Letters, Notes, and Answers

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ANY QUESTIONS?

Monckeberg's Senile Degeneration

Q.—*A lady aged 60, with blood pressure about 250/130 and symptoms of cardiac deficiency, suffers from attacks of severe pain in both calves, coming on only with walking. X-ray films reveal slight calcification of the tibial arteries. Nicotinic acid upsets her. Would sympathectomy help?*

A.—This patient is suffering from Monckeberg's senile medial degeneration of the tibial arteries. The presence of calcification in the middle coats shows that the disease is well advanced, and there must certainly be a considerable degree of obliteration of the channels. It is not possible to do much at this stage of the disease. Sympathectomy would be of little use, and she is old for this. Great care must be taken of the feet to preserve the skin from injury. Papaverine is sometimes helpful in relieving the pain on walking.

Smoking and Hypertension

Q.—*In his article "The Antidiuretic Action of Nicotine" (JOURNAL, March 24, p. 403), Prof. J. H. Burn states that smoking raises the blood pressure. Would you kindly tell us if it definitely aggravates hypertension and should therefore be stopped?*

A.—An answer to a rather similar question was published in the *Journal* of June 10, 1944 (p. 801). The blood pressure has been observed to rise on the average about 20 mm. systolic and 15 mm. diastolic when a normal subject smokes two cigarettes, even though he is a habitual smoker. The pressure returns to normal within five to fifteen minutes. The rise is apparently due to peripheral vasoconstriction. No comparable data have been noted for the rise in blood pressure in hypertensive subjects on smoking. It is generally agreed, however, that tobacco smoking is *not* an aetiological factor in essential hypertension, and it is further stated that patients with chronic tobacco poisoning have a low blood pressure. There is, in fact, no evidence that smoking aggravates hypertension and no justification for stopping it in this disease. On the other hand, there is a great deal of evidence that the vasoconstrictor action of tobacco is harmful in effort syndrome, neurocirculatory asthenia, angina pectoris, Buerger's disease, and other disorders of the peripheral circulation, and that it should be stopped in these conditions. In theory it may also be harmful in wound shock if the blood supply to a limb is imperilled by arterial injury.

Giant Urticaria

Q.—*What is the most promising line of treatment for a case of giant urticaria, with irritating and crippling effusions into the feet and joints? Calcium has not helped. Are peptone injections likely to be of use?*

A.—Treatment of urticaria, and especially giant urticaria, is often unsatisfactory, as shown by the large number of different therapeutic procedures. The allergic theory provides for only a proportion of the cases, sensitiveness to food or focal infection being well-known examples. Common foods are not often causal factors, because of automatic desensitization to them: the scratch tests or passive transfer method of Prausnitz and Kuestner may help to solve the problem of the cause, but as in other allergic manifestations skin-testing never offers final evidence of aetiology. Elimination diets are more likely to be helpful. A psychological factor is so often present that a sedative mixture may be included. The investigation requires a detective's mind and application to seek out and possibly discover some unexpected internal or external determining agency. General measures should include treatment of the nervous system by rest, change of environment, or of work; and desensitization by non-specific procedures, such as intramuscular injection of peptone. Alternatively an acid mixture after meals, or peptone 7 grains one hour before meals. Adrenaline injections during the attack may be required, and, finally, focal infection should be treated if found.

Hunter's Test for Bile in Urine

Q.—*What is the technique for Hunter's test for bile in the urine (referred to in your recent annotation on the treatment of hepatitis —March 24, p. 415)?*

A.—The following description of Hunter's test is taken from the second edition of Dr. G A. Harrison's *Chemical Methods in Clinical Medicine:* "In a centrifuge tube place 10 c.cm. of urine; if it is not acid, it must be made slightly so with acetic acid. Add 4 c.cm. of 10% barium chloride, mix, and mark the upper level of the fluid with a grease pencil. Centrifuge and decant completely. Add distilled water to the mark, mix thoroughly, centrifuge, and decant completely again. Stir the precipitate with 0.5 c.cm. of van den Bergh's diazo reagent by means of a capillary pipette of which the end has been sealed in the flame. Add 2 c.cm. of alcohol (absolute or 96%) and 0.3 c.cm. of 6% $Na_2HPO_4 . 12H_2O$. Mix and centrifuge. If bilirubin is present the supernatant fluid will be red, due to the formation of azobilirubin."

Vasomotor Instability

Q.—*A woman of 23 suffers from extreme vasomotor changes in the hands and feet, most marked in the fingers. In warm weather, or after exercise, piano-playing in particular, the hands become red, swollen, and painful. In cold weather she has a chilblain type of circulation. She has had all the recommended treatments, but they are of no avail. What can be done for her?*

A,—This is a most difficult problem in therapeutics, and success in treatment is uncertain. The patient evidently suffers both from the effects of vasodilatation which warmth induces in the digits and from vasoconstriction in response to cold. It is not at all clear that the degree of such changes is outside the limits of normal variation, and it is possible that the abnormal feature in the patient is her mental reaction to the variations in her circulation. It is suggested, therefore, that treatment along general lines with particular attention to the patient's personality and her orientation towards the circumstances of her life may prove the most satisfactory treatment. Neither vasodilator nor vasoconstrictor drugs nor surgical operation offer any rational or empiric therapeutic prospects in this condition.

Methods of B.S.R. Estimation

Q.—*There is much variation in the method of recording sedimentation rates (B.S.R. or E.S.R.). Is it legitimate to divide the results obtained by the 200-mm. Westergren method by 2 in order to obtain a percentage, so as to be comparable with other results expressed initially as percentages?*

A.—To divide the reading obtained from the Westergren method by 2 is not strictly correct in comparison with other methods. For practical purposes comparable results may be obtained providing the other methods calculate the percentage on the amount of plasma. For example, the figures given are from experimental results, the normal values showing the most divergence.

No.	Westergren Method; 200-mm. Tube. Plasma mm. (and mm. %)	Modified Zeckwer and Goodell Method; 10-cm. Tube. Plasma mm. %	Micro-method; 100-mm. Tube. Plasma mm. %
1	50 (25)	30	24
2	36 (18)	26	18
3	10 (5)	5	8
4	4 (2)	2	5

Trichomonas Infection

Q.—*What is the technique of "blueing" in resistant cases of trichomonas infections of the vagina? What strength of solution of gentian violet is used?*

A.—In resistant cases of trichomonas infestation, first the vagina should be irrigated or swabbed with a solution of sodium bicarbonate; it should then be dried and painted with a 1–2% aqueous solution of viola crystallina (gentian violet) or liquor tinctorum, which consists of crystal violet and brilliant green, 0.5% of each in equal parts of alcohol and water. The application may be made through a Cusco or Fergusson speculum according to the preference of the operator.

Unilateral Flush after Food

Q.—*A boy aged 2 years has since birth had a facial erythema almost immediately after beginning his meals. It persists for 1/2 to 3/4 hour after feeding and then clears. The part of the face affected is that extending from the temporal region downwards across the malar bone to the angle of the mouth—on the left side; it is about two inches wide and fairly well defined. What are the exact condition, aetiology, and treatment, if any?*

A.—This is a curious story, rather like the rare "jaw-winking" phenomenon in which a congenital ptosis is temporarily improved when the child opens the mouth. Jaw-winking is usually explained

as an atavistic regression to a condition present in fishes. It may be, in the present case, that the area described as affected corresponds to a "gill-opening." Essentially, the description is of an unusual vasomotor reflex action, and, provided there is no underlying naevus or naevoid condition, there is no treatment.

Radium for Rodent Ulcer

Q.—*I have recently had a rodent ulcer excised, and the base cauterized by the electric cautery. I have been told that the use of radium may cause cataract. Is this so? And if so, is there no method of using radium that will prevent such a contingency? The ulcer was near the left canthus, between the nose and the eye.*

A.—There is no danger of a cataract resulting from the proper use of radium for a rodent ulcer in the situation given. As a rule, the dose reaching the conjunctiva is insufficient to produce any conjunctival reaction, so that it is quite certain that the lens—where the dose is still smaller—will be uninjured.

Consent for Operation on Minors

Q.—*Is it legally necessary or desirable to obtain the parents' consent before doing in a minor a lumbar puncture under a local analgesic for diagnostic or therapeutic reasons (e.g., relieving intracranial pressure)? If it is necessary, it would seem that consent should previously be obtained for many minor operations—e.g., exploratory puncture of the chest, opening a quinzy, giving of intraperitoneal saline—even though no anaesthetic be used.*

A.—In strict law even the slightest physical interference with the person of another is an assault, for which damages can be awarded in a civil action or punishment in a criminal prosecution. Most kinds of physical interference which would otherwise be assaults may be justified by the consent of the person who suffers them, and among these justifiable forms of interference are medical and surgical procedures which are not in themselves unlawful. As a minor cannot give a legally valid consent, his parent or guardian must consent for him. Consent must, to be valid, be given freely and with substantial knowledge of the nature and purpose of the interference. The law knows also, however, an implied consent. By placing a minor in hospital, a parent doubtless gives an implied consent to his treatment by reasonable measures which carry no material risk to health or life. Where the medical adviser proposes to adopt a measure which involves drastic interference and carries risk, he owes the duty of first obtaining valid consent. As in so much of our law, the line between ordinary measures of treatment to which consent may be assumed, and drastic (not a legal adjective this, but one selected for convenience) treatment to which special consent ought to be asked, cannot be drawn in general terms. Its precise position in each situation is a question of fact, and in drawing it a court would consider such factors as the degree of pain, disturbance, or risk involved; or whether the particular act complained of was a usual part of the treatment of the particular illness, so that the person who had the right to consent or refuse might reasonably be held to have agreed to it by the act of bringing his child for treatment; and the like. The doctor should always bear in mind the need for consent to a class of procedures which may here be loosely but not inappropriately called "serious." If he asks himself whether he, in the parent's place, would prefer to be given the chance of refusing consent, he will probably not go far wrong.

Fatigue after Removal of Ovaries

Q.—*A patient aged 45 had a fibroid uterus and cystic ovaries removed eighteen months ago. She menstruated regularly until her operation, and her blood pressure, taken at the time, was 132/71. She now has "palpitation" and a tendency to fatigue. Her heart and pulse are normal. Her blood pressure is now 135/98. I propose to treat her with hexoestrol mg. 1 t.d.s. Will this have any effect on her blood pressure?*

A.—A patient who has had the uterus and both ovaries removed is likely to suffer from menopausal symptoms. These most commonly take the form of headaches, hot flushes, and emotional disturbances, though palpitations and a tendency to fatigue may also occur. Hexoestrol in the dosage mentioned is likely to relieve such symptoms and to give the patient a general sense of well-being, and —provided anaemia is excluded, and treated if necessary—this would seem to be the correct treatment in this case. The dosage should be gradually reduced as the symptoms improve. It is unlikely, however, that this treatment will have any effect on the rising blood pressure. This patient is probably suffering from benign hypertension in a mild form, and it is likely that the pressure will continue to increase with age. Hypertension is common, and according to S. C. Robinson and M. Brucer (*Arch. intern. Med.*, 1940, **66**, 393) slightly over 40% of the adult population is actually or potentially hypertensive. In the case described the condition is so slight that no treatment is indicated, and it is doubtful if the rise of pressure is great enough to cause the symptoms of which the patient complains. The possibility of a functional element should not be overlooked, and reassurance will probably help the patient a great deal.

LETTERS, NOTES, ETC.

Climate and Burns

Dr. FRANK MARSH (pathologist, A.I.O.C., Persia) writes: In the *Journal* of March 10 (p. 344), Prof. Kenneth Black, in a letter on climate and mortality from burns, brings evidence to show that a warm climate lessens this fatal incidence. We "enjoy" a climate with a very hot summer, and, by European standards, a moderately cold winter. It is true that we see more fatal cases of burns in the winter, but I think the main reason is that in cold weather cooking fires are lighted *in the dwellings*, and in summer the cooking is usually done outside. A very common cause of severe and fatal burns among women is the explosion of a "primus"-type stove designed to work with kerosene, and used, through ignorance or misplaced ingenuity, with gasoline. Such accidents are infinitely worse when they occur in a small room than in the open air, judging from results. In the open a metal or dried mud screen is built round the fire as a wind shield, unnecessary indoors. Kerosene and petrol burns are usually very severe, and a certain proportion are not accidental but malicious; frequently the victim is young, well developed, and good-looking. It is not claimed that these latter are factors affecting the mortality unfavourably, although statistically, no doubt, a case could be made out. Dirt is an unfavourable factor associated with cold; a sweating skin is probably a relatively clean skin. Certainly the mortality is much lower in the warm weather, but I have always thought this variation due to a number of contributory causes—such as more clothing worn out of doors than indoors, the exceptional severity of indoor-inflicted burns, the concealment afforded by a small windowless room for malice, the greater danger of explosions, etc., in a confined space, and the absence of wind shields, etc. I do not think the climate—blameworthy as it is in nearly every respect—can take the whole burden for the high mortality in Glasgow.

Oedema of the Ankles in Hot Climates

Dr. GEOFFREY HALL (Cunderdin, Western Australia) writes: In the *Journal* of Aug. 19, 1944 (p. 262), I see a reference to swollen ankles in hot climates. You might be interested to hear of a phenomenon I have seen here in pregnant women. In my last 100 midwifery cases there was one case of pre-eclampsia with albuminuria, but the percentage of cases of definite pitting oedema of the feet in the absence of varicose veins or any local condition was 5. Swollen ankles in the absence of albuminuria or other signs of toxaemia developed in these 4% of cases in the last three months of pregnancy, and invariably the patient volunteered that the swelling came up in hot weather and disappeared completely in cold. Thus the syndrome is analogous to swollen ankles in hot climates. In my cases no doubt the pressure of the head on the pelvic veins produces venous stasis in the lower limbs and aggravates the condition, but I feel that in both instances the syndrome is primarily due to peripheral vasodilatation from the heat, with increased capillary permeability. I can find no reference to swollen ankles in the condition known as "heat disease," but as the treatment of this is sodium chloride, I wonder whether such treatment would be effective in the conditions under discussion.

Treatment of Supraspinatus Tendinitis

Mr. J. R. ARMSTRONG, F.R.C.S. (Ely), writes: In discussing the treatment of supraspinatus tendinitis your correspondent (March 31, p. 468) does not mention excision of the acromion. This procedure, described by Watson-Jones in 1943 (*Fractures and Joint Injuries*, 3rd ed., p. 418, Livingstone, Edinburgh), is a certain, and in some cases the only certain, method of dealing with these lesions. The supraspinatus tendon impinges on the overlying acromion in the middle range of abduction, when the tendon is swollen or inflamed. This pressure produces pain and causes the painful arc of shoulder movement which is a characteristic feature of supraspinatus tendinitis, with or without calcification. Moreover, these repeated small traumata further aggravate the condition of the tendon. The rationale of excision of the acromion is obvious. Supraspinatus lesions seem to fall into two broad classes: those which tend to clear up spontaneously and those which do not. In the latter class the results of injection of the tendon have, in my hands, been inconstant and disappointing. This contrasts markedly with the almost dramatic relief produced by excision of the acromion. The operation itself is comparatively simple, the post-operative convalescence is short, and the subsequent function of the shoulder is normal.

Electrically Induced Convulsions in Epilepsy

Dr. H. PULLAR-STRECKER (Falmouth) writes: The idea of "letting-off steam" under controlled conditions of time and place appears useful in selected cases. As a criterion, however, tables should have a third column, showing the average number of spontaneous plus induced convulsions per month. In the four illustrative cases given by Dr. Gerald Caplan (April 14, p. 511), such number is roughly as follows: B.I. 4.5; O.P. 8.5; M.T. 10; C.A. 4.