Headache after Ephedrine

Q.—*Recently a long-standing asthmatic has begun to have severe frontal headaches after taking ½ to 1 gr. (32 to 65 mg.) of ephedrine. What is the explanation of this and its treatment?*

A.—Headaches sometimes accompany or follow asthmatic attacks, especially if severe, but presumably this patient's headaches are definitely related to ephedrine. Headache is one of the many side-effects which may occur with ephedrine. Usually such side-effects are the result of overdosage, but very occasionally even the smallest dose causes upsets.

Aminophylline, 0.2 g. by mouth, might be tried instead of ephedrine, or an inhalant such as isoprenaline sulphate compound spray (*N.F.*). Preparations which are usually well tolerated are those which combine small doses of ephedrine with phenobarbitone or some other barbiturate and theophylline. Methylephedrine, which is less effective but has fewer side-effects than ephedrine, has also been recommended in such patients.

Congenital Dislocation of the Hip

Q.—*(1) What are the chances that the children of a parent with bilateral congenital dislocation of the hip will be similarly affected? (2) Is pregnancy likely to worsen the condition of a patient with this condition? Is caesarean section helpful in such cases? (3) What percentage of affected children can be cured if treatment is begun at the earliest possible moment?*

A.—(1) The chances are very remote that a man with congenital dislocation of the hips will father children similarly affected. The chances that a woman with this disorder will produce offspring whose hips are congenitally dislocated are, however, quite real. The exact incidence of direct inheritance of this disorder has not yet been worked out, but in parts of the world like one area in Brittany, where congenital dislocation of the hips is very common, direct inheritance appears to be almost the rule. The risk of transmitting congenital dislocation of the hips in Britain is certainly not great enough to deter potential parents from raising a family.

(2) Pregnancy is not likely to worsen the condition of a patient with congenital dislocation of one or both hips. The need for caesarean section in such patients will be determined entirely by the degree of pelvic deformity which may have resulted. Usually, even in a completely untreated unilateral congenital dislocation, the worst that happens is an oblique contraction of the pelvis on the sound side. This is no bar to a natural, normal delivery.

(3) If treatment of congenital dislocation of the hip is begun within the first six months of a child's life, the result will be perfect in an enormous majority of cases. A very small minority with such additional anatomical peculiarities as dysplasia of the acetabulum, or absence of the head of the femur, cannot, of course, be cured, however early treatment is undertaken. The critical time is when walking begins. If treatment is begun before the child has started to stand and to walk, an excellent prognosis can be given with real confidence. If treatment begins at the age of 2 or later, the prognosis must be much more guarded, though many first-rate cures can be obtained.

Discharge at Corners of Eyes

Q.—*What is the cause of the thin white waxy discharge which collects at the corners of the eyes in some patients, usually men?*

A.—White secretion accumulated at the inner and outer canthus is a product of the mucus and Meibomian glands, together with dust and other debris of which the scavenging is facilitated by eyelid movements. Within limits this discharge should be regarded as physiological. It is slightly commoner in men, because more of them are engaged in dusty occupations; but we should also remember that the average woman is more fastidious than the average man about facial details—that is to say, she is more likely to remove the secreted material before it has accumulated to any conspicuous degree.

Impotence after Excision of Rectum

Q.—*What might be the cause of impotence after a resection of bowel, plus colostomy, for carcinoma a year ago? The patient has now recovered full vigour and leads a very active life. What advice should he be given?*

A.—This question does not specifically state that the patient has had a radical excision of the rectum performed, but if he was left with a permanent colostomy this may be presumed. Seeing that a year has now elapsed since the operation and the patient is stated to have fully recovered his health and vigour, he can no longer be considered to be in the phase of post-operative debility. It seems likely, therefore, that his impotence will prove to be an organic disability of neurogenic origin—that is, due to surgical injury of the nervi erigentes or the pelvic plexuses. According to Goligher[1] this occurs in about one-third of patients after excision of the rectum. The best advice would be to discuss the matter frankly with the patient and explain that this disability should be accepted with philosophic resignation as one of the occasional but unavoidable sequelae of this operation. No special treatment is indicated.

REFERENCE
1 Goligher, J. C., *Proc. roy. Soc. Med.*, 1951, **44**, 824.

NOTES AND COMMENTS

Prognosis After Two Intrauterine Deaths from Rhesus Incompatibility.—Mr. E. A. WILLIAMS (Oxford) writes: I would like to comment on the last paragraph of your expert's reply ("Any Questions?" December 10, 1955, p. 1461). With proper management, despite two previous intrauterine deaths due to hydrops, the outlook for successful pregnancy need not be hopeless, although it is admittedly serious. Last week you printed an account of a patient successfully treated in the Area Department of Obstetrics and Gynaecology at Oxford over five years ago.[1] Since then a further two patients equally in this so-called "hopeless class" have been successfully delivered of healthy children. Nor is this experience unique, and the aggregate of successfully managed pregnancies must be considerable in this country. It is being realized more and more[2] that timely induction offers distinct advantages and has a much wider application than was suggested by earlier reports.[3 4] Finally, I would like to suggest that any patient with this trying problem should at least be aware of the possibility of achieving successful pregnancy with appropriate management. Only she can decide whether it is worth while to try again.

REFERENCES
1 *British Medical Journal*, 1956, **1**, 152.
2 Kelsall, G. A., and Vos, G. H., *Lancet*, 1955, **2**, 161.
3 Mollison, P. L., and Walker, W., ibid., 1952, **1**, 429.
4 Davies, B. S., Gerrard, J., and Waterhouse, J. A. H., *Arch. Dis. Childh.*, 1953, **28**, 466.

Correction.—In the acknowledgments accompanying the paper by Drs. Mary G. McGeown and D. A. D. Montgomery on "Multiple Myelomatosis Simulating Hyperparathyroidism" (January 14, p. 86), Dr. James B. Gibson should have been thanked for the post-mortem examination.

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