

It is true that such a reinforcing dose may be unnecessary for a person who has had a full, properly spaced, primary course of immunization within the previous five years or so. But it should be given, because (1) it can do no harm; (2) it can boost the primary course; (3) there is not always time to ascertain whether the primary course was full or fully effective; (4) it is administratively easier to have a definite direction to give adsorbed tetanus toxoid to every injured person than to confuse a casualty officer with exceptions to the rule. There are, however, bound to be exceptions: a motor-cyclist who is prone to appear twice a year in the casualty room obviously should not receive another dose of tetanus toxoid on every occasion.

There is a limit to the number of reinforcing doses. Some persons become sensitized to the antigen and suffer increasingly severe local reactions with further injections. It is thought to be unnecessary to give more than two to three reinforcing doses, at intervals of five to ten years, after a full, properly spaced primary course of immunization.

Holiday Abroad for Pregnant Diabetic

Q.—A pregnant diabetic woman stabilized on soluble insulin night and morning wishes to visit Madeira, the Canaries, and Gibraltar or Malta when she will be in the fifth month of pregnancy. Is this advisable?

A.—One would have to know a great deal more before giving advice. For example, how intelligent is the patient and does she understand the implications of diabetes and its management? What has diabetic control been like in the past? Is this a first baby? How long is she staying away, and will she be with friends or relatives or living in hotels? Who is to accompany her?

The guiding principles for the pregnant diabetic are that adequate control is essential and that delivery before term will probably be advisable. I would not condemn out of hand a holiday abroad in the fifth month provided the patient realizes how to deal with such inconveniences as intercurrent gastrointestinal infections and foreign food and wine.

Ultra-violet Light for Herpes Zoster

Q.—Is ultra-violet light effective in the treatment of herpes zoster?

A.—Ultra-violet light is not effective in the treatment of zoster and might in fact be dangerous. The virus is susceptible to ultra-violet light *in vitro*, but such high doses would be required to destroy intracellular virus that considerable tissue destruction would result.

McMurray's Osteotomy

Q.—What is McMurray's osteotomy for arthritis of the hip?

A.—Years ago the main problem of the elderly patient with osteoarthritis of the hip was the adduction deformity which caused much apparent shortening of the leg. Early in orthopaedic history it was obvious that an osteotomy in the subtrochanteric region with abduction of the adducted leg and correction

of the associated flexion deformity would make these patients walk much better. This was done with increasing frequency, and the technique was perfected by Professor McMurray, of Liverpool. This became known as McMurray's osteotomy, though Alan Malkin, of Harlow Wood Hospital, was developing this very much at the same time.

It became quickly apparent that these patients not only had correction of the deformity but lost much of their pain, a rather unexpected finding. This has become such an important aspect of the operation that we now do McMurray's osteotomy for undeformed, painful, mobile osteoarthritic hips. The operation is to divide the femur at the level of the shaft just above the lesser trochanter, and the shaft is displaced medially. In the past this used to be followed by a plaster spica, but in these elderly patients stiffness of the knee became a problem, and

it is now almost universally accepted that internal fixation with a pin and plate provides a good method of post-operative immobilization with the opportunity of keeping the knee moving.

The result of this operation is that some 80% of patients obtain very worth while relief of pain. It is a simple procedure, and if it fails to continue to give relief after a number of years other procedures can be done, such as arthrodesis or arthroplasty. There is also accumulating evidence that osteoarthritic deterioration of the hip is slowed or even reversed after a McMurray's osteotomy. Though the benefits of the operation are ill-understood and it remains an empirical procedure it has become an increasingly commonly performed operation here, and now in the United States, because of its simplicity and the reasonable certainty of relief to the patient.

Notes and Comments

Magnesium Oxide Fume.—Mr. E. F. EMLEY (Chief Metallurgist, Magnesium Elektron Limited, Swinton, Manchester) writes: With reference to the answer to this question ("Any Questions?" 8 May, p. 1236), is there factual evidence of metal-fume fever arising from prolonged inhalation of magnesium oxide fume, or is this a matter of expectation based on the supposition that magnesium oxide fume, like other metal fumes, will contain magnesium metal? Actually, I would think it extremely unlikely that there could be any appreciable free metal in magnesium oxide fume. The metal does indeed have some volatility at and below the melting point, but the vapour is, of course, extremely easily oxidized in air. If the supply of oxygen is restricted the vapour is nitrided. We have ourselves never seen any trace of metallic magnesium in magnesium oxide fume. Efficient local exhaust will in any case be desirable since other vapours (HCl) are evolved from magnesium alloy melts treated with the normal fluxes.

OUR EXPERT replies: The factual evidence for metal-fume fever arising from the inhalation of magnesium oxide fume is well known and has been published.^{1,2} It is appreciated that the concentrations of magnesium oxide in the air of melting rooms can be low,³ but all possible environmental exposures had to be considered in answering this question.

REFERENCES

- 1 Drinkler, P., Thomson, R. M., and Finn, J. L., *J. industr. Hyg.*, 1927, 9, 187.
- 2 Drinkler, K. R., and Drinkler, P., *ibid.*, 1928, 10, 56.
- 3 Williams, C. R., *ibid.*, 1942, 24, 277.

Safe Aperient.—Mr. H. REID (Liverpool 1) writes: A reply given to an inquiry ("Any Questions?" 3 April, p. 913) as to the safety of bisacodyl contained a disparaging reference to Senokot. I wonder why, of the many laxatives available, Senokot was chosen for comparison? I have used it for many years with great satisfaction. On a question of griping, I know of no published comparative trials which show Senokot to be inferior to bisacodyl. With Senokot, in contrast to the older unstandardized senna preparations, griping appears to have been virtually eliminated.¹

In regard to the alleged action of Senokot as an "irritant" the publication of the work of Douthwaite and Golding² and a note under "To-day's Drugs"³ indicate that Senokot has a stimulant and not irritant action. No reference is made to the interaction between bisacodyl and alkalis which even the manufacturers themselves rightly draw attention to as a contraindication.

There is no such limitation on the use of Senokot.

Finally, what should not be overlooked is that Senokot is the most widely prescribed laxative under the N.H.S.; that it is virtually free from side-effects;⁴ that straining at stool is reduced;⁵ that its action on the chronically constipated bowel is re-educative;⁶⁻¹² and that a recent authoritative statement says, "of all the laxatives available, the claims of standardized senna (Senokot) for general use appeared outstanding."¹² Furthermore, Senokot is cheap.

OUR EXPERT replies: The question was about the safety and suitability of bisacodyl for children, pregnant women, and the aged, and I was not attempting in my reply a general discussion on the relative merits of different aperients. Senokot (like glycerin) was not mentioned for purposes of disparagement but merely to imply that bisacodyl in the opinion of some (but obviously not all) might be preferable in such situations to other excellent and widely used preparations. Admittedly Senokot is cheaper, and used in the correct dosage rarely gives griping or "irritation," but there is, I think, a *prima facie* case for preferring a non-systemic and direct-acting drug, especially during pregnancy.

I am grateful to Mr. Reid for pointing out the interaction between enteric-coated bisacodyl tablets and alkaline stomach powders. A simple way round this occasional dilemma, however, would presumably be to use the suppositories.

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- 1 *British Encyclopaedia of Medical Practice, Cum. Suppl.*, 1964, p. 213. Butterworth, London.
- 2 Douthwaite, A. H., and Goulding, R., *Brit. med. J.*, 1957, 2, 1414.
- 3 *Ibid.*, 1959, 2, 125.
- 4 Suarez, J., Garcia, C. A., and Shepard, J., *Int. Rec. Med.*, 1960, 173, 639.
- 5 Halpern, A., et al., *Angiology*, 1960, 11, 460.
- 6 Herland, A. L., and Lowenstein, A., *Quart. Rev. Surg. Obstet. Gynec.*, 1957, 14, 196.
- 7 Campbell-Mackie, M., *Practitioner*, 1959, 183, 732.
- 8 Dubow, E., *Arch. Pediat.*, 1960, 77, 261.
- 9 Smith, C. W., and Evans, P. R., *Geriatrics*, 1961, 16, 189.
- 10 Abrahams, A., *Brit. J. clin. Pract.*, 1964, 18, 1.
- 11 *Lancet*, 1962, 1, 1010.
- 12 Haward, L. R. C., and Hughes-Roberts, H. E., *Gut*, 1962, 3, 85.

Correction.—In the letter on "Mediastinoscopy and Radiotherapy" by Mr. Anthony Green (22 May, p. 1378), the second sentence in the first paragraph should have read "Although 'air' mediastinography with tomograms may show up mediastinal nodes, mediastinoscopy is advantageous, as it enables a biopsy to be taken."