Wednesday

GLASGOW UNIVERSITY: DEPARTMENT OF OPHTHALMOLOGY.—April 4, 8 p.m., "*Ascorbic Acid and Corneal Lesions*," by Dr. T. A. S. Boyd.

ROYAL COLLEGE OF SURGEONS OF ENGLAND, Lincoln's Inn Fields, London, W.C.—April 4, 3.45 p.m., "*Tubercle of Bone*," Erasmus Wilson Demonstration by Mr. P. H. Mitchiner.

●ROYAL INSTITUTE OF PUBLIC HEALTH AND HYGIENE, 28, Portland Place, London, W., April 4, 3.30 p.m., "*The Common Cold*," by Dr. C. H. Andrewes, F.R.S.

SOCIETY OF PUBLIC ANALYSTS.—At Chemical Society, Burlington House, Piccadilly, London, W., April 4, 7 p.m., papers by (1) J. Hubert Hamence, M.Sc., Ph.D., F.R.I.C., (2) E. I. Johnson and J. King, O.B.E., F.R.I.C., and (3) J. A. Kitchener, Ph.D., A. Liberman, B.Sc., Ph.D., D.I.C., and D. A. Spratt, B.Sc., A.R.C.S.

Thursday

FACULTY OF HOMOEOPATHY, Royal London Homoeopathic Hospital, Great Ormond Street, London, W.C.—April 5, 5 p.m., "*Experiences in Recent Influenza Epidemic*," by Dr. James Hamilton; "*Observations on Influenzal Complications and Their Treatment*," by Dr. C. O. Kennedy. Discussion to be opened by Dr. Hector MacNeill.

INSTITUTE OF OPHTHALMOLOGY, Judd Street, London, W.C.—April 5, 5.30 p.m., "*Some Aspects of the Pathology of Fat*," by Mr. E. Wolff.

QUEEN'S UNIVERSITY (GREAT HALL), Belfast.—April 5, 8.30 p.m., "*A Medical Survey of the Irish Famine of 1846*," Robert Campbell Memorial Oration by Sir William MacArthur (postponed from January 11).

SOCIETY OF ENDOCRINOLOGY.—At Royal Society of Medicine, 1, Wimpole Street, London, W., April 5, 5.30 p.m., "*Studies on A.C.T.H. and Cortisone in Disease*," by Professor J. S. L. Browne (Montreal).

Friday

BIOCHEMICAL SOCIETY.—At Department of Physiology, University of Bristol, Bristol, April 6, 2 p.m., 296th meeting. Papers will be read.

INSTITUTE OF OPHTHALMOLOGY, Judd Street, London, W.C.—April 6, 5.30 p.m., "*The Ophthalmological Aspects of Disseminated Sclerosis and Allied Diseases*," by Dr. S. Behrman.

ROYAL COLLEGE OF SURGEONS OF ENGLAND, Lincoln's Inn Fields, London, W.C.—April 6, 5 p.m., "*Diagnosis of Stone in the Urinary Tract*," Urology Lecture by Mr. F. J. F. Barrington.

WHIPPS CROSS HOSPITAL MEDICAL SOCIETY, Whipps Cross Hospital, London, E.—April 6, 8.30 p.m., "*The Action of Carcinogenic Chemicals on the Skin*," by Dr. M. H. Salaman.

BIRTHS, MARRIAGES, AND DEATHS

BIRTHS

Alexander.—On March 10, 1951, to Mary (formerly Stubbs), wife of David F. Alexander, M.B., Ch.B., D.R.C.O.G., Stratton St. Margaret, near Swindon, Wilts, a daughter.

Collins.—On March 13, 1951, at the General Infirmary, Burton-on-Trent, to Violet, wife of Dr. W. Collins, a son.

Perrott.—On March 17, 1951, at Fernwood House, Newcastle-upon-Tyne, to Nancy (formerly Hodgson), wife of Dr. John William Perrott, twin sons.

Playfair.—On March 21, 1951, at Cambridge, to Margaretta, wife of Dr. A. S. Playfair, a daughter—Anthea.

Smith.—On February 14, 1951, at Preston, to Dr. Kathleen Smith (formerly Turner), wife of Irvine Smith, F.R.C.S., a daughter—Anne.

Smithson.—On March 12, 1951, to Harriet (formerly Gregson), wife of Dr. R. G. Smithson, of Wetherby, Yorks, twin sons.

Tate.—On March 12, 1951, at Mansfield Nursing Home, to Margaret, wife of Malcolm Tate, B.M., a brother for Philip—Alan.

Waldron.—On March 9, 1951, at Bristol, to Laura, wife of Dr. E. A. Waldron, 124, Pembroke Road, Bristol, a son.

DEATHS

Cromie.—On March 15, 1951, at Surbiton, Surrey, Mortimer John Cromie, M.R.C.S., L.R.C.P., Lieutenant-Colonel, R.A.M.C., retired, aged 70.

Crowe.—On March 2, 1951, at Witney, Oxon, George Arthur Crowe, L.M.S.S.A., aged 80.

Dalgliesh.—On March 11, 1951, William Dalgliesh, M.B., Ch.B., of Hillrise, Witney, Oxon, aged 70.

Eatough.—On March 15, 1951, Robert Eatough, M.D., late of Mossley, Manchester, aged 88.

Gibson.—On March 20, 1951, at The White House, Aldershot, John Hutchinson Gibson, M.R.C.S., L.R.C.P., aged 92.

Hirst.—On March 18, 1951, at Southmead Hospital, Bristol, Geoffrey Greatrix Hirst, M.R.C.S., L.R.C.P., Lieutenant-Colonel, I.M.S., retired, formerly of Heath House, Finchampstead, Berks, aged 72.

Jack.—On March 14, 1951, at his home, 67, Forest Road, Aberdeen, William James Jack, M.B., Ch.B., late of Adlington, Lancs, aged 54.

Kryszek.—On March 15, 1951, at Kota Kota, Nyasaland, Monica Margaret Kryszek (formerly Renner), M.B., Ch.B.

Lundie.—On March 20, 1951, at Dundee Royal Infirmary, Alexander Lundie, M.B., Ch.B., D.P.H., of 25, Charlotte Street, Dundee.

Milne.—On March 21, 1951, at Greystones, Witham, Essex, Charles Milne, O.B.E., M.B., C.M., Colonel, I.M.S., retired, aged 81.

Mitchell.—On March 19, 1951, at "Three Trees," Dukes Wood Drive, Gerrard's Cross, Bucks, Godfrey William Mitchell, M.D., D.P.H., D.M.R.E., aged 65.

Oliver.—On March 21, 1951, at the Brighton General Hospital, Matthew James Oliver, M.B., C.M., D.P.H., of Hove, Sussex.

Sandoe.—On March 15, 1951, at "Greenbank," Bodmin, Cornwall, John Worden Sandoe, M.D., aged 89.

Any Questions?

Correspondents should give their names and addresses (not for publication) and include all relevant details in their questions, which should be typed. We publish here a selection of those questions and answers which seem to be of general interest.

Rh Antibody and Precautions at Confinement

Q.—*Is it safe for an Rh-negative mother, whose husband is Rh-positive, to be delivered of her second child in a nursing-home where there are no facilities for blood-typing or for transfusion? The first child was normal in every respect. Maternal blood tests during the 30th and 34th weeks of the present pregnancy showed no rhesus antibodies.*

A.—If no Rh antibody is present in the mother's serum at the 34th week of pregnancy it is still possible that the antibody may develop during the last six weeks. However, experience shows that Rh antibody which is detected for the first time during the last few weeks of a pregnancy never causes severe signs in the infant, and in the great majority of cases the infant pursues an entirely normal course. Accordingly, if a test at 34 weeks shows that no Rh antibody is present it may be assumed that the infant is not going to need treatment, and the infant can safely be born in a place where there are no facilities for blood typing or for transfusion.

Sensitization to a Plastic Eye

Q.—*I have a patient, a boy of 8, who wears an artificial eye. It is found that when he wears a plastic eye the socket becomes inflamed and discharges. Could this be an allergic reaction to the plastic, and, if so, is there any test, in the nature of a patch test, which could be carried out to discover if it is, in fact, the plastic which is responsible?*

A.—The simplest test whether a discharge from a socket is due to a plastic shell is to change the plastic shell for one of glass or porcelain. Some sockets tend to become inflamed with any artificial eye, but provided the socket is well healed this should be readily amenable to control. There is, however, no doubt that some patients do not tolerate plastic shells, just as a number of people develop contact dermatitis from plastic spectacles. J. Macivor (*Canad. med. Ass. J.*, 1950, **62**, 164) reported eight cases of contact allergy in a series of 100 patients with an artificial eye. In two of these eight cases there was a plastic implant and the remaining six patients wore plastic artificial eyes. The patch test on the forearm with a powdered polymer and liquid monomer of methyl methacrylate gave a positive result for the polymer in 96 hours in three cases, and in a fourth case the test was positive for both polymer and monomer. In the remaining four cases the skin patch test was negative to both, but in all cases the insertion of a small button of clear plastic in the socket produced a typical allergic response. In these eight cases the removal of the plastic implant or the substitution of a glass eye for a plastic artificial eye cleared the symptoms.

Treatment of Raynaud's Disease

Q.—*What recent advances have there been in the treatment of Raynaud's disease? What is considered the best treatment for this condition?*

A.—Recent changes in the treatment of Raynaud's disease have been directed to the search for an effective vasodilator drug the effect of which would be of sufficient duration to be of real value for a constitutional disease, and which would not have unpleasant secondary effects. At present 2-benzyl-4:5-imidazoline hydrochloride ("priscol") offers the nearest approach to these requirements.

The best treatment for Raynaud's disease is to go and live in a warm climate, or at least to follow an occupation in which work is done in warm surroundings. For those who must live in a cold climate and who suffer only slight disability, warm clothing and active exercise may suffice, with priscol as an adjuvant in cold spells. For the more severe cases sympathectomy usually provides substantial relief of symptoms, though it is difficult or impossible to tell beforehand which patients will derive the greatest degree of benefit from the operation.

Vitamin A, Influenza, and the Common Cold

Q.—*Is there any evidence that vitamin A is a good prophylactic or treatment for influenza or the common cold?*

A.—One of the most prominent lesions in experimental vitamin-A deficiency is usually a xerosis of the mucous membranes, including those of the upper respiratory tract, and infections are often superimposed. It might be expected, therefore, that substantial doses of vitamin A would help to prevent influenza and colds. Most of the trials in which groups of normally nourished volunteers have been dosed with extra vitamin A, however, have failed to demonstrate that any benefit is derived. No trials appear to have been made on the value of vitamin-A therapy in reducing the severity of the catarrh and coughs which so frequently follow colds.

Is there a Safe Period?

Q.—*I have been asked to give evidence in court on the following matter: a young man has been accused of being the father of a child. He has denied this, and the girl in question has taken him to court. In the course of her evidence the girl has stated that she had intercourse with the accused on the fifth day of her period. Normally her periods last six or seven days. This is all the intercourse she admits. Is conception possible as a result of coitus during a menstrual period?*

A.—Although conception is unlikely except when intercourse takes place between the 10th and the 18th days of a 28-day cycle, there is evidence that pregnancy has sometimes resulted from single acts of intercourse on any day of the cycle. If, therefore, in this case intercourse is admitted at any time, paternity cannot be said to be impossible. The cycle is not stated, but, if this is less than 28 days, then the chance of pregnancy from coitus on the fifth day would be greater than usual. The fact that the girl was still menstruating at the time does not affect the issue.

Booster T.A.B.

Q.—*I received the usual T.A.B. inoculations five years ago. What is necessary to bring my immunity up to a satisfactory level now?*

A.—The original course of T.A.B. vaccine should have established a good basal immunity. If the inquirer is going to an area where typhoid is common, or wishes to have his immunity boosted for any other reason, he needs only one additional dose of 0.5 ml. of T.A.B. vaccine. He should, however, remember that artificial immunization does not guarantee complete protection, and all hygienic precautions should be taken against the risk of enteric infections.

Pros and Cons of Spinal Analgesia

Q.—*What are the principal indications and contraindications for spinal analgesia?*

A.—Spinal analgesia is used by some for pain relief alone when other methods of analgesia would be either less safe or less efficient. The burly seaman who is to have, say, a hernia repaired is an example, for such a patient may tax the resources of the anaesthetist if simple inhalation anaesthesia is chosen. Spinal analgesia is more usually indicated when profound muscular relaxation is necessary for the operation and when it is considered that this state cannot be produced more safely by other means. This indication includes the whole field of extensive abdominal and pelvic surgery in fit patients, although the former supremacy of this method is now challenged by the relaxants.

There are two general contraindications to a spinal. One is any difficulty or uncertainty in providing perfect asepsis of the patient's skin or the instruments. The other is any anxiety about the general state of health of the patient. Spinal analgesia has its best use in the robust. Many other more specific contraindications to spinal analgesia have been given, but the following meet with fairly general agreement: (1) Patients who have a large abdominal tumour which restricts movement of the diaphragm. Superimposed intercostal paralysis here may lead to grave respiratory difficulty. (2) Extensive lung disease contraindicates the method, because respiratory efficiency is inevitably lowered by spinal analgesia. These patients are better off with general anaesthesia, where temporary respiratory difficulty can be countered by the anaesthetist. (3) Patients with a past history of coronary disease or angina are poor subjects for high spinal analgesia on account of the fall in blood pressure. An E.C.G. which reveals myocardial damage should preclude spinal analgesia. (4) The low blood pressure likely to occur during a spinal probably precludes this method in patients with poor excretory function. The patient suffering from latent uraemia may not be able to afford to exist for one or more hours without kidney function.

Boiled or Raw, Sir?

Q.—*Which is more digestible—a raw egg or one lightly boiled?*

A.—Cooked eggs appear to be more readily digested than raw eggs, which tend to escape digestion in the stomach and to pass unchanged into the duodenum. The value of raw eggs in feeding patients unable to retain other food probably depends on their small activity in stimulating the digestive processes of the stomach. In work with rats raw egg-white has been found to contain avidin, an antivitamin which immobilizes biotin and causes skin lesions and a characteristic hunched attitude. Some caution may therefore be necessary if large quantities of raw egg have to be given to patients over long periods. At the present stage of our knowledge, however, theoretical considerations should not perhaps be allowed to influence methods of giving eggs which have been found by long-established practice to give satisfactory results. There would seem to be no good reason either to give raw eggs to patients capable of eating an ordinary diet or to refrain from giving them to those who are unable to tolerate other forms of food.

Pigeon Chest

Q.—*How may the development of pigeon chest with Harrison's sulcus be prevented? Is there any treatment for the deformity once it has developed?*

A.—The cause of pigeon chest is uncertain. Many still believe that it is due to rickets or respiratory obstruction. If it is due to rickets, the method of preventing and treating the condition—namely, by vitamin D—is obvious. Brodkin (*Pediatrics*, 1949, **3**, 286), however, has presented evidence that it is due to a congenital abnormality in the attachment of the diaphragm. If this is the case, prevention is impossible, and no treatment is likely to be of value.

All communications with regard to editorial business should be addressed to THE EDITOR, BRITISH MEDICAL JOURNAL, B.M.A. HOUSE, TAVISTOCK SQUARE, LONDON, W.C.1. TELEPHONE: EUSTON 2111. TELEGRAMS: *Aitiology, Westcent, London.* ORIGINAL ARTICLES AND LETTERS forwarded for publication are understood to be offered to the *British Medical Journal* alone unless the contrary be stated.
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