

uncommon, and sensitization is relatively unimportant, particularly since these antibiotics are rarely given systemically. An area to which penicillin may still be legitimately applied is the eye, whether for the prevention of ophthalmia neonatorum or for the treatment of acute conjunctivitis due to a penicillin-sensitive organism such as the pneumococcus or the Morax-Axenfeld bacillus. There appears to be no evidence that sucking penicillin lozenges or pastilles has any more tendency to sensitize than swallowing tablets to obtain a systemic effect, but, on the other hand, the value of local treatment in the mouth is doubtful. When there is a clear indication for penicillin treatment, such as a Vincent's gingivitis, systemic treatment is certainly more dependable and rapid in its effects.

Sensitivity to penicillin can result from administration by any route: most accounts of serious reactions include a history of previous injections. The belief that sensitization is more readily caused by local application should not stand in the way of any clearly indicated form of such treatment.

Penicillin and Psoriasis

Q.—After a course of penicillin three years ago for bronchopneumonia, a patient's extensive psoriasis, which she had had for many years and which had resisted the usual treatments, completely disappeared for 18 months. Is there any evidence that penicillin could have any effect on psoriasis?

A.—Psoriasis is a particular pattern of reaction to stress, physical or mental, occurring in the skin of an individual so predisposed. Like other patterns of reaction, psoriasis tends to improve or clear completely during a serious organic illness. It is probable that bronchopneumonia rather than penicillin caused the psoriasis to disappear. Certainly penicillin given to patients with psoriasis who are suffering from mild infections (e.g., boils) does not benefit their psoriasis.

Electrically Heated Insecticide Vaporizers

Q.—I would be grateful for any information on electrical fly-killing devices, their method of operation, and any long-term or cumulative toxic effects they might have.

A.—The only truly "electrical fly-killing devices" I have seen were in the fly-breeding rooms of an American laboratory. They consisted of meshes of alternate high-tension wires put over the windows to kill escaped flies (which were rather numerous). Every few minutes a fly would alight on the mesh and electrocute itself, to the accompaniment of a sizzle and a smell of burnt fly.

The questioner, however, presumably has in mind the electrically heated insecticide vaporizers which can be plugged in to the ordinary electricity supply. These instruments usually contain undiluted insecticide (often D.D.T. or gamma B.H.C.) which is maintained at a high temperature and slowly dissipates, either by sublimation or as a very fine aerosol. Much of this insecticide is deposited on the walls or ceiling in the vicinity of the apparatus, where it acts as a residual deposit. The remainder may act directly on insects flying in the room.

The insecticidal effects depend partly on the rate of volatilization per unit volume of the room and partly on the amount of ventilation. Both may vary considerably, as explained in a paper by P. J. Spear.¹ Thus, a vaporizer adjusted to emit 1 g. per 24 hours was found to vary between 0.3 and 2.5 g., according to local air currents. Regarding ventilation, it appears that the air in a room may change completely from five to several hundred times a day, according to structure and conditions.

General observations on the performance of these vaporizers indicate that they are effective in controlling house-flies, mosquitoes, and midges, provided the amount of room ventilation is not excessive. However, like other uses of modern synthetic insecticides, they are liable to be nullified by insecticide-resistance.

These insecticide vaporizers must, of course, be considered in regard to health hazards; especially since they are likely to be used in restaurants, kitchens, and food shops. An inter-departmental committee on pest control in Washington in 1951 recommended that they should be operated under the following conditions. Not more than 1 g. of insecticide should be volatilized per 15,000 cu. ft. per 24 hours; the vaporizers to be situated above head height and not less than 3 ft. (91 cm.) from the ceiling.

A paper by Hensill and Leyland² records analysis of food samples and data of exposure of rats in a treated room which suggest that the vaporizers are perfectly safe when used as directed.

REFERENCES

- ¹ Spear, P. J., *Soap and Sanitary Chemicals*, 1952, 28, No. 8, 147, 173.
- ² Hensill, G. S., and Leyland, S. J., *ibid.*, 1952, 28, No. 11, 119, 141

NOTES AND COMMENTS

Obesity After Hysterectomy and Oophorectomy.—Dr. A. LEWIS (London W.9) writes: Perhaps it is because I have for so long been trying to advocate that the days of the limited calorie diet for the treatment of obesity are over that I find it somewhat irksome to see it once more put forward in your issue of July 1 ("Any Questions?" p. 65). It is no longer justifiable to keep patients hungry, with or without the help of dextro-amphetamines, except in special circumstances. Exclusion of all fat and permission of limited kinds of carbohydrate-containing foods (Marriott's Diet Card, H. K. Lewis) allows the patient to eat in unlimited amounts good varied meals and lose weight steadily (1 to 2 lb. [0.5 to 0.9 kg.] per week after initial loss). Alternatively, exclusion of all carbohydrate and permission of all protein- and fat-containing foods is almost as good, though in my hands not quite so effective. For those who want quick results and are able to face a more stringent regime, my own method (roughly no fats, only protein and foods containing up to 5% carbohydrates, with limited exceptions) will work twice as fast. In none of these methods should the patient go short of food.

OUR EXPERT replies: The diets Dr. Lewis mentions are usually effective because they tend to lead to decreased calorie intake while maintaining a relatively high bulk of food. Carbohydrate has a low satiety value, so that exclusion of this class of food-stuffs leaves a diet the components of which have a relatively high satiety value, and hence a moderate amount of relatively low-calorie value will satisfy the patient. Exclusion of fat and allowing only low carbohydrate foods means, in effect, calorie restriction pure and simple. But it is ludicrous to suppose that anyone can eat *unlimited* amounts of either of these types of diet and still lose weight.

Correction.—We regret a misprint in Appendix I of the paper by Miss Rosan Spencer-Smith and Dr. Gerald Blanshard on "Cost of Diets" (July 1, p. 27). The price of skimmed milk in Central London during October, 1959 (column A in the appendix), should have read 7d., not 1s. 7d.

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