

is lasting compared with the temporary protection given by the injection of tetanus antitoxin.

Penicillin-sensitivity

Q.—What is the prospect of a reaction to the parenteral administration of penicillin in a case where glossitis followed the use of penicillin lozenges and a severe dermatitis occurred after the application of penicillin cream and ointment? Would the use of pure penicillin lessen the tendency to reaction?

A.—Glossitis is not necessarily due to penicillin itself; it may be due to the lozenge base, since it appears to be commoner with lozenges than with the original gelatin pastilles. The same explanation is possible, although less likely, in connexion with dermatitis following the use of an ointment or cream. Assuming that the patient is sensitive to the drug itself, the use of pure penicillin is not likely to overcome this; many such patients have been found to be sensitive to the pure product as well as to the impure commercial material. O'Donovan and Klorfajn (*Lancet*, 1946, 2, 144) desensitized a patient by giving 15,000 units by mouth several times a day for a fortnight. If parenteral administration is urgently indicated in such a case it should certainly not be withheld.

Chronic Glaucoma

Q.—What is the best treatment for a male patient of 70 with chronic primary glaucoma? He has been treated with pilocarpine for the past four years, but the vision is deteriorating—the right eye being blind, while there is only some central vision in the left. He refuses surgical treatment.

A.—Pilocarpine is obviously not controlling the tension in this patient. Presumably drops in a concentration of 1% are being used three times a day. More frequent instillation may be helpful, and gutt. physostigmin. sulphas. 0.5%, or even 1%, may have to be used. The essential thing is to find out by actual measurement whether the tension can be controlled by pilocarpine or physostigmine, what concentration is necessary, and how frequently applications are to be made. It is possible that no miotic will control the tension in this patient. In such circumstances the only alternative to operation is irremediable blindness. There are newer remedies that can be employed to tide over an acute emergency. These are useful pre-operative measures, but have no place in the treatment of chronic glaucoma.

Urinals

Q.—Can you recommend a fool-proof urinal for night use in bed? The usual rubber urinal is useless in the recumbent position.

A.—We know of no really satisfactory urinal for use in the recumbent position. Most patients who suffer from incontinence sleep either with a urine bottle between their legs or else with a large pad of cotton-wool. Nothing is said in the question about the cause of the incontinence. If it is due to impairment of sphincter control in the male a penile clip may prove effective. This is a clip which exerts sufficient pressure on the penile urethra to prevent the dribbling away of urine. When the bladder contains enough urine to make it necessary to void, the patient is awakened and micturates.

Sterilization of Syringes

Q.—At a hospital where the water supply contains a large quantity of lime salts, syringes and instruments boiled in the ordinary sterilizers come out covered with a film of precipitated chalk. Can this be prevented harmlessly by adding sodium hexametaphosphate or some other chemical to the water in the sterilizer? Any practical suggestions would be appreciated.

A.—This question is dealt with in "The Sterilization, Use, and Care of Syringes" (M.R.C. War Memo No. 15), where it is mentioned that sodium hexametaphosphate, although preventing chalk deposit, "may precipitate alkaloidal solutions, and, by combining with protein, may affect serum reactions." Since syringes are perhaps more often used either for administering drugs or for withdrawing blood than for any other purposes, these are serious objections. A carboy of distilled water costs only a few shillings and will last a long time; rain-water is a possible alternative.

NOTES AND COMMENTS

Treatment of Cataract.—Dr. SYDNEY TIBBLES (London, W.) writes: Dr. Ronald Kerr (Aug. 2, p. 196) rightly objects to the answer given in the *Journal* of June 21 (p. 911), which implies that any treatment other than surgical for cataract is futile. True, one can only get rid of a mature cataract by removing it surgically from the eye, although in the East they used to depress them out of the line of vision. The late Col. Elliot wrote a book on the evils of "couching" as it was called. For years past fully a quarter of my patients have been people with cataract. Those ready for operation were treated accordingly. However, I have people still coming after twenty and even thirty years' treatment by iodides who still require no operation, which must be the experience of many of my colleagues. There is no secret in it, as years ago we used a French ointment of calcium iodide, but with the cutting off of supplies during the war we either fell back on home products, similarly manufactured, or used potassium iodide as drops, or some similar preparation. We also use iodides in chronic rheumatism, bronchitis, and other conditions, and they appear to be of use clinically. As we hardly know the *modus operandi* of such drugs, nor of the sulphonamides or of penicillin, surely they cannot be condemned as scientifically futile—science presumably meaning systematic, i.e., according to plan, or formulated knowledge. Certainly the proportion of cases I have to operate on is very small compared with the large number of early cataracts seen. The scientists tell us that such changes in the lens cannot be "reversed," which belief I held till one day I met socially an old patient whom I thought had deserted me. She explained that, after years of treatment, she was convinced that she was entirely better, which was borne out at a further examination, when I found that the lenses had become completely clear again. I however had to operate on both eyes when she was in her late seventies, ten years later. Prior to the recent war there were many nature-cure homes in the country that specialized in the treatment dietetically of cataract. In 1938 I had the interesting experience of operating in one of them on a lady with a mature cataract of one eye. She had been kept on orange juice and a low diet, mostly vegetable, but in spite of my scepticism of such treatment by diet she was up and out for a walk at the end of seven days. Now I hold no brief for special diets in such cases, but her blood stream must have been pretty pure. For one patient requiring operation there are myriads who have cataract in various stages. If these can be kept as they are, without being allowed to degenerate further, that must surely be a great comfort to the patient. It certainly is more spectacular to make a blind eye see by means of an operation, but Dr. Kerr is quite right in stressing all the alternatives; and, after all, why should not everything be tried if it will give any relief to the patient? Finally, I hope nobody will get the impression that I am advocating nature-cure methods, as I have had no time for treatment by diets, ionization, or the many things suggested, but have merely used iodides in some shape or form, as, after thirty-odd years of seeing such cases, I am convinced that they do prevent early cataracts from becoming worse. It is very unscientific to say we do not know how, but possibly they act like other alternatives in stimulating metabolism.

Sweating Hands.—Lieut.-Col. S. S. VAZIFDAR, I.M.S.(ret.) (Berkhamsted, Herts), writes: With reference to the reply under the heading "Sweating Hands" (Aug. 16, p. 281), I would confidently recommend, if the young lady's examination be not over, that she be given intravenously 3 ml. of a 10% solution of NaCl. Over ten years ago I saw a girl of 17 from whose palms sweat dripped as water from a tap. The effect of one injection lasted for about a week, when it was repeated.

Correction.—Lieut.-Col. J. G. FOSTER writes: In your obituary notice of the Indian Medical Service (Aug. 23, p. 300) you mention, as a member of that Service, Timothy Lewis, but he was a member of the Army Medical Service, and is shown in Johnston's *Roll*. There is no mention of Timothy Lewis in Crawford's *Roll of the I.M.S.* Lewis's name was Timothy Richards Lewis.

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