

intake of some 15 minims, and it is usually believed that in chronic arsenical poisoning skin manifestations precede toxic effects on the liver. After animal experiments prompted by the Manchester "epidemic" of arsenical poisoning in beer drinkers, Delépine³ concluded that a dose of 1/150 to 1/25 gr. (0.4 to 2.6 mg.) daily was capable of producing injurious effects in the ill-fed or weak individual. The 1 minim dose of liquor arsenicalis contains about 0.6 mg. or 1/100 gr. of arsenic trioxide. The development of chronic arsenical poisoning depends on the dose, the form in which the arsenic is taken, the duration of exposure to risk, and any special susceptibility. It may be expected that the effects of alcohol, arsenic, infection, etc., may well be synergistic and lead to changes in the liver which might not occur with one agent alone.

It is difficult to justify the inclusion of liquor arsenicalis in sedative mixtures, and in view of what has been said above it would be wiser not to prescribe for repeated use mixtures containing even such small quantities of a potentially dangerous cumulative poison.

REFERENCES

- Franklin, M., Bean, W. B., and Hardin, R. C. (1950). *Amer. J. med. Sci.*, 219, 589.
- Stockman, R. (1921). *Edinb. med. J.*, 27, 1.
- Delépine (1903). Report of Royal Commission on Arsenical Poisoning. 1, app. 16, p. 185. H.M.S.O., London.

Sudden Loss of Hair

Q.—*A healthy man of 42 lost every hair on his body more or less overnight over five years ago, and there was no sign of any regrowth until recently following an emergency gastrectomy for severe haematemesis with transfusion of four pints of blood. What could be the cause of such a sudden loss of hair in the absence of any illness or emotional upset? Is the recent regrowth connected with either the shock following haemorrhage and operation or the blood transfusion?*

A.—It seems almost certain that this is a case of alopecia totalis, usually regarded as a severe form of alopecia areata. The cause of this disorder is quite unknown, though if there has been an antecedent illness, stress, or shock it is tempting to attribute the baldness to this. Recovery from alopecia totalis is sometimes complete, but when it has already existed for some years the chances of much hair regrowing recede.

It is less often that regrowth of hair can be attributed to shock or other disturbances. However, Dillaha and Rothman¹ have reported recovery as a result of cortisone treatment, and presumably the recovery in the case mentioned may be related to this mechanism. In Dillaha and Rothman's cases the hair fell out again when cortisone was stopped.

REFERENCE

- J. Amer. med. Ass.*, 1952, 150, 546.

Where to Sit for Television Viewing

Q.—*Is there any ratio between the size of the television screen and the distance between that screen and the eye for obtaining the optimum clarity of image, yet at the same time freedom from visual discomfort?*

A.—Since the number of lines in the structure of television images is fixed, there is a ratio between the size of the screen and the viewing distance at which the lines will be indistinguishable. The value of this ratio will depend on the visual acuity of the viewer. The number of lines in the B.B.C. transmissions is such that persons whose vision is not better than 6/6 will not distinguish the line structure of the picture on a 12-inch (30 cm.) diameter television tube at a viewing distance greater than about 6 feet (1.8 metres). The vision of many people is, however, 6/4.5 or better, and the lines on such a screen will be visible, though not unpleasantly conspicuous, at a viewing distance of 8 feet (2.4 metres) or more. If a receiver having a larger screen is used, it follows that the viewing distance must be proportionately increased if it is desired not to see the lines. However, freedom from visual discomfort when viewing television depends chiefly on other factors than line visibility. It is important to have the viewing room moderately illuminated, though in such a way that viewers

cannot see the light sources directly nor see images of them mirrored by the screen they are watching. If this is done the screen should not prove glaring, nor will the brightness contrasts of which the picture is composed be spoiled. It is also important that the angle subtended by the screen at the viewer's eyes (the angular size of the field of attention) should not be too small, since unwonted restriction of eye movements is a potent cause of feelings of strain and ocular fatigue. For this reason it is better to have a relatively high ratio of screen size to viewing-distance, and accept the consequent visibility of the lines, than to insist on a ratio which is low enough to prevent detection of the lines.

Uric Acid Gravel

Q.—*I have a patient, a robust man of 35, who has repeated attacks of renal colic, not confined to one side. He then passes several small calculi about the size of a large pin's head. Analysis of the calculi show them to consist of uric acid and urates. Two complete urological investigations reveal no abnormality; there is apparently no mechanical defect, and his kidney function is excellent. Are there any measures, dietary or therapeutic, which would prevent the formation of these small calculi?*

A.—Uric acid gravel can to some extent be prevented by maintaining an alkaline urine and avoiding food rich in purines. The patient should avoid strong tea and black coffee, and the rich protein foods associated in idea with a Lord Mayor's banquet. Liver, kidneys, sweetbreads, and offal in general should be forbidden. The diet should contain an abundance of fruit and vegetables, and a fluid intake of about 5 pints (3 litres) a day should be the aim.

Cloudy Urine after Acetic Acid

Q.—*Are all phosphates in a cloudy urine dissolved by dilute acetic acid, or are some not soluble, or is the residual cloudiness due to something else?*

A.—All phosphates in a urine are dissolved on the addition of acetic acid. Any residual cloudiness might be due to oxalates or bacteria. If the cloud is due to oxalate it will become soluble on the addition of a little hydrochloric acid.

NOTES AND COMMENTS

Corrections.—In Table II in the medical memorandum on "Extreme Sensitivity to Insulin," by Dr. A. I. Roith (June 5, p. 1306), the amount of insulin given should have been 0.03 unit per kg. body weight, not 0.3 unit.

In the report of Mr. Ivor Lewis's contribution to the luncheon discussion on massive gastro-intestinal haemorrhage, at the recent sectional meeting of the American College of Surgeons in London (May 29, p. 1258), the number of cases on which he had operated personally should have read 96, not 196.

In the report by the Joint Committee of the Medical Research Council and Nuffield Foundation on "A Comparison of Cortisone and Aspirin in the Treatment of Early Cases of Rheumatoid Arthritis" (*Journal*, May 29, p. 1223), under the heading "Allocation to Treatment," "(c) . . . seven to nine months" should have read ". . . six to nine months." Similarly in Table I "Duration of symptoms" should be 6-9 months and not 7-9 months. In Table V under "Week 8 to 1 Year" +0.8 should have been -0.8.

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