

**Unilateral Recurrent Irritation of the Tongue**

**Q.**—I should be grateful for an indication of the possible causation and treatment of unilateral recurrent irritation of the tongue. The condition has been said to be possibly aphthous ulceration, but few textbooks seem to have much detail on the subject. A careful routine physical examination has not revealed any abnormality and I wonder whether the condition is possibly due to some dietary deficiency.

**A.**—Unilateral recurrent ulceration or irritation of the tongue suggests a mechanical cause, possibly in the form of repeated traumata from a denture or a tooth. It would be advisable for the patient's dentist to exclude these possibilities. The sore tongue of nutritional deficiency is usually affected symmetrically. Deficiency of several members of the vitamin-B complex is associated with sore tongue; this symptom has been relieved, in different patients, by nicotinic acid, riboflavin, pantothenic acid, "marmite," and injections of liver extract. Thus, even if the clinical phenomena are not characteristic, it is worth giving treatment by the vitamin-B complex a trial. There are a number of ill-understood conditions in which recurrent ulceration of the mouth and tongue have been noted. The condition is sometimes associated with a cyclical granulocytopenia.

**Gin and Benedict's Solution**

**Q.**—A patient who is a severe diabetic, recently stabilized in hospital, is on the following dosage of insulin taken at 8.15 a.m.: 60 units protamine zinc insulin; 40 units soluble insulin. In spite of this, his urine, tested four times daily, showed, on testing with Benedict's solution, light or heavy green or yellow coloration. He is normally abstemious, but a week ago he was persuaded to take two small gins in the evening. His urine the next day showed no reaction with Benedict's solution. Since then he has taken  $\frac{1}{2}$  to 1 oz. (14 to 28 ml.) of gin at midday and at 7 p.m., and tests with Benedict's solution have been completely negative. What is the explanation of this phenomenon?

**A.**—In order to offer an explanation more information is required about the level of the blood sugar when sugar was being excreted in the urine before the gin was taken and its level now. It is possible, but unlikely, that the blood sugar is now lower than it was, though alcohol is not known to have this effect. The more likely explanation is that the threshold of the kidney is now higher than it was and sugar is not excreted for this reason. Estimations of the blood sugar should be made now in order to ascertain whether it is above the threshold value of 180 mg. per 100 ml.; if it is, the urine tests are now misleading.

**Intravenous Salicylates**

**Q.**—Is intravenous sodium salicylate useful for rheumatism, myalgia, lumbago, etc.? There is a Chinese preparation of sodium salicylate 5%, sodium iodide 5%, in a 20-ml. solution for intravenous injection, and a similar Indian preparation. Both seem to be better than sodium salicylate mixture by mouth. Would it be harmful to continue these injections, and could they be used, say, in acute rheumatic fever?

**A.**—The analgesic effect of salicylates in the symptomatic treatment of the conditions named is undoubted. As salicylates are rapidly absorbed from the jejunum nothing is gained by giving them by injection. Repeated injections of sodium salicylate in the high concentrations mentioned will cause sclerosis of the veins. In the treatment of acute rheumatism an adequate blood concentration of salicylates is achieved by regular four-hourly oral therapy. Gastric irritation can nearly always be avoided by diluting the medicine with water and adding sodium bicarbonate, 10 gr. (0.65 g.) to every 20 gr. (1.3 g.) of sodium salicylate. For the very occasional patient who is unable to tolerate the drug by mouth, 1,000 ml. of a 1% solution can be given by slow intravenous drip infusion. The intravenous administration of such large amounts of fluid to patients with an acute rheumatic infection, however, carries with it the danger of overloading the right side of the heart.

**Plasma-cell Myeloma**

**Q.**—What is the treatment and what is the prognosis in a case of plasma-cell myeloma? This was responsible for a pathological fracture of the femur just over a year ago in an elderly woman. Should stilbamidine be given? Is any vitamin therapy likely to be helpful? What other methods of treatment might be tried?

**A.**—Plasma-cell myeloma is, in almost every instance, a diffuse neoplastic disease of the bone marrow. An occasional case of a solitary tumour has been reported. It is assumed that the patient in question has the usual type of multiple myelomatosis referred to in the opening sentence. This disease is always fatal, the average period of survival being between two and three years from the first appearance of symptoms. Vitamins have no effect on the course of the disease; stilbamidine and pentamidine have proved disappointing in most cases although they sometimes relieve pain; anti-moniales, such as "neostibosan," are no more efficacious. If there is an apparently solitary lesion which has led to pathological fracture and is causing pain, local irradiation is most useful, although giving only symptomatic relief. There is no treatment which favourably influences the progress of the disease.

**NOTES AND COMMENTS**

**Intra-articular Injections for Arthritis.**—Dr. LESLIE HARTLEY (Camberley) writes: I was very surprised at the answer in "Any Questions?" (May 13, p. 1156) on intra-articular injections for arthritis, and I was very pleased to see Mr. Grant Waugh's comments (July 1, p. 60). As a patient who has been treated for arthritis by this method, the answers I would give are: (1) The results obtained have been excellent in most cases. (2) The technique for the knee-joint is very simple. An injection of 5 ml. of lactic acid (and not 10 to 20 ml. as suggested in the answer) is given into the knee-joint with a No. 20 needle 2 in. long of the same type as used in ophthalmic surgery for a retrobulbar injection, and it is given with the knee in a flexed position. It is not necessary to inject procaine into the skin or into the synovial membrane, as, with a needle of this type, the procedure is practically painless. Actually, each injection is less painful than the previous one, owing to the beneficial effect of the lactic acid on the synovial membrane. (3) Any case of arthritis is likely to benefit, possibly osteoarthritis coming first. It is of particular value in cases of arthritis of the hip and prevents ankylosis of the joint if given in time, but this injection is difficult and requires the skill of an orthopaedic surgeon. (4) The best mixture to use is lactic acid (pH 5.4 to 5.8) with or without procaine 2%. Your answer stated that in practice it was of no value except perhaps as a placebo, but I feel that this technique can hardly be compared with some coloured water in a medicine bottle given to quieten a neurotic patient. It is not claimed by Mr. Grant Waugh, who has been the pioneer in this work, that it is a cure for arthritis or that its value is anything except local. On the other hand, there are many patients who have been incapacitated or rendered immobile by an arthritic joint which has not responded to rest, heat, etc., but has recovered either partially or fully after six or more weekly injections of lactic acid. It is quite true that after a year or two it may be necessary to have further injections, but, again, any arthritic patient is grateful for any restoration of function, even if it is only temporary, particularly so in a disease like arthritis where nobody can claim any permanent cure; and this applies to the new cortisone, which must be given daily. Finally, your opinion is not shared by our Continental colleagues—otherwise they would not have invited Mr. Grant Waugh to Paris to lecture and to demonstrate his technique to the Académie Nationale de Médecine.

**Correction.**—Relying upon what is usually a trustworthy source of information, we stated in error in last week's *Journal* that the honorary degree of LL.D. of the University of Liverpool had been bestowed on Dr. E. A. Gregg and Dr. C. O. Stallybrass. The degree conferred was M.D.

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