

pressure is unusual in essential hypertension and should suggest the possibility of some other cause such as phaeochromocytoma, renal disease, or hyperaldosteronism.

In patients with hypertension from any cause treated by sympathectomy or ganglion-blocking agents there is, of course, a marked postural fall in blood-pressure when the patient stands up.

REFERENCES

- ¹ Pickering, G. W., *High Blood Pressure*, 1955. J. and A. Churchill, London.
² Smithwick, R. H., *Hypertension: The First Hahnemann Symposium on Hypertensive Disease*, ed. John Moyer, 1959. W. B. Saunders, Philadelphia and London.

Hackett's Sclerosing Solution

Q.—*Can you please give me the formula of Hackett's sclerosing solution for intramuscular injection?*

A.—The formula of Hackett's sclerosing solution (zinc sulphate-phenol stock solution) is:

Zinc sulphate	8 g.
Liquid phenol	12 ml.
Glycerin	24 ml.
Distilled water	add to 100 ml.

The solution for injection is mixed as follows:

Zinc sulphate-phenol stock	4 ml.
Amethocaine hydrochloride, 0.15% .. .	42 ml.
Normal saline	42 ml.

This solution is not intended for intramuscular injection but for provoking aseptic inflammation, followed by scarring with contracture, in ligaments. Hackett¹ describes the process as fibrous proliferation. It is clearly well suited to mechanical lesions at the lower lumbar spine. Here increased stability of the intervertebral joint held by ligaments rendered more taut is an obvious advantage. Hackett advises three injections at weekly intervals, whereupon the patient has to wait another month for the process to become complete.

REFERENCE

- Hackett, G. S., *Ligament and Tendon Relaxation*, 1958. Thomas, Springfield, U.S.A.

Inheritance of Facio-scapulo-humeral Muscular Dystrophy

Q.—*A young woman's father and elder brother both developed muscular dystrophy of the facio-scapulo-humeral type. What are the chances of her children developing the disease if she marries?*

A.—The facio-scapulo-humeral type of muscular dystrophy nearly always behaves as if due to a dominant mutant gene, and this is probably the case here too, since father and son are affected. The chance at birth that the young woman inherited the gene concerned, and would develop the disease, was 1 in 2, and, since she is a young woman, she may still develop it. The total risk to any child of hers is a little less than 1 in 4, and will improve as she gets older without having developed the disease. If she does develop the disease, then the risk to her children will be 1 in 2.

The genetic status of shoulder-girdle types without facial involvement is less certain; families suggesting both dominant and autosomal recessive inheritance have been described.^{1,2} However, if this is the correct diagnosis in this family, the family history suggests dominant inheritance, and the risks given above still apply.

REFERENCES

- ¹ Becker, P. E., *Acta Genet. (Basel)*, 1957, 7, 303.
² Walton, J. N., *Ann. hum. Genet.*, 1955, 20, 1.

Epidermolysis Bullosa

Q.—*Is there any effective treatment for epidermolysis bullosa?*

A.—There is no effective treatment for epidermolysis bullosa.

Long Incubation in Scarlet Fever

Q.—*I have observed a few instances of typical, though mild, scarlet fever with a positive throat swab and with an incubation period of 2 to 3 weeks, judging by its spread within the family. What is the explanation of this lengthy incubation period for the group A haemolytic streptococcus? I have also seen rather more instances of the same condition, including a long incubation period, in which throat swabs are negative, both in the patient and in the siblings. What is this disease?*

A.—The explanation of the apparently long incubation period probably lies in the low infectivity of mild scarlet fever. When a child sickens with scarlet fever it does not follow that all the other susceptibles in the family are simultaneously infected. It is a matter of degree of infectivity: a child with measles is highly infectious, and the majority of exposed susceptibles develop measles within the recognized incubation period; a child with scarlet fever may be only slightly infectious at the outset, but should he develop minor complications, such as rhinitis, he becomes much more infectious. The infectivity of a streptococcal carrier also varies according to the state of his mucosa, and such a carrier in a household might explain the occurrence of a series of cases of scarlet fever occurring after apparently long incubation periods.

When throat swabs are negative in a series of patients then the disease can hardly be scarlet fever. "Fourth disease" has a long incubation period and a scarlatiniform rash followed by desquamation—but there is some doubt whether such a disease really exists. Rubella may be a difficult disease to diagnose from scarlet fever.

NOTES AND COMMENTS

Napkin-rash.—Dr. A. WHITE (Amersham, Bucks) writes: I was surprised that in reply to the question for a suggested cure for a persistent napkin-rash ("Any Questions?" November 26, p. 1616) no mention was made of the possible danger of using boric acid in the final rinse of the napkin. Absorption of boric acid through the skin of excoriated buttocks has caused poisoning and death in the young child, and is especially dangerous for long-continued use. The so-called "ammonia rash" caused by the action of urea-splitting organisms in the bowel acting upon the urea may also be a cause of persistent napkin-rash. This condition can be treated both therapeutically and prophylactically by benzalkonium chloride in the form of a cream.

Corrections.—The N.H.S. basic price of "furamide" should have been given as 43s. 9d. in "To-day's Drugs" (January 28, page 285). The results of the five-day course were referred to, but at present the manufacturers state that they recommend a 10-day course of administration.

We regret a misprint in Mr. N. Slade's letter on control of urinary infections (Feb. 4, p. 361). The seventh line should have read "but *fortunately* it is normally due . . .", not "unfortunately."

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