of cysticercosis may be difficult. It is important to establish the history of possible exposure. Excision and examination of the subcutaneous nodules which may be present may lead to the identification of the larval stages of the worm. It may be necessary to examine the whole body, including the head, by radiographs in order to identify the shadows of calcified cysts.

Boy or Girl?

Q.—*A well-developed healthy child was noticed at birth to have no scrotum. The child is now 3 months old. The penis and prepuce are well developed, slightly larger than usual for the age, but the skin posterior to the penis is smooth, and shows a slight dimpling in the middle line with a faint outline on the skin suggesting a vulva. No testes can be felt. How should the sex be established? What treatment is advised?*

A.—If there was a maldevelopment of the penis and urethra, such as hypospadias, one would be more concerned with the possibility of pseudohermaphroditism. As, however, these appear to be normal it seems more likely that the condition is one of congenital defective or delayed development of the scrotum. In such a case I have seen the scrotum develop adequately after daily local inunction of 1 g. testosterone ointment (containing 25 mg. testosterone propionate to the gramme) for several weeks. If a scrotal sac is thus developed, it is not unlikely that the testicles will descend into it, but if not injections of gonadotrophins might be considered at a later stage.

Speaking more generally, if the sex is in doubt, the only sure way of establishing it is to do a biopsy of the gonads. Where they are not externally palpable an abdominal laparotomy will be necessary.

Multiple Myelomatosis

Q.—*What are the latest views on the aetiology, treatment, and prognosis of multiple myelomatosis?*

A.—It is generally agreed that multiple myelomatosis is a malignant neoplasm arising in bone-marrow, histogenetically related to the myeloid leukaemias and to the lymphoid tissue tumours. The cell type involved is believed to be an abnormal plasma cell. As in malignant disease generally, the aetiology is unknown, and there is no satisfactory evidence that chronic infections, trauma, or exposure to any known irritants act as predisposing factors.

Multiple myelomatosis is always progressive and fatal. The average duration of life is three years, but some cases survive 10 years. Spontaneous remissions lasting several months may interrupt the progress of the malady, and in some cases the patients can lead almost normal lives for a large part of the course. Death is usually due to complications such as renal failure, chronic urinary infection supervening on compression paraplegia, intercurrent respiratory infections associated with chest deformities and multiple rib fractures, progressive anaemia, and sometimes haemorrhagic states.

There is no specific treatment. Apart from the treatment of the various symptoms as they arise—for example, excision of growths encroaching on the spinal cord and nerves with resulting relief of paraplegia, or chemotherapy for intercurrent infections—radiotherapy offers the best chance of relieving pain, and may be given repeatedly in short courses to successively painful sites. When the pains become generalized and no longer within the scope of radiotherapy, some patients gain temporary relief from such drugs as stilbamidine isethionate, urethane, oestrogens, nitrogen mustards, and radioactive phosphorus, the use of which requires close supervision, but in most cases these substances are of little help and may induce unpleasant side-effects. The particular circumstances of each case require careful consideration before prescribing a course of one of these drugs. Thus stilbamidine is said to be most effective when given in conjunction with a low-protein diet, which is clearly not desirable for a debilitated patient. Stilbamidine is also contraindicated if renal function is impaired, which is frequently the case. The injections cause sweating, tachycardia, and vasodilatation, and a common delayed effect is anaesthesia of trigeminal distribution. Stilbamidine is therefore best avoided until other methods have been tried. Urethane may be given orally for long periods but often causes depression, anorexia, nausea, and vomiting. Like nitrogen mustard and radioactive phosphorus it induces leucopenia, and when these drugs are used repeated blood counts, including differential leucocyte counts, are a necessary accompaniment of treatment.

NOTES AND COMMENTS

Fatal Wasp Stings.—Dr. A. M. WOOLMAN (Switzerland) writes: In the answer to the question on wasp stings ("Any Questions?" November 17, 1951, p. 1231), treatment with ephedrine or *iso*-propyl-*nor*-adrenaline and an antihistaminic is recommended. It does not appear to be widely known that the intravenous injection of a calcium salt can be as dramatic in affording relief as the injection of a preparation of the adrenaline type. In view of the dangers associated with intravenous injections of adrenaline derivatives, this method deserves wider recognition. Continental doctors are more calcium-minded than British doctors, and several reports on the calcium therapy of bee, wasp, and hornet stings have appeared in Continental literature. Some striking cases are described, for instance, by Schapschal, Serjakoff, and Kifaloff (*Schweiz. med. Wschr.*, 1940, **70**, 374). They employed the double salt of calcium gluconate and calcium lactate, and recommend intravenous injection of 10 ml. of the 10% solution.

OUR EXPERT writes: In my answer I emphasized the value of adequate subcutaneous adrenaline and intravenous aminophylline in the treatment of severe anaphylactic (allergic) reactions to wasp stings. The literature to which Dr. A. M. Woolman refers can be read in a summarized form in English in "The Emergency Treatment of Bites and Stings with 'Calcium-Sandoz,'" issued by Sandoz, Ltd. (Switzerland). The results recorded are certainly quite striking, as Dr. Woolman points out. The value of calcium therapy in allergic conditions is debatable and has been the subject of much attention over many years, and on this subject Dr. R. A. Cooke, one of the leading American authorities on allergy, writes: "First the blood calcium was said to be low in allergy, and when this was disproved it was then claimed that the amount of ionized calcium was too low. When this was not verified the idea was put forth that the ratio of calcium to other bases as potassium and sodium was abnormal. Actually there is no evidence that there is any disturbed calcium metabolism or that calcium therapy by mouth or vein has any effect on any allergic reaction" (R. A. Cooke, *Allergy in Theory and Practice*, 1947, p. 548, London). Dr. L. Tuft, another leading American authority on allergy, writes: "In spite of the absence of adequate laboratory or even clinical proof of its efficacy in allergic conditions, calcium therapy still is employed extensively in treatment of such allergic conditions as urticaria, angioneurotic oedema, and serum disease. Its value is doubtful" (L. Tuft, *Clinical Allergy*, 1949, p. 124, London). My personal experiences with intravenous calcium in acute allergic episodes of the angioneurotic oedema type have not been in any way so consistently or dramatically beneficial as is suggested by the literature to which Dr. Woolman draws our attention. I regret I cannot support Dr. Woolman. May I also comment on "Continental doctors are more calcium-minded than British doctors"? This is certainly not my impression from recent visits to the Continent, although my experience is, of necessity, limited to individuals especially interested in allergic conditions, individuals, I may add, of international fame.

Correction.—The name of Dr. N. W. Rawlings, who has been promoted to Commander (Brother) in the Venerable Order of the Hospital of St. John of Jerusalem, was omitted from the list of promotions in, and appointments to, the Order published in the *Journal* (January 19, p. 160).

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