The distinction between the two types depends entirely upon the radiological appearance. The pathological differences show that the walls of the saccules do not contain cartilage, whereas those of the cylindrical type do, but the probability is that a saccule is a dilated terminal bronchiole which does not contain cartilage in its normal state, and in the cylindrical cases dilatation is in the larger bronchi, which, of course, normally contain cartilage.

Antibiotics in Renal Tuberculosis

Q.—*What regime of antibiotic therapy is advised for cases of renal tuberculosis? What are the chances of drug resistance developing, and how is it best avoided?*

A.—Although antibiotic therapy forms part of the treatment of almost every case of renal tuberculosis it must not be assumed that it has replaced nephrectomy as the main curative measure. When there is a cavity demonstrable by radiography the lesion will not heal under antibiotics alone. The cases most suitable for antibiotic therapy without nephrectomy are those of "tuberculous bacilluria" where no lesion can be demonstrated on either side, those with minor unilateral disease showing minimal pyelographic changes, and those of bilateral disease affecting both sides equally, for which surgery is contraindicated. Streptomycin should also be given as a pre-operative and post-operative measure to patients who undergo nephrectomy.

The usual regime is 0.5 g. of streptomycin by intramuscular injection twice daily up to a total of 90 g.; the total amount should be reduced if vestibular symptoms appear. Alternatively a single dose of 1 g. every third day has been used, and improved results have been claimed from the prolongation of the course. Potassium citrate, in sufficient quantity to keep the urine alkaline, aids the action of streptomycin. Bacterial resistance to the drug does develop in a number of cases; it may be avoided or delayed by giving P.A.S. concurrently with the streptomycin in doses increasing to 4 g. three times a day. Rest, a liberal diet, and an approach towards a sanatorium regime will also aid healing. Treatment should be continued for at least six months and progress checked by monthly examination of the urine and six-monthly excretion urograms. Cystoscopy, when necessary, should be done under streptomycin cover.

Treatment of Homosexual Tendencies

Q.—*I have a male patient, aged 18, who has noticed for several years that his interests have been more akin to those of a girl than a boy. This tendency extends to his sexual interests, in that he is more attracted to men than to women, but is more at ease in the company of the latter. His primary and secondary male sexual characteristics seem to be fully developed. Can anything be done to help?*

A.—An expert psychiatric opinion is always necessary before deciding whether homosexual tendencies which persist well after puberty represent a reversible or an irreversible disposition. A psychiatrist usually finds that narco-analytical exploration on one or more occasions is of the greatest help in enabling him to make a decision. Even if it appears unlikely that analytical psychotherapy would be successful in effecting a thoroughgoing reorientation, skilled psychotherapy can always be counted on to help the patient to make a satisfactory social and moral adjustment to his disability.

Unusual Reaction to a Strychnine Tonic

Q.—*A man of 64 was given a tonic containing 1/27 gr. (2.4 mg.) strychnine to the 1/2 oz. (14 ml.). Within two minutes of taking the medicine he complained of generalized itching all over, went outside, and collapsed, where he was found ten minutes later unconscious and foaming at the mouth. One hour later I saw him; he was cold, pulse 50 to 60 a minute, of rather poor volume, his reflexes were present and his plantar response flexor. He came round fairly quickly and his arms gave one or two "jerks." Later in hospital I could find no gross disease: blood pressure 150/100. He did the same thing apparently on "metatone," which contains even less strychnine. He did not look like textbook strychnine poisoning: what was it?*

A.—An overdose of strychnine gives rise to symptoms quite different from those described in the question. The picture closely resembles the manifestations seen in patients who are hypersensitive to a drug—that is, symptoms represent an allergic response: some, if not all, of the symptoms are due to histamine release. Several observers have recently recorded this type of reaction to injections of procaine penicillin, but almost any organic compound may act as a sensitizing agent. The standard textbooks do not describe similar cases to the one recorded in the question, and it must be very rare for strychnine to behave in this way.

NOTES AND COMMENTS

Dangers from the Use of Relaxants in E.C.T.—Dr. N. F. COCKETT (Coventry) writes: I hope that my temerity may be pardoned, but I would disagree with your expert in the answer given to a query about the dangers attached to the use of muscle-relaxants and intravenous barbiturates for E.C.T. ("Any Questions?" May 2, p. 1005). It is stated that the only risk is from respiratory arrest, but I should have thought that there was also a real danger of regurgitation of stomach contents. Regurgitation and vomiting are among the commonest causes of death under anaesthesia, as has been shown by a recent survey carried out by the Society of Anaesthetists, and an excellent article by Morton and Wylie[1] contains a few points on this subject worth perusal. These authors point out that the use of relaxants and thiopentone can lead to regurgitation, since the relaxation produced allows stomach contents to flow out by gravity, and they also list a number of conditions leading to the presence of material in the stomach, some of which obtain in patients attending for E.C.T. These are as follows: food and drink given prior to induction (is it not necessary, therefore, to make sure that the patient has had no food for at least four hours prior to the proposed E.C.T., not even "just a cup of tea"?); and prolonged emptying time of stomach, which may be due to emotional stress, which is surely not uncommon in patients attending for E.C.T., or to pyloric obstruction, which is a sufficiently common condition to warrant a few preliminary inquiries about any "history" which might lead one to suppose that this was present. In view of all this, would it not be advisable before embarking on the use of relaxants and barbiturates in any particular case to make as sure as possible that the stomach is empty, and to have at hand facilities to deal with regurgitation should it occur—namely, an efficient mechanical sucker, a laryngoscope, and endotracheal tubes?

REFERENCE

[1] *Anaesthesia*, 1951, **6**, 190.

Correction.—The price of *Polyglot Medical Questionnaire*, by S. Chalmers Parry, is 12s. 6d., not 18s. 6d. as stated at the head of the review published in the *Journal* of May 16 (p. 1092).

Acknowledgments.—The portrait photograph of the Queen facing p. 1207 is by Dorothy Wilding. On p. 1213 the photograph of the Queen laying the memorial stone at the Royal College of Surgeons is a *Daily Herald* copyright photograph, and that taken at St. Hyacinthe Hospital is a Canadian official photograph. Barratts Photo Press Agency supplied the picture taken at the Royal College of Surgeons in 1951, the Graphic Photo Union that taken at the Royal College of Obstetricians and Gynaecologists, and the "Topical" Press Agency Ltd. that taken in Nairobi.

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