silent on this point, but clearly the practitioner should take some steps to ensure that the surplus is destroyed or, where desirable, recovered by him and placed in his locked cupboard.

Treatment of Naevus

Q.—*A baby girl, aged about 4 weeks, has a naevus which covers the nose, with small flecks on both upper and lower eyelids on each side. What is the best time to start treatment, and what type of treatment is recommended?*

A.—It is presumed that this is a naevus of the port-wine stain type. Painting with an alcoholic solution of thorium X, 1,500 e.s.u. per ml., once every month or six weeks for, in the first instance, twelve paintings may effect considerable paling of the lesions. The part should be cleaned gently with spirit before painting, and treatment may be started immediately.

Inheritance of Spina Bifida

Q.—*A patient aged 45 has a spina bifida occulta which has never given any trouble, and which was only discovered accidentally in the course of an x-ray examination. The brother of the patient has an only child, aged 7, who has recently undergone an operation for a cerebellar tumour. A first cousin (daughter of the patient's father's sister) has had two children, of whom the first died at the age of 3 months from spina bifida; the second child has survived to the age of 6 with a spina bifida, but cannot walk. The cousin's siblings have produced nine normal children, but the patient's siblings (apart from the brother) have produced none. The patient contemplates matrimony, and wants to know what are the chances of his producing healthy children. Nothing is known of the heredity of the proposed spouse.*

A.—This is rather a difficult question, because the chances for relatives other than brothers and sisters of affected persons are hardly known. Nor is the genetic relation of spina bifida occulta to the manifest condition understood as yet. Nevertheless, on the facts given, the increased risk for any children of this patient is probably very small. It is probably not larger than the one-in-forty chance that any random pregnancy will end in a serious malformation of one kind or another. Hence it seems safe to advise that the patient should ignore the slight added risk implied by a family history of this type.

Prognosis of Primary Syphilis

Q.—*What is the prognosis of primary syphilis with modern treatment? What are the chances (a) of a complete cure, and (b) of being able to produce non-syphilitic children?*

A.—The prognosis of primary syphilis treated by modern methods is extremely favourable, particularly if treatment is started in the sero-negative stage. (*a*) No method of proving biological cure has yet been devised, but presumptive cure, as evaluated by absence of clinical signs and persistently negative serum reactions (including tests of the cerebrospinal fluid) over a period of at least two years after treatment, may be expected in nearly 100% of adequately treated sero-negative primary cases and in 90% or more of sero-positive primary cases. (*b*) Adequate treatment of both males and females should ensure their children being non-syphilitic. Penicillin, which is the treatment of choice for syphilis, has been employed only since 1943, so that some years must elapse before we can be sure that late manifestations such as cardiovascular syphilis and neurosyphilis will not appear; however, provided it is used in optimum dosage, preferably combined with bismuth and perhaps an arsenical, there is every reason to suppose that cure will be obtained in the vast majority of cases.

Treatment of Iritis

Q.—*What mydriatic should be used in the treatment of iritis in a patient of 65 to 70? The tension of the eye is normal.*

A.—In most cases it would be safe to start treatment with ½% atropine twice daily, increasing the strength up to 1% three times a day. If, however, there is some question whether the tension of the eye is raised—and this rise may be due to the iritis—it is better to start with ½% homatropine twice daily. If after twelve hours there is some relief of symptoms, go on to 1% homatropine three times a day. With continued improvement proceed to 1% atropine twice daily, and later three times a day if necessary. The point about using homatropine is that its effect can be overcome fairly quickly by eserine.

Thymus and Growth

Q.—*Can you please tell me of any substances—for example, thymus gland—which may be used to increase growth? I want to try out their effects with exotic fish, which I breed as a hobby.*

A.—Some years ago Rowntree in America reported experiments with extracts of thymus gland which appeared to indicate that growth and development were accelerated through several generations. The effect reported was really an increase in the rate of development, rather than any absolute increase in growth. These experiments have never been repeated with similar results, and it is generally held that they can no longer be sustained as indicating such an action of the thymus gland. The growth hormone of the pituitary gland was originally used with salamanders, a point which might be of interest in connexion with experiments on tropical fish.

NOTES AND COMMENTS

What is a Chill?—Dr. A. V. ADAMS (Heathfield, Sussex) writes: May I request enlightenment about the disturbance of normal physiology underlying the clinical condition—so conspicuously unmentioned in medical literature—known as "a chill"? At sea I have found that a sudden fall in relative atmospheric humidity is followed almost invariably by a high incidence of chills. There may well have been no corresponding fall in atmospheric temperature, and the victim may well have not been exposed to draughts. An especially bad zone for chills is the Gulf of Suez when travelling north from the Red Sea, and I have become a victim myself on all too many occasions, despite the most careful precautions in the direction of avoiding draughts and putting on extra clothing. These chills may take many forms. . . . The diagnostic importance of this syndrome is clearly considerable. If the chill is sudden and severe in onset, as is frequently the case, and if the ship has come from India, both smallpox and the typhoid group immediately call for exclusion. But the problem of differential diagnosis is of obvious enough importance. The problem on which I seek enlightenment is what disturbance of physiology is going on, and what organ or organs are the seat of the disturbance. Can one incriminate a sudden alteration in ionic balance and water metabolism due to environmental changes of similar suddenness and violence, which renal function cannot deal with fast enough? . . . My own view, and I have no evidence to prove it, is that a violent change in *milieu extérieur* produces a concomitant change in *milieu intérieur*, and that it takes a while for the *status quo ante* of the *milieu intérieur* to be restored.

Management of Diverticulosis.—Dr. C. EDWARDS (Bournemouth) writes: I would suggest that one answer to this question is this. Since the removal of roughage from the food affects the quantity to be evacuated, the addition of one of the gel-forming preparations would increase the bulk in the rectum. Instead of the dried scybala (in spite of liquid paraffin) a bulky soft stool is formed, and the paraffin may be reduced and perhaps abandoned.

The "Medical Directory."—The Editor of the *Medical Directory* (104, Gloucester Place, London, W.1) writes: To maintain the accuracy of our annual volume we rely upon the return of our schedule, which has been posted to each member of the medical profession. Should the schedule have been lost or mislaid, we will gladly forward a duplicate upon request. The full name of the doctor should be sent for identification.

Correction.—In the later issues of the *Journal* of June 10 (p. 1351) it was incorrectly stated that Barrowmore Hospital was previously known as "Borrowdale Sanatorium." This should have been "Barrowmore Sanatorium."

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