

effect may in part be psychological, but is mainly because the need to have an operation and to enter hospital brings to a harassed woman her only opportunity to rest her aching muscles, to be relieved of her daily household responsibilities, and to receive the sympathy and attention of relatives and friends which she would otherwise not obtain. To have her cervix cauterized is sometimes a tired housewife's only means of prompting her husband to give her a bunch of flowers, to bring her tea to bed in the morning, and to help with the washing up.

#### Gelatin for Brittle Nails

**Q.**—*Advertisers recommend taking gelatin for various beauty purposes, the suggestion being that it is a "remedy for brittle and breaking finger-nails." Is there any evidence to support such a claim?*

**A.**—I am not aware of any convincing evidence to support this claim. Gelatin has been recommended as a treatment for psoriasis of the nails. From my own experience I believe that it is sometimes, though by no means always, effective. When it is, a daily dose of about  $\frac{1}{2}$  oz. (14.2 g.) of gelatin has to be taken for a period of usually at least two or three months before improvement is evident. If the treatment is stopped the psoriasis of the nails is likely to relapse in the course of a similar period of time. Fragile and brittle nails<sup>1</sup> are not usually the result of psoriasis, and I doubt whether gelatin treatment will affect this complaint. In any event, one would hardly expect to see improvement within a month, and probably at least a three months' trial would be necessary in order to judge.

#### REFERENCE

- <sup>1</sup> *Brit. med. J.*, 1960, 1, 1828.

#### Latent Syphilis

**Q.**—*A man aged 81 with aortic incompetence has been found to have positive W.R. and Kahn reactions. His three children are all about 50 years of age and apparently in good health. Should they be subjected to blood tests or is it justifiable to leave well alone? The mother died of cancer 22 years ago.*

**A.**—The three children should certainly be tested. Latent syphilis, congenital or acquired, can be present for many years and then become manifest with serious results. The tests should be done without disclosing the diagnosis in the case of the father, because to do so would probably cause great unhappiness to everyone concerned. There are many reasons for taking blood tests, and the story of a low-grade infection of long standing which occasionally affects other members of the family is usually acceptable.

#### Haemophilia in a Family

**Q.**—*A girl aged 20 is contemplating marriage. The family history is that her maternal grandfather suffered from haemophilia, but, in spite of this, had three sons, said to be normal, and three daughters. Of the sons' families, all the offspring appear normal, but of the daughters one has two sons who are both haemophiliacs, another has two daughters, and the third, my patient's mother, has also two sons with haemophilia. What are the chances of this girl producing a normal child who would not, in turn, pass on this inheritable disease?*

**A.**—This is a typical pedigree of a sex-linked recessive condition. Since the maternal grandfather had the gene for haemophilia on his X chromosome, all his sons, to whom he has transmitted his Y chromosome, will be unaffected and cannot have affected children. His daughters, to whom he has transmitted his X chromosome, are all carriers of the gene for haemophilia. The patient's mother is therefore a carrier of the gene, and this is confirmed by the fact that she has had two sons with haemophilia. The chance of the patient being a carrier like her mother is 1 in 2; the risks to her children are, therefore, for the boys 1 in 4

of having haemophilia, and for the girls 1 in 4 of being a carrier of haemophilia.

While, in general, carrier women cannot be identified by laboratory tests, such as estimations of the anti-haemophilic globulin titre, there are families with mild haemophilia in which such tests are helpful in detecting carrier women,<sup>1</sup> and an expert haematological investigation of this family would be worth while.

#### REFERENCE

- <sup>1</sup> Graham, J. B., *Amer. J. hum. Genet.*, 1956, 8, 63.

#### Congenital Dysplasia of the Hip

**Q.**—*How should one examine for and diagnose congenital dysplasia of the hip, especially in bilateral cases, in very young babies?*

**A.**—Congenital dysplasia of the hip in very young babies presents either as a partial displacement or as a complete dislocation. Dysplasia should be suspected in babies with a family history of congenital dislocation of the hip. Asymmetric buttock creases and limitation of hip abduction warrant radiological examination—even in bilateral cases the buttock creases are usually asymmetric. It should be noted, however, that these clinical signs are not always accompanied by radiological evidence of displacement.

Ortolani<sup>1</sup> described a simple method for detecting congenital dislocation of the hip in the newborn—a click is felt when the leg is maximally turned outwards in maximal abduction. Arthrography confirms that the click occurs as the head snaps over the socket wall.

All suspected cases should be examined radiographically. (1) A shallow acetabular angle with no displacement of the upper end of the femur does not necessarily imply impending dislocation.<sup>2</sup> Such cases may be x-rayed again at 4 months, by which time the majority will have formed a normal acetabular angle. (2) Upward or lateral displacement of the upper end of the femur indicates definite subluxation or dislocation. The upper end of the femur should not lie above a line drawn through the upper margin of the symphysis.<sup>3</sup> (3) Dislocation of the hip in the newborn may be demonstrated radiographically by forcible abduction to at least 45° with appreciable inward rotation of the femora.<sup>4</sup> The head is forced either into or out of the socket. If dislocated, the line of the femur shaft will point above the upper edge of the bony acetabular wall. (4) Treatment of doubtful cases by simple abduction will restore stability within a few months.

#### REFERENCES

- <sup>1</sup> Ortolani, M., *La Lussazione Congenita dell' Anca*, 1948. Capelli, Bologna.  
<sup>2</sup> Caffey, J., Ames, R., Silverman, W. A., Ryder, C. T., and Hough, G., *Pediatrics*, 1956, 17, 632.  
<sup>3</sup> Rosen, S. von, *Acta orthop. scand.*, 1956, 26, 136.  
<sup>4</sup> Andren, L., and Rosen, S. von, *Acta radiol. (Stockh.)*, 1958, 49, 89.

**Correction.**—We regret a printing error in the paper "A Freeze-dried Vaccine from Isoniazid-resistant B.C.G." (May 27, p. 1500). In Table II the percentage positive, with isoniazid, with batch 331 of the resistant vaccine should have been 100, not 104 as printed.

#### Collected Articles from the "British Medical Journal"

The following books are available through booksellers or from the Publishing Manager, B.M.A. House. Prices, which include postage, are now the same for both inland and overseas.

*Refresher Course for General Practitioners*, Volume 3 (26s. 9d.).  
*Any Questions?*, Volume 3 (8s. 3d.).

All communications with regard to editorial business should be addressed to THE EDITOR, BRITISH MEDICAL JOURNAL, B.M.A. HOUSE, TAVISTOCK SQUARE, LONDON, W.C.1. TELEPHONE: EUSTON 4499. TELEGRAMS: *Atitology, Westcent, London*. ORIGINAL ARTICLES AND LETTERS forwarded for publication are understood to be offered to the *British Medical Journal* alone unless the contrary be stated. Authors desiring REPRINTS should communicate with the Publishing Manager, B.M.A. House Tavistock Square, W.C.1, on receipt of proofs. ADVERTISEMENTS should be addressed to the Advertisement Director, B.M.A. House, Tavistock Square, London, W.C.1 (hours 9 a.m. to 5 p.m.). TELEPHONE: EUSTON 4499. TELEGRAMS: *Britmedads, Westcent, London*. MEMBERS' SUBSCRIPTIONS should be sent to the SECRETARY of the Association. TELEPHONE: EUSTON 4499. TELEGRAMS: *Medisecra, Westcent, London*. B.M.A. SCOTTISH OFFICE: 7, Drumsheugh Gardens, Edinburgh.