources of irritation, such as irritant foods, dental sepsis, smoking, etc., should be eliminated, and a regular and careful watch kept for the appearance of papilliferous overgrowth, fissuring, or ulceration. At the first recognition of any of these a local excision should be done, preferably by diathermic cutting. It is best not to use any local application—for example, chromic or silver salts—but the normal mild antiseptic hygiene of the mouth and teeth should be continued. The presence of dissimilar metals

in dentures and fillings which might set up an electrolytic couple should be looked for and corrected if necessary. Incidentally, lichen planus of the tongue, although rare, may closely resemble leukoplakia and must be excluded. It is usually of a lavender hue and there may be similar lesions on the skin.

Drowsiness in an Old Man

Q.—*What is the likely cause of drowsiness amounting to narcolepsy in an old man, with some prostate obstruction (but no elevation of the blood urea), auricular fibrillation, and early evidence of heart failure? He can fall asleep while eating a meal or standing up. There is no sugar or albumin in the urine. Can any treatment be recommended? Methylamphetamine hydrochloride and amphetamine have had little influence.*

A.—The presence of a normal blood urea and the absence of albumin in the urine do not, of course, exclude the possibility of renal failure being the cause of the drowsiness. However, the type of drowsiness is unlike that of renal failure in that it occurs when the patient is standing or eating a meal, as well as, presumably, at other times. This, as the questioner points out, is like true narcolepsy. It seems most likely that the drowsiness is due to a combination of cerebral arteriopathy and probably heart failure leading to a local ischaemia in the hypothalamic region, and thus to the symptoms of narcolepsy. In such a case methylamphetamine hydrochloride and amphetamine are unlikely to have much influence unless given in large doses, and treatment of the co-existing cardiac failure and anaemia, if any exists, is probably the most important factor in producing relief of the drowsiness. However, no great benefit from treatment can be expected in this case.

Plasma Potassium Estimation

Q.—*What is the simplest reliable method of estimating the plasma potassium?*

A.—Flame photometry is the simplest and most reliable method of estimating the plasma potassium, given a flame photometer and an experienced operator. In the absence of such facilities, the best method is cobaltinitrite precipitation, which is described in detail by King (*Micro-analysis in Medical Biochemistry*, Churchill, 1946). Samples of blood must be unhaemolysed, as the cells contain twenty times as much potassium as the plasma and contamination by cell content would lead to gross error; for the same reason, separation of plasma and cells should be done as soon as possible after withdrawing blood. It is also important to remember that the plasma potassium level may be misleading as an index of the state of potassium balance—for example, in diabetic coma the plasma potassium level may be high or normal until dehydration is corrected, although there is potassium depletion.

Correction.—In Table II in the paper on "Arsenamide Treatment of Filariasis due to *W. bancrofti* and *A. perstans*" by Drs. J. A. McFadzean and F. Hawking (April 24, p. 956) the weights of patients 19 and 23 ought to have been 51 kg. and not 31 kg. as printed.

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