

therapy. The main side-effects are postural hypotension or giddiness, lassitude, exertional hypotension, failure of ejaculation, and limb weakness. In a third of these cases the side-effects disappeared in spite of continuous therapy. Diarrhoea was noted in eight out of 200 cases, but disappeared in four after continued therapy. The main problem is the effect on S.G.O.T. and S.G.P.T., but the significance of these enzyme changes is not yet known.

In summary, guanoclor is an effective antihypertensive agent, especially in combination with a thiazide diuretic, and should be taken into consideration when considering initiation

of antihypertensive drug treatment. It is not the ideal drug, because it is not universally effective or free from side-effects; this, of course, applies equally to all the other potent antihypertensive agents available.

Judgment on its toxicity must be reserved until further reports on the significance of the occasional elevation of S.G.O.T. and S.G.P.T. are determined.

REFERENCE

- ¹ *Brit. med. J.*, 1964, 1, 402.

ANY QUESTIONS?

We publish below a selection of questions and answers of general interest.

Hyperostosis Frontalis Interna

Q.—What is the aetiology of hyperostosis frontalis interna? What is the prognosis and is there any treatment?

A.—Hyperostosis frontalis interna occurs more commonly in middle-aged women than in men. The proliferated bone of the inner table of the skull is always adherent to a thin dura which may sometimes be penetrated by it. The aetiology is unknown; it is not associated with trauma or osteitis deformans. It is very slowly progressive. Patients with hyperostosis frontalis interna sometimes may suffer from headache, but many more who have the condition have no neurological symptoms. No causal relationship between the two has ever been established. The syndromes of Morgagni and Morel, described in the eighteenth and nineteenth centuries, should no longer be regarded as clinical entities.

Only symptomatic treatment is indicated, but other causes for the patient's complaints should be sought.

Flying After Stapedectomy

Q.—What advice on flying in an aircraft should be given to a patient aged 55 who has had a successful operation (stapedectomy and the insertion of a polythene tube in the middle-ear cavity) for otosclerosis?

A.—There is no reason why a patient should not fly after a successful stapedectomy. Probably it would be better to fly in a pressurized aircraft. I would advise the patient not to fly if he has a head cold. This applies to anybody, but particularly to a person who has had a stapedectomy.

Restless Leg Syndrome

Q.—What is the "restless leg" syndrome, and what is the treatment?

A.—The "restless leg" or Ekbom syndrome^{1,2} is not very uncommon. It usually occurs in middle age and either sex may be affected. The symptoms come on only when the sufferer is sitting relaxed in a chair or when he is in bed. He develops an intolerable discomfort in the legs, most commonly in the shins. It is described as

burning, crawling sensations, feelings of tightness, and sometimes actual pain, and Ekbom's term *anxietas tibiarum* seems a particularly good description of the symptoms. If the sufferer walks about the symptoms rapidly improve. There are no abnormal signs, either neurological or vascular.

The condition is benign but may cause very considerable discomfort. The aetiology is quite unknown but is almost certainly organic. Treatment is unsatisfactory. A few patients are helped by oral carbachol and

Status Asthmaticus in a Child.—Dr. D. GAIRDNER (Addenbrooke's Hospital, Cambridge) writes: Your expert ("Any Questions?" 6 June, p. 1490) advises aminophylline suppositories 0.18 g. given up to 4-6 hourly to a 5-year-old child. This works out at a maximum dosage of 1.08 g./24 hours, or about 60 mg./kg./24 hours. From the observations of those who have gone carefully into the numerous reported deaths following aminophylline^{1,2} the conclusion can be reached that the maximum safe dosage of aminophylline should not exceed about 15 mg./kg./24 hours by all routes. Your expert therefore advises some four times the safe dosage. He makes no mention of the dangers of overdosage of this drug, and, furthermore, advocates giving ephedrine "later" without warning that if ephedrine and aminophylline are combined the toxicity of aminophylline is much enhanced.

OUR EXPERT replies: Dr. Gairdner is right to point out that deaths have occurred particularly in children under 4 years from treatment with aminophylline. However, the total number of deaths recorded up to 1957 was only 11—a very small number considering the frequency with which this drug is used. In some of these cases there was gross overdosage by any standard and in others death may have occurred from other causes—for example, in one case fulminating pneumonia is mentioned. It is, however, important to watch for restlessness, excitability, and vomiting, which may indicate intolerance, and it would be safer to prescribe 100-mg. suppositories rather than 180 mg. if the dose is to be repeated, since the effects are cumulative. Most clinicians consider that the drug given as rectal suppositories is tolerated in considerably larger doses than by the intravenous route.³

Dr. Gairdner is, of course, quite right in pointing out that ephedrine should not be given at the same time as aminophylline, and this is the reason for stating "later" in my answer.

others by a vasodilator such as inositol. Chlorpheniramine has also been recommended. In some patients it seems to be impossible to relieve the symptoms.

REFERENCES

- ¹ Ekbom, K. A., *Acta med. scand.*, 1945, Suppl. No. 158.
² — *Neurology (Minneapolis)*, 1960, 10, 868.

Trichlorofluoromethane Spraying

Q.—What are the hazards of trichlorofluoromethane spraying?

A.—Trichlorofluoromethane (Freon II) is relatively non-toxic. High concentrations may cause mild irritation of the upper respiratory tract or narcosis.

Notes and Comments

REFERENCES

- ¹ White, B. H., and Daeschner, C. W., *J. Pediat.*, 1956, 49, 262.
² Soifer, H., *ibid.*, 1957, 50, 657.
³ Nelson, W. E. (Editor). *Textbook of Pediatrics*, 1959, 7th ed. Saunders, Philadelphia.

Premenstrual Fetor Oris.—Dr. SHEELAH R. N. JAMES (Hollymoor Hospital, Birmingham 31) writes: In reply to this question ("Any Questions?" 13 June, p. 1559) your expert does not mention the work of Findlay.¹ He observed a gingivitis occurring always at a fixed period in the menstrual cycle. In the course of his investigations he noted that the gingival condition disappeared, generally, with marriage. Owing to the unpleasant fetor associated with this form of gingivitis immediate treatment is demanded, often by gingivectomy in conjunction with oestrogen therapy.

REFERENCE

- ¹ Findlay, J., *Gingival and Periodontal Conditions as related to Menstruation and Endocrine Disorders in the Female*, 1959, Ph.D. thesis, University of Glasgow.

Cramps in Pregnancy.—Dr. B. S. C. GASTER (Evershot, Dorset) writes: With reference to your expert's comments ("Any Questions?" 20 June, p. 1619) I find giving vitamin B₁, 10 mg. three times a day, quite effective, and it certainly has none of the disadvantages of quinine in pregnancy.

OUR EXPERT replies: Vitamin B₁ may be effective in the doses suggested in selected cases and can do no harm. As a general rule, however, cramps not only in pregnancy but at other times respond better to small doses of quinine.

Correction.—We regret a misprint in the answer to the question on Testosterone for Male Sterility ("Any Questions?" 4 July, p. 38). Testosterone implants were recommended to be repeated every 5 to 6 months, *not* every 5 to 6 weeks.