Letters, Notes, and Answers

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ANY QUESTIONS?

Metabolism of the Nervous System

Q.—*Please give an account of the metabolism of the nervous system. What is the influence of the central nervous system on the general metabolism?*

A.—The gaseous metabolism of the brain has been studied in animals, including man, by comparing the composition of arterial and venous (internal jugular) blood and measuring the cerebral blood flow. Studies of isolated brain tissues (sliced or minced) have also been made. It seems likely, because the R.Q. is usually 1, that the brain gets its energy mainly by the oxidation of carbohydrate. Both glucose and lactic acid are taken up from the cerebral blood and apparently oxidized, since there is no evidence of glycogen storage. The reserves of carbohydrate are low. The mental confusion, delirium, and possibly convulsions which develop in animals in "insulin shock," or after hepatectomy, are probably due to hypoglycaemia, and the relief of the condition by the injection of glucose suggests its importance in the normal functioning of the brain. Vitamin B_1 probably acts as a coenzyme in facilitating the oxidation of glucose; this may explain the nervous symptoms which accompany B_1 deficiency. The scope of the question is, however, so large that no adequate answer can be given here and the questioner is referred to Page, *The Chemistry of the Brain* (1937), and Holmes, *The Metabolism of Living Tissue* (1937).

Diphtheria in the Immunized

Q.—*I saw recently a fatal case of diphtheria in a girl of 6 who had been immunized about two years ago. Would it not be desirable for county authorities to record the number of diphtheria cases that have actually been immunized?*

A.—The occurrence of diphtheria in inoculated persons is now generally recognized and accepted; the incidence of infection among the inoculated has been estimated from the annual returns of local authorities to be in a ratio of 1 : 3½ of the uninoculated. There are several possible explanations for the appearance of diphtheria in inoculated persons. (1) Diphtheria toxoid immunizes against the toxin of the organism and not against the organism itself, so that strains of the diphtheria bacillus that have a certain "invasive" power, as seems to be the case with the *gravis* and *intermedius* types, may be able to establish a local throat infection with membrane formation (diphtheritic tonsillitis) but without toxaemia. (2) The antitoxic immunity which develops after a child has received a course of diphtheria prophylactic begins to wane after some months, and in two or three years may have fallen to a very low level. If at this stage the child is attacked by the diphtheria bacillus the antitoxic response of the tissues may not be mobilized quickly enough to prevent the formation of enough toxin to do some damage. As a rule such infections are not severe and a fatal issue is rare. Thus, the mortality among immunized children has been estimated at a ratio of 1 : 25 of unimmunized children. (3) The immunizing agent may be a poor one, as happened in the early years of the war with a particular batch of A.P.T., but the chance of this happening in this country to-day is minimal.

To reduce the risk of infection among children who have been immunized in infancy and who may have lost a good deal of their antitoxic immunity in the pre-school years, a boosting dose of 0.2 ml. A.P.T. should be given when the child goes to school, and this dose may, if thought necessary, be repeated five years later. In this way antitoxic immunity is maintained at a reasonably high level and the chances of fatal infection are very small.

Proper recording of the state of immunization of the child community is certainly needed, and has been strongly advocated by the Ministry of Health (see *Monthly Bulletin*, September, 1944, p. 142). Provision has now been made for improving the returns made by medical officers of health so that the incidence of diphtheria in immunized and unimmunized children of different age groups can be compared, and more precise data will thus be obtainable on any deaths from diphtheria in immunized children.

Glass and Ultra-violet Light

Q.—*Does glass specially made to permit the passage of ultraviolet light lose this property with age? If so, what is the rate of loss?*

A.—Such special glasses do lose their transparency for ultraviolet light to some extent with age—i.e., duration of exposure to ultra-violet radiation. The rate of loss, and the final, stable transmissivity, differ for different glasses. When used in windows the ageing of the glass is usually complete within twelve months, and the transmission factor may be reduced appreciably—in some specimens by as much as 20%. The loss is due to the presence of impurities in the glass, and can be made small by careful control of materials in manufacture. A high degree of stability is claimed for some of these transparent glasses.

Wuchereria bancrofti

Q.—*Is there any specific treatment for filariasis due to Wuchereria bancrofti?*

A.—There is no drug therapy which can be relied upon to eradicate *Wuchereria bancrofti*, but several compounds, particularly the organic antimonials, may bring about a temporary disappearance of the microfilariae, and on occasion may even appear to succeed in eradicating the infection. Thus of 30 patients treated with 0.3 g. of neostibosan on alternate days for from five to seven weeks, 13 were free from circulating microfilariae after twelve months. Little or no change occurred in the microfilarial levels during, or immediately after, treatment, and it is suggested that the slow loss of the microfilariae was due to the action of the drug on the adult worm. Progressively increasing doses of filarial antigen may relieve patients of symptoms presumably due to sensitization to products of the parasites, but here again treatment is uncertain in its effects.

Subarachnoid Haemorrhage

Q.—*A man of 50, previously healthy and with a normal blood pressure, did four years' service in the Middle East. He was subjected to considerable physical and mental strain for some months before he collapsed with a subarachnoid haemorrhage. He is now well again, apart from some loss of energy and drive. (1) What is the prognosis? (2) What precautions should be advised to avoid a recurrence? (3) Is it true to say that the subarachnoid rupture of a presumably congenital aneurysm is quite unrelated to earlier physical and mental strain? (4) Is 50 the usual age for such cerebral accidents?*

A.—(1) The prognosis must be guarded as there is always a prospect of recurrence. In Magee's series of 150 cases, 50 patients had a recurrence of bleeding; and as 52 of the total original series died, the 50 recurrent cases are to be related to the surviving 98 (*Lancet*, 1943, **2**, 497).

(2) It is difficult to formulate dogmatic rules to prevent such a catastrophe, especially as in most cases of spontaneous bleeding no precipitating, or even provocative, features can as a rule be traced. Nevertheless, common sense enjoins that the patient should be warned against lifting heavy weights, or cranking his car, or making any sudden and strenuous physical exertion. Over-tiredness from sustained and excessive physical and mental work should also be avoided so far as possible.

(3) Earlier physical and mental strain may well be claimed as an aetiological factor provided that there is a reasonably

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short interval between such strain and the onset of the haemorrhage.

(4) For the first occurrence of bleeding from a congenital aneurysm 50 years is certainly rather late. Of Magee's series, only 6% were over 40 years of age. The prognosis is rather more serious in these older patients, both as regards immediate mortality and as to liability to relapse.

Daffodil Dermatitis

Q.—*How should I treat a patient with dermatitis caused by handling daffodils? She is in the flower trade, and the usual remedies are of little avail. She finds it impossible to work with gloves, and equally impossible to avoid handling the flowers.*

A.—The prospects are not very hopeful for the rehabilitation of this woman to enable her to overcome her sensitization to daffodils. It is possible that nothing short of avoidance of contact (with cut stems and pollen) will be of any avail. Some workers are undoubtedly able to wear gloves, and fabric-lined rubber gloves are perhaps the best. Failing this, one of the barrier preparations of the waterproof variety might assist, but is unlikely to give complete protection. If other manifestations of allergic response are present, these should also be considered.

Cyclical Urticaria

Q.—*After her second confinement six years ago a patient of 29 suffered from intermittent buccal ulceration with large blebs on her legs and hands. Eighteen months later the same condition recurred and it continues to do so. The attacks are worst eight or ten days before a menstrual period, and they clear when the period begins. Her menstrual history is normal. She is now two months pregnant and has been completely free from symptoms since conception. This appears to be an endocrine disorder, and I should welcome suggestions for treatment should she have a recurrence after delivery.*

A.—The cyclical appearance of urticarial rashes, herpes, acne, and other skin reactions in relation to menstruation is well recognized but little understood. One particular syndrome is cyclical stomatitis or buccal ulceration, which is sometimes associated with simultaneous ulceration in the vagina or vulva. Lesions of this kind most often occur just before, or during, menstruation, tending to heal in the interval, and their appearance is remarkably constant, so the case quoted is by no means typical. However, it conforms to the rule in that the ulceration disappears during pregnancy. This kind of trouble almost invariably reappears a few months after delivery, and observations of this kind have led to a belief that there may be an endocrine disturbance, although the nature of it is unknown. Another theory is that the lesions are an allergic manifestation, and a family history of various forms of allergy can sometimes be obtained. This possibility should be explored in this case and sensitivity tests carried out. If a determining factor can be found, desensitization may be expected to give a cure. Endocrine therapy is largely empirical—all the sex hormones have been used with varying degrees of success in individual cases. On the whole, chorionic gonadotrophin gives the best results, but it may have to be continued almost indefinitely. It might be tried in this case, or, failing that, progesterone.

Coeliac Disease

Q.—*Is it possible to summarize briefly modern views on the cause and treatment of coeliac disease?*

A.—There is usually no real difficulty in deciding the diagnosis of coeliac disease. However, in some cases of steatorrhoea in infancy or early childhood it is important to exclude the possibility of congenital pancreatic deficiency (fibrocystic disease of the pancreas). The stools in the latter disease are of a peculiar waxy appearance, and it may be necessary to determine the enzyme (lipase, etc.) content of the duodenal juice. In coeliac disease the enzymes are present.

The cause of coeliac disease is still unknown. In fact, the whole problem of normal fat absorption is under close and elaborate reconsideration (Frazer, 1946). One of the remarkable facts in coeliac disease is that quite a good percentage of fat is absorbed, and it is a strange thing that the loss of, say, 8 to 10 g. of fat out of an intake of, say, 50 to 60 g. a day should be related to such severe clinical disorder. Clearly some deeper processes are at fault in the intestinal tract—as suggested by the peculiar radiological appearances in the active disease—but in most cases the abnormality is not irreversible. Since the disease usually begins in late infancy or early childhood (it may not be diagnosed at that time), it suggests an early partial failure or exhaustion of one or more of the complex enzyme factors which probably contribute to fat absorption, as outlined by Frazer's "partition theory." Whether this is interlocked with abnormal requirements in vitamins of the B group is at the moment a matter of considerable interest and importance, and especially so in the light of the alleged clinical and biochemical success of folic acid in the treatment of the possibly allied disease, sprue (*Journal*, April 6, p. 529). A clinical trial of folic acid in adequate dosage in coeliac disease is awaited with keen interest.

May *et al.* (1942) consider that the defect in the intestinal absorption of fat and carbohydrate in coeliac disease lies in the intestinal mucosa, and that the absorption of fat, intestinal motility, absorption of glucose, and the clinical course are favourably influenced by crude extract of liver and the vitamin B complex given parenterally. For the considerable details of this treatment May's paper should be consulted. His clinical results, over periods of one to six months, appear favourable, and especially the increased vitamin A absorption as an index of biochemical improvement. Paterson *et al.* (1944), while admitting that the malabsorption of fat and carbohydrate remains unexplained, claim satisfactory gains in height, weight, and general health in the early weeks on a similar course of therapy; and that if the treatment is sufficiently intensive and prolonged, there is a diminished loss of fat in the stools. A less dramatic improvement is noted in cases receiving only parenteral liver extract and B complex orally. However, in some cases, even with intensive therapy, the high-fat content of the stools may persist, although there is a gain in weight and general improvement; some cases are refractory and fail to improve on the treatment. It appears from the study of these reports that no specific remedy has yet been discovered. Be it noted, however, that the folic acid content of the material used was not known, or it may have been present in insignificant amounts.

It should be stated that Ross (1936) obtained significant evidence that injection of liver extract increased dextrose absorption and utilization, and it may well be that the therapeutic response is in some degree due to changes in this function rather than to a direct check on the steatorrhoea. Personal observations on the newer forms of treatment have not yielded the anticipated dramatic results, and we believe that it is most desirable, at present, to continue the low-fat-diet regime as a basis, add adequate amounts of ascorbic acid, carotene, and calciferol, and give oral or parenteral B group and concentrated crude liver extract, 2–4 ml. intramuscularly each week. In the more severe cases it may be desirable to proceed to an "intensive course" of parenteral therapy as outlined by May, but even so dietetic control is still considered necessary. Slow progress is often good progress in this disease. Intercurrent infections, especially the inhibitory and possibly devastating upper respiratory infections, must be attacked urgently to avoid an acute intensification of the coeliac syndrome.

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Infectiousness of Stuttering

Q.—*A patient who stuttered ten years ago now speaks normally. He has not stuttered since his mate joined the Army. His mate stuttered badly and was his constant companion. Is it catching?*

A.—Stuttering, like any form of neurosis, may be the result of suggestion, direct or indirect, and of identification. When one individual is fond of another he is usually suggestible to the other, and therefore may take over his characteristics. This form of identification is very common in early childhood, when the child impersonates people round about in its play, and takes over their mannerisms, both normal and abnormal. I have had

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such a case. A small boy, listening to a major and a colonel both of whom stammered, and being filled with admiration for them, likewise began to stammer, and continued to do so till he was about 30. He then decided to give it up and spoke normally. Unfortunately, most cases of stammering are much too deeply involved to be cured so easily. There seems little doubt that, in the case mentioned, with the departure of his mate the identification was broken, and, the suggestibility coming to an end, the patient spoke normally.

Spontaneous Combustion of Quilts

Q.—*A patient put her baby out in the sun in his perambulator. For no apparent reason the baby's quilt, made of artificial silk lined with splint wool (upholsterer's wadding), burst into flames. Are such quilts likely to undergo spontaneous ignition in sunshine?*

A.—In the writer's opinion this accident is to be attributed solely to the wadding lining of the quilt, which has become contaminated with oil—probably in a high local concentration. The conditions of warmth have led to rapid oxidation of the oil with an increase in temperature, leading ultimately to combustion. This phenomenon is well known with unscoured oily, or subsequently oil-contaminated, fibre when the conditions are favourable. The writer came across a similar instance in an aeroplane seat about 1916. In that case local concentrations of kapok-seed oil in the kapok stuffing were shown to have caused spontaneous combustion. A rapid and efficient method of determining the liability of oils on fibre to develop heat spontaneously is provided by the Mackey cloth oil tester, which is obtainable as a standard apparatus.

Red Hair and Bleeding

Q.—*Do patients with red hair show an undue tendency to bleed during surgical operations?*

A.—In thirty-five years of surgical experience the writer has never noted that patients with red hair have shown any undue tendency to bleed during a surgical operation, nor has he ever heard anyone put forward that suggestion. However, the matter could easily be put to the test by estimating the coagulation time of a series of red-haired patients and comparing with a control series.

INCOME TAX

Car Expenses

J. P. bought a car in 1939 for £148 and has been allowed depreciation on it every year; he sold the car on Dec. 31, 1945, for £210 and then bought a new car for £400. The practice accounts are made up to April 4. What should he claim "for the year ending April 4, 1946"?

⁂ The depreciation and similar allowances are due for the financial year, not as a deduction from the profits of the year of account. The relevant question is, therefore, what allowances should be claimed for the *financial* year ending April 5, 1947. No allowance is due in respect of the old car. As regards the new car, the following allowances should be claimed: (*a*) an "initial" allowance of 20% of £400 = £80, and (*b*) a "depreciation" allowance of 25% of £400 = £100.

Sale of Practice and Cars

M. M. asks two questions: (*a*) He sold his practice and two cars on Jan. 1, 1946. Is he liable for "balancing charges" on the excess of the amount obtained for the cars over their written-down value? (*b*) He bought the share of a deceased partner in 1942. Does that raise his limit in respect of insurance premiums (Sec. 9 of the Finance Act, 1941) by the income his late partner derived from the practice in 1938-9?

⁂ (*a*) M. M. is not liable for balancing charges, and his partner can claim allowances based on the amounts at which the cars changed hands. (*b*) No. Under the provision referred to the limit of income is "the total income of the year of assessment or . . . for the year 1938-9, whichever is higher." Life insurance relief is a personal matter, and the 1938-9 income is M. M.'s income, unaffected by subsequent events.

Remittances from Colonial Earnings

N. C. M. has bought a house in the United Kingdom and consequently ranks as a "British resident."

⁂ He will be liable as a British resident for the whole of the present financial year—i.e., the year to April 5, 1947. Remittances to this country will not be liable to income tax if the period of Colonial employment is three years or more *and* he is absent for the whole of the financial year concerned. Remittances from capital are not liable as income, but the discrimination involves difficult questions. If, for instance, there is foreign current income available for the remittance and the amount is remitted to meet current (i.e., non-capital) expenditure here, the claim that the remittance was one of capital might fail.

Claim for Arrears of Tax

D. C. was employed during 1940-2 as M.O.H. to four authorities in a combined appointment; it was understood that tax would be deducted by the authorities from their payments for salary but not from their payments for expenses. He has now been informed by the local tax office that the deductions made for the year 1940-1 were insufficient and that he is liable to account for the balance of £125.

⁂ It seems that something must have gone very wrong with the collection arrangements to produce so unfortunate a result, and D. C. is, we think, entitled to a much fuller explanation than he has so far received. But if the full amount of tax due has been assessed—in which case D. C. will presumably have received a formal notice—but part remains uncollected, it is still a legal liability, and we fear that D. C. cannot avoid it even if he is in a position to show that either the tax office or the authorities, or both, were to blame for failing to obtain the tax at the proper time.

LETTERS, NOTES, ETC.

Peritoneal Gloves in Primitive Surgery

Gp. Capt. G. STRUAN MARSHALL writes from Edinburgh: Dr. A. R. Eates mentions (May 4, p. 709) the use by Arabs of ants as Michel clips. There will be found, in a book written about twenty years ago—*Secrets de la Mer Rouge* by Henri de Monfreid—and published, I think, in Paris, a fairly detailed account by an intelligent layman of an operation in the Sinai Desert that should still further amuse Dr. Eates's *virtuosi*. De Monfreid seems to have been a pearl fisher in the Red Sea, intermittently dodging those who would interfere with his apparently nefarious trade. He writes of an occasion when he had landed and gone up country; a tribesman was brought in, suffering from a deep spear wound of the belly. After some delay a native "doctor" appeared and gave the injured man something to suck that seemed to blunt his sensation. Then he examined the wound, and got an acolyte to hold it open. He extended the wound with a blade dipped in very hot melted butter, and exposed the stomach, which had been penetrated by the wounding spear and was gaping. He now had a goat killed and its belly opened; he extracted the omentum and draped it over his hands, and with these natural gloves handled the stomach. Holding the cut edges of the stomach wound together, he took a large ant from a vessel, held it just behind the head, and brought it to the approximated edges of the wound, when the ant's mandibles closed firmly on them. At this moment he brought his nails together, nipping off the ant's head, which remained clamped to the cut edges, holding them together securely. Four points of interest emerge: the anaesthetic, in a country where alcohol is forbidden; the keratinous Michel clips, or rather visceral clips, which would presumably not be dissolved by the peritoneal fluid for a very long time, if at all; the surgical gloves of the only ideal material imaginable, which, being themselves peritoneal, would not injure the peritoneum in the slightest; and the sterilization by moist heat, probably greater than that of boiling water, in a medium that would lubricate the knife. I write from a tenuous memory, and may have got minor details slightly wrong, but I am sure of the major ones, and can only wonder at so modern a development of surgical technique in a country where communication is difficult and scanty. *Ex Africa semper aliquid novi*—well, not quite Africa but near enough.

A Close Shave

Dr. FRANK CROSBIE (Ealing) writes: The communication from Dr. L. Erasmus Ellis (May 4, p. 710) tempts me to offer to my fellow "tender-skins" the gleanings from upwards of half a century's trial and error. The points in order of importance are: (1) Cold water for both lathering and washing off. (2) A sharp open razor and a pannikin of really hot water into which the blade should be dipped frequently throughout the operation. (3) Perform the operation after the tub, preferably in the shirt and trousers stage. (4) The use overnight of an ointment containing a few grains each of acid. salicyl. and pulv. sulph. praecip. ad 1 oz. (28 ml.) eucerin base. (5) Liq. hamamelidis (B. W.) is unrivalled for post-operative purposes. (6) A base of soap from a stick on the face plus an overlay of cream on the brush; to preserve the life of the latter (a consideration these days) don't remove the remains of the old soap till just before re-use.

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Proctalgia

Col. N. J. C. RUTHERFORD (Farnham) writes: This correspondence has interested me as I started the subject in the *Journal* in 1929 by asking for suggestions for treatment. Quite a few doctors answered, but "I evermore came out by that same door where in I went." I have had the complaint since the 1914–18 war. The attacks come on at any time, day or night, and the pain can be severe enough to make one halt if walking or sit down if in the house. The only cure I know is heat; at night sit on a hot-water bottle or electric pad; during the day, when or where available, crouch down, semi-sitting, over an electric or gas fire. Another member of my family, a lady, has also had the complaint for over twenty years. In future I shall try the gastro-colic reflex advised by Prof. F. C. Pybus. Threadworms and slight eczema were suggested to me as causes, but did not fit in my case. As I get older I find the attacks come at longer intervals; perhaps I may grow out of them in my octogenarian years!

Dr. N. H. STEIN (Edinburgh) writes: I suggest that the symptoms described under the headings of proctalgia, etc., are due to a prolapse of the lower part of the pelvic colon into the rectum, occurring intermittently and leading to a congested state of the mucous membrane. Incomplete return leads to a small faecal mass being caught in the inflamed area, increasing spasm, and acute pain. The initial cause of the prolapse may be some congenital weakness in this part of the gut, the presence of a polyp, or obstruction by kinking due to the adhesion of neighbouring structures. An adherent appendix would tend to produce this. In many cases, if not in all, it is simply the persistence into later life of the condition of prolapse recognized in young children. In an extreme case, in which this prolapse was easily demonstrable, there was a history of this. I shall be glad to give further details to those interested.

Nocturnal Erections

Dr. WRIGHT LAMBERT (Keighley) writes: Oestrogenic therapy was suggested to me by Mr. H. Hamilton Stewart, of Bradford, for the treatment of troublesome and frequent nocturnal erections in a patient, 58 years of age, on whom Mr. Stewart had performed prostatectomy (5 oz. (140 ml.) of residual urine) by the transurethral route, and whose priapism, without any apparent sexual libido, was not cured by the operation. Stilboestrol, 5 mg. daily, keeps him entirely free from the condition, but he relapses almost as soon as he stops treatment. Mr. Stewart recently suggested that dienoestrol 0.3 mg. would be equally effective and be less liable to produce untoward side-effects. This patient got no relief from phenobarbitone gr. 1/2 (32 mg.) at bedtime. Whilst oestrogenic therapy for this condition would seem to be based on sound physiology, I cannot see why the androgen testosterone (June 1, p. 864) should be successful. Mr. Hamilton Bailey in the *Medical Annual* (1945, p. 232) mentions Cave's operation, incision of the corpora cavernosa, evacuation of blood clot, and packing with gauze, as having been completely successful in one case.

Nasal Cleanliness

Dr. PERCY TATCHELL (London, S.W.5) writes: The late Sir Buckston Browne was emphatic that by taking snuff he avoided colds in the head. Snuff-taking was a common practice in the last century, with the object largely of preventing infection. This presumably it did by creating a profuse discharge, which washed out the nose. There is no need, however, to take snuff to attain that end; it is easily done manually when washing the face. One may say: "Why not use a spray, is that not better?" People will not be bothered; they use the spray once or twice, and get tired of the paraphernalia and the mess. Besides, a spray by-passes the glutinous mucus found in the wings of the nose, a first-class nidus for bacterial growth. It is only a matter of a few moments to do it with the soapy fingers, and experience will show that soap does not sting appreciably unless sucked up to the turbinate bones. In this region matters can be left to one's natural defences. I believe, by the adoption of this simple routine, the risk of infected colds, all the fevers of adolescence, and such mysterious air-borne ailments as influenza, and the appalling catastrophe of infantile paralysis, can be greatly diminished.

Remedies for Herpes Zoster

Dr. W. H. MARSHALL (East Grinstead) writes: The experience of general practitioners is often different from that of consultants. In my experience pitressin 1 ml. (0.5 ml. for the aged) gives striking relief to almost all cases of herpes zoster if given in the early stage before the rash has finished coming out; the earlier crops lose their pain, and the later ones appear as an erythema and then vanish with little or no vesicle formation. Relief is obtained within five minutes, or at the most half an hour, or not at all.

Dr. HUGH DICKIE (Morpeth) writes: May I give a brief account of an accidental discovery of mine which appears to be a complete cure for herpes zoster? While acting as M.O. to Offlag IVc in Germany I was desperate to find some relief for a young officer with a very severe attack of dermatitis herpetiformis. I had tried everything in my short range without effect, and, more in an attempt to raise his general tone, I gave him 4 ml. of a liver extract intramuscularly. The next day he was well! No new spots and the pain had gone from the old ones. Five months later he had another attack; same treatment immediately and the whole thing aborted. We then tried this "treatment" on a French lieutenant with a very severe intercostal herpes. This man had some experience of shingles—his wife and mother had both been very ill with it some years previously. On the day after the injection of liver extract I was overwhelmed with a profusion of Gallic thanks—all the pain had gone, no new eruptions, and within a week all the original papules had healed. Next came two British soldiers, with equally startling results. I have now "treated" 7 civilians at home in this way, age range from 26 to 81 years, with herpes ranging from supra-orbital to twelfth dorsal. All cases were treated within the first forty-eight hours of the appearance of the rash, and all responded overnight. Admittedly the number of cases, 10 in all, is slight, but the results are so striking that I feel some publicity should be given to them, and perhaps someone with a more scientific outlook may find the reason.

Contramine for Herpes

Dr. E. S. HAWKES (Budleigh Salterton) writes: May I correct your reply to the first of "Any Questions?" (May 25, p. 822). If you refer to a Medical Memorandum (Sept. 25, 1943, p. 391) you will find my article which gives the inquirer the information he seeks. It will be noted that it does not apply to a few isolated cases, but a series of 15. The remedy is effective only in early cases. It is also most effective in early chicken-pox.

"Cord Round the Neck"

Dr. V. P. ROBINSON (Norfolk) writes: It may be of interest to report that I recently confined a girl aged 16; the cord was round the neck loosely and was easily slipped over, but the child was born dead. A tight knot was found in the cord, which was 39 inches (1 m.) long. Movements had ceased for about two days.

Injections on Board

Mr. C. D. L. STEWART-FORSHAW (Roche Products, Ltd.) writes: Surg. W. S. Parker in referring (May 18, p. 775) to a specially developed "tubonic" ampoule appears to be unaware of the remarkably efficient unit called "tubunic" ampoule syringe (tube unique) originally introduced by my firm some years before the war. This unit is essentially for such emergencies. During the war it was part of the equipment in the Merchant Navy in all lifeboats, and it was also employed by a number of special units of the Services. I am proud to say that it was responsible for saving a number of lives.

Medical Journals for Hungary

Mr. EDWARD FULLER, Editor of the *World's Children*, writes from 20, Gordon Square, London, W.C.1: Some little time ago you very kindly gave publicity to a letter from me, passing on a request from the Save the Children Fund's administrator in Hungary, for British medical periodicals, to help bring Hungarian practitioners' knowledge up to date. A number of your readers generously responded—and some pass on their own copies regularly after use. These—and any prospective new donors—may like to know that I have to-day had a letter from the Hungarian correspondent, who says: "Please thank for me all who are concerned in sending the medical papers. They are of infinite value. They go round among the doctors and will finish their career in the library of the central clinic."

Medical Golf

By courtesy of the Stockport Golf Club the annual competition of the Manchester and District Medical Golfers' Association will be resumed on the course at Torkington on Wednesday, June 26. The Challenge Cup will be competed for by medal play under handicap; the winner will hold the cup for one year, and the captain (Mr. R. L. Newell) will give a second prize. The Walter Gold Medal will be held for one year by the member returning the best gross score, and the Walter Silver Medal by the member returning the best gross score from among those with handicaps of ten and upwards. Prizes will be provided for the winners in lieu of replicas. All correspondence should be addressed to the hon. secretaries, Manchester and District Medical Golfers' Association, c/o British Medical Bureau, 33, Cross Street, Manchester, 2.

Correction

The figure 0.4 in line seven under the subheading "Results" in the article by Dr. R. C. Browne on "Amphetamine and Caffeine Citrate in Anoxaemia" in last week's issue (p. 871) should read 1.2.

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