to 1 million units three times a day. If candidiasis is extensive and has spread beyond the intestine the unpleasant alternative of amphotericin-B infusions may have to be considered. Vitamin-B supplements are often given, though there is unlikely to be significant avitaminosis unless the patient is debilitated.

For the pruritus ani itself the patient should be advised to avoid wool clothing ; he should not use toilet paper but rather wash the anal region after defaecation and carefully dry it, using talcum powder. Aqueous cream (*B.P.* 1958) should be used instead of soap. Nystatin ointment (100,000 units per g.) or a 0.5% aqueous solution of gentian violet applied to the anus three times a day may help if *C. albicans* is indeed the cause. If it is not a solution containing a mixture of menthol one part, eucalyptol two parts, and sodium bicarbonate and powdered alum each eight parts is more likely to be of use.

Hydrocortisone acetate ointment 1% may be tried in severe cases, and Lubowe[1] describes a method for producing permanent relief with subcutaneous injections of depot methyl prednisolone. Local antihistamines should be avoided, but they may be given orally to lessen the itching.[2] Sedation is often necessary.

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[1] Lubowe, I. I., *Antibiot. Med.*, 1960, 7, 702.
[2] Spinka, H. M., *Amer. J. Proctol.*, 1961, 12, 309.

Barr Bodies

Q.—*Does the fact that the Barr body occurs in some 5% of mucosal scrapings in 5% of apparently normal males and occurs in only up to 50% of cells in mucosal scrapings from apparently normal females indicate that many people are chromosome mosaics?*

A.—This does not indicate that many people are chromosome mosaics. Most workers have found no Barr bodies in normal males, and positive findings are probably due to technical difficulties.[1 2]

The reason why only about 50% of female cells contain a Barr body is again probably because of technical difficulties, the condition of the cells, and the practice of accepting as Barr bodies only those on the periphery of the nucleus. Guard,[3] using vaginal smears, which are more satisfactory than buccal smears, and employing a differential staining technique which permitted the identification of Barr bodies even when not on the nuclear membrane, found such bodies in 96 to 98% of vesicular nuclei in the vaginal cells.

REFERENCES

[1] Moore, K. L., and Barr, M. L., *Lancet*, 1955, 2, 57.
[2] Dixon, A. D., and Torr, J. B. D., *Brit. med. J.*, 1956, 2, 799.
[3] Guard, H. R., *Amer. J. clin. Path.*, 1959, 32, 145.

Precipitation of Schizophrenia

Q.—*To what extent do emotional upsets cause the onset of symptoms in a person who has latent inherited schizophrenia? If such precipitating factors do not operate is it possible for the disease to remain dormant in this type of person?*

A.—In considering the question of schizophrenia apparently precipitated by emotional upset it is important, first of all, to be quite certain of the diagnosis ; hysterical states and depersonalization reactions may be erroneously diagnosed as schizophrenia. Some authorities claim to distinguish a specific psychogenic psychosis which resembles schizophrenia but is genetically unrelated and carries a good prognosis.[1 2] However, some genuinely schizophrenic illnesses appear to be precipitated by emotional disturbance, and one estimate puts the proportion as high as 20%.[3] Emotional disturbance can also be a symptom of the psychosis.

Current genetic theories of schizophrenia leave plenty of scope for the effect of environmental factors. According to the theory which accounts for the facts most closely only about 1 in 4 of the gene carriers actually develops the disease.[3] It is therefore quite possible for the disease to remain dormant. Indeed, it does so in 3 out of 4 of those genetically predisposed. It is, however, not possible to say that the psychosis would never have appeared if a particular event had not occurred.

REFERENCES

[1] Faergeman, P. M., *Psychogenic Psychoses*, 1963. Butterworth, London.
[2] Labhardt, F., *Die Schizophrenieähnlichen Emotionspsychosen*, 1963. Springer-Verlag, Berlin.
[3] Slater, E., *Brit. J. Psychiat.*, 1964, 110, 114.
[4] —— *Acta genet. (Basel)*, 1958, 8, 50.

Norwegian Scabies

Q.—*What is Norwegian scabies and how does it present?*

A.—This type of scabies was first described in Norwegian lepers. It is generally seen in the aged or in those suffering from nervous or mental disease. It presents as a widespread, sometimes generalized, thickened, scaling eruption of a dirty brown appearance and may affect any or all parts of the body. It is sometimes called "crusted scabies," and is often not associated with obvious itching. Whereas most patients suffering from scabies present on examination not more than 5 to 10 burrows, patients with Norwegian scabies may have 3 to 4 million, and examination with a lens shows serried rows of burrows over the skin. A section of such skin shows tier upon tier of burrows with pregnant mites lying in the crusted horny layer of the skin. The result is that almost every scale shed by the patient carries a pregnant mite and is capable of infecting others. It is thus that ward epidemics arise, especially in geriatric and mental hospitals.

The response to treatment with benzylbenzoate emulsion is satisfactory if pursued assiduously.[1]

REFERENCE

[1] Ingram, J. T., *Brit. J. Derm.*, 1951, 63, 311.

Early Menarche and Growth

Q.—*A girl aged 10 has had two menstrual periods two months apart. The parents are worried about the effect of this early menarche on her growth. Would the use of a progestogen for a period of three to four years help to suppress ovulation and so permit normal growth?*

A.—I do not think that the patient mentioned in this question requires any treatment at all. The effect of a relatively early menarche would be to cause the pubertal growth spurt (which is not very marked in girls anyway) to occur earlier than usual. The time at which the epiphyses closed would also be relatively earlier. However, it is doubtful if the ultimate height attained would be much different if the menarche had occurred at, say, the age of 12 or 13. In any event, ovulation has nothing to do with the problem, and to suppress it with steroids, which themselves might contribute to epiphysial closure, would certainly not affect the situation in the patient's favour.

Rheumatoid Arthritis and Potency

Q.—*Is there any known relationship between rheumatoid arthritis and reduction of sexual potency?*

A.—There is no specific reduction of sexual potency in rheumatoid arthritis, although this, like any chronic or disabling disease, does tend to reduce its expression. Females also tend to have fewer children, even before onset of rheumatoid arthritis, but this is only evident by statistical examination of a large number of cases.

Notes and Comments

Mechanism of Referred Pain.—Mr. F. R. BROWN (Dundee) writes : In answer to the question posed ("Any Questions?" 18 April, p. 1034) your expert refers to the anatomical maybes and the imaginative explanations of the physiologists, but wisely concludes with : "The true facts in any individual example of the phenomenon are not known." In my opinion, and as I have previously written,[1 2] there is no such phenomenon as referred pain. Pain, like touch, taste, and smell, is a specialized system, and pain is excited by an adequate stimulus which is naturally accepted by the peripheral nerve endings, but can also be excited by an abnormal stimulus to any other part of the afferent nerve pathway to the centre in the sensorium. The abnormal stimulus—if adequate—provokes the normal response in a predetermined position. The presence or absence of tissue is immaterial—for example, phantom-limb pain. If pain is referred why not also touch and taste? Why not a glossocutaneous reflex or radiation? Let us stick to facts rather than to illogical fancies.

REFERENCES

[1] Brown, F. R., *Brit. med. J.*, 1942, 1, 543.
[2] —— and Smith, G., *Lancet*, 1945, 1, 10.

Corrections.—In the summary of the paper by Mr. J. A. Chalmers on the Malmström vacuum extractor (*Brit. med. J.*, 9 May, p. 1216) the period during which this instrument was used at the Obstetric Unit, Ronkswood Hospital, Worcester, should have been stated as 1958 to 1963, *not* 1948 to 1963.

In the last column of Table I of the paper by Drs. J. Anderson and V. Parsons on "Maximal Tubular Resorptive Rate for Inorganic Phosphate in Hyperparathyroidism" (*Brit. med. J.*, May 2, p. 1150) the figures for the TmP (mg./min.) should have read 0.18, 0.94, 0.83, *not* 1.81, 1.95, 1.83. The final TmP should have been 1.19 mg./min.