

draughts. This, with slight opening of the top sash, should generally give good ventilation—but enough heat must be supplied.

Climate and Catarrh

Q.—*What type of climate will most likely help to cure persistent recurrent catarrh of the nasopharynx? Can you name some places in England or Wales where such a climate may be found?*

A.—Though the term nasopharyngeal catarrh can include a variety of disorders with differing causes, it is most commonly employed to describe the dropping down of mucus from the nose into the throat.

It is a natural process for mucus to be carried by the ciliated epithelium lining the nose backwards into the throat, but if this becomes a conscious process it means that there is an excessive secretion of mucus by the nasal epithelium. The commonest cause of this is irritation, which may be from tobacco or possibly as the result of inhaling particles of dust to which the subject is allergic. It is in the latter type of case that geographical location may play a part, and it has been generally found that mountainous and seaside locations are the least likely to be contaminated, by the common allergens.

Other causes of nasopharyngeal catarrh include sinus infection and atrophic rhinitis, and neither of these conditions is likely to be influenced by any change of climate experienced within the British Isles.

Haemorrhage into the Amniotic Sac

Q.—*What are the causes of haemorrhage into the amniotic sac? What symptoms does it cause, and what action is indicated?*

A.—Haemorrhage into the amniotic sac may be maternal or foetal in origin. It can occur during pregnancy or labour, but it cannot be diagnosed until the membranes rupture or are punctured and the blood-stained liquor is seen. If some of the blood can be collected for examination its source can be determined by examining stained smears. Foetal blood usually contains a significant number of nucleated red cells. More complicated tests, such as determining its group and comparing it with that of the mother, might also be possible. In any case, however, a good idea of the source of the haemorrhage is obtained by the clinical features. If the blood is foetal, the foetus is likely to show signs of asphyxia and to die *in utero*, the mother being unaffected. If the bleeding is maternal in origin, there is usually other evidence of antepartum haemorrhage in the mother. Apart from some bleeding vaginally the woman might, for example, show signs of collapse or suffer pain over the uterus. The foetus may or may not be asphyxiated—depending on the degree of associated placental separation.

Maternal bleeding takes place from sinuses in the uterine wall; the affected sinus may be at the placental site, at the margin of the placenta, or elsewhere in the uterine wall. The blood at first lies in the chorio-decidual space and then bursts through the membranes into the amniotic sac. The initial haemorrhage may be caused by the passage of an instrument such as a bougie or Drew Smythe catheter outside the membranes, or by puncture of the pregnant uterus through the abdominal wall. In such circumstances the instrument may not only cause the haemorrhage, but may provide the opening through which the blood leaks within the amnion. Often, however, the initial haemorrhage is spontaneous and constitutes accidental antepartum haemorrhage, which may be of the concealed variety. In such cases the burst through into the amniotic sac can be spontaneous.

Although it is theoretically possible for the foetus itself to bleed from some lesion such as a surface haemangioma, in practice haemorrhage of foetal origin usually comes from foetal vessels of a normal or abnormal placenta, from the cord, or from a large vessel running in the membranes (velamentous insertion of the cord). The last is the most common explanation and is particularly likely if the vessel lies low in the uterus. A *vasa praevia*, however, more often

bleeds externally (and is mistaken for accidental antepartum haemorrhage) than into the amniotic sac, or the vessel and the membranes rupture together and a mixture of blood and liquor then appears and is quickly followed by signs of foetal asphyxia.

If amniotic haemorrhage is maternal in origin the treatment is the same as for accidental haemorrhage. If it arises from foetal vessels, however, it is unlikely that the diagnosis will be made until the foetus has died and until it and the secundines are examined after delivery. If, however, the diagnosis is made before the foetus is irreparably damaged, delivery should be completed immediately by the method best suited to the obstetrical circumstances.

Are Phosphates Deposited in Acid Urine?

Q.—*Can a urine cloudy with a deposit of phosphates be either acid or alkaline?*

A.—A phosphatic deposit is nearly always found in an alkaline urine, but it is possible to have some phosphate deposited from a urine when the reaction is only just over the neutral point on the acid side and where the urine is concentrated. The calcium hydrogen phosphate (stellar phosphate) is the one likely to be found.

Pyrexia in Köhler's Disease

Q.—*A boy of 6 has Köhler's disease of the tarsal navicular. The x-ray appearances are classical, showing condensation and fragmentation of the nucleus with no sign of rarefaction of surrounding bones. His temperature has been persistently slightly elevated, averaging 98.8° F. (37.1° C.) in the morning and 99.6° F. (37.6° C.) in the evening for over four weeks, during which time he has been in a resting plaster with no weight-bearing whatever. There are no signs of any other focus of infection and the x ray of the chest is normal. Is this low-grade pyrexia an unusual feature, and should its presence delay the application of a walking plaster?*

A.—The pyrexia in this boy is probably unrelated to the Köhler's disease, which is thought to be due to an avascular necrosis or some other vascular abnormality. Weight-bearing need not be delayed. A plaster is not really necessary: the more usual treatment is to support the foot with a valgus sponge-rubber insole.

Ultra-violet Light for Vitamin-D Deficiency in the Tropics

Q.—*Is it worth prescribing ultra-violet light for vitamin-K deficiency diseases in a tropical country where there is plenty of sunlight?*

A.—No, provided exposure to sunlight can be assured.

Correction.—In our account (July 10, p. 107) of the presentation of honorary degrees by the University of Glasgow during the Annual Meeting we should have stated that the Vice-Chancellor, Sir Hector Hetherington (not, as we reported, the Chancellor), presented the degrees.

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